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Also available on website @ [https://com-surgery-main.sites.medinfo.ufl.edu/files/2015/08/Surgical_Associate_Manual_16-17.pdf](https://com-surgery-main.sites.medinfo.ufl.edu/files/2015/08/Surgical_Associate_Manual_16-17.pdf)
EDUCATIONAL MISSION STATEMENT

The fundamental mission of the Department of Surgery at the University of Florida is to provide excellence in patient care, research and education. The purpose of the training program in general surgery is to offer a supportive, learner-centered educational environment that maximizes the potential of each surgical resident to become independent practitioners capable of providing the highest quality surgical care. The department is dedicated to this educational mission that also encourages educational innovation and continuous programmatic improvement.

INTRODUCTION

The goal of the surgical residency program is to prepare the resident to function as a qualified practitioner of surgery at the high level of performance expected of a board-certified specialist. The education of surgeons for the practice of general surgery encompasses education in basic sciences, training in cognitive and technical skills, development of clinical knowledge, and maturity in the acquisition of surgical judgment. The educational program uses a variety of educational methods to facilitate learning of the fundamentals of basic science as applied to clinical surgery, including: the elements of wound healing, homeostasis, hematologic disorders, oncology, shock, circulatory physiology, surgical microbiology, respiratory physiology, gastrointestinal physiology, genitourinary physiology, surgical endocrinology, surgical nutrition, fluid and electrolyte balance, metabolic response to injury including burns, musculoskeletal biomechanics and physiology, immunobiology and transplantation, applied surgical anatomy, and surgical pathology.

Professional attitudes highly valued by this program include complete dedication to patient care, the ability to make sound ethical and scientific judgments in the care of patients, a scholarly mind set and dedication to lifelong learning, the ability to work well with others and to become part of a team, and the capacity for hard work with a positive attitude. The residents in this program are expected to teach and share knowledge with colleagues, students and other health care providers. Critical thinking based on a thorough reading of the available literature and respect for the cultural, religious, and individual preferences of the patient and family will be the basis for decisions made that affect the lives of patients. The well-trained surgeon must be aware of the cost and societal implications of decisions and be able to adapt to the evolving health care system in this country. Individuals completing the surgery residency will have the skills to be leaders and valued members of the medical community in whichever setting that individual wishes to practice.
## CLINICAL FACULTY

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<td>Burn</td>
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<td>Loyola University</td>
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<td>Zingarelli William MD</td>
<td>General/GI Assistant Professor</td>
<td>University of Florida</td>
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Surgery Housestaff 2016 – 2017

**BASIC SURGERY RESIDENTS I**
Abitz, Allison
Aguirre-Alarcon, Adela
Bergamo, Jeremy (Urology)
Dersch, Justin
**Elder, Craig**
Falasa, Matheus
Filiberto, Amanda
**Jacobs, Christopher**
Khan, Tabassum
Kuo, Jennifer (Urology)
Mazzuccolo, John (OMFS)
Murphy, Christopher
Pruitt, Eric
Rabley, Andrew (Urology)
Soltani, Tandis
Starnes, Austin
Underwood, Patrick

**BASIC SURGERY RESIDENTS II**
Bashirov, Latif
Cadavid, Felipe (PGY 3)
Cates, Jonathan
Cox, Michael
Dessaigne, Camille
Gray, Sarah
Martin, Andrew
Miller, Elizabeth

**GENERAL SURGERY RESIDENTS III**
Anderson, Tiffany
Ayub, Suniah (LAB/3) Vascular
Brown, J. Christian (LAB/4) Katz
Delitto, Daniel (PGY 6)
Gerber, Michael (LAB/3) Hughes
Go, Kristina (PGY 5)
Hawkins, Russell
Laquian, Liza (PGY 5)
Lysak, Nicholas (LAB/3) Bihoric/Moldawer
Mira, Juan (LAB/4) Moldawer
Raymond, Steven (LAB/3) Larson
Rehfuss, Jonathan (PGY 5)
Yang, Ming-Jim (PGY 5)

**GENERAL SURGERY RESIDENTS IV**
Cunningham, Lisa
Gaillard, W. Foster
Hall, David (Lab/4) Machuca
Kuppler, Christopher (PGY 6)
Loftus, Tyler (LAB/5) Mohr
Mathias, Brittany (PGY 6)
Peters, Charlie
Staton, Kyle (LAB/4) Vascular
Stortz, Julie (LAB/4) Moldawer
Szpila, Benjamin (PGY 7)

**GENERAL SURGERY CHIEF RESIDENTS**
Chen, Sugong (PGY 7)
DeSart, Kenneth (PGY 8)
Raza, Ahsan (PGY 6)
Rosenthal, Martin (PGY 7)
Schmit, Bradley (PGY 7)
Vanzant, Erin (PGY 7)

**PEDICIANTIC SURGERY**
Khan, Faraz (PGY9)

**PLASTIC SURGERY**
Campbell, W. Joseph (PGY 8)
Felice, Peter (PGY 9)

**PLASTIC SURGERY - INTEGRATED**
Buchanan, Patrick (PGY4)
Cohen-Shohet, Rachel (PGY 3)
Ehanire, Tosan (PGY 2)
Prince, Noah (PGY 4)
White, Jared (PGY1)

**THORACIC SURGERY**
Demos, Daniel (PGY6)
Gallegos, Juan (PGY6)
Jeng, Eric (PGY 7)

**VASCULAR SURGERY**
Ayo, Diego (PGY7)
Kim, Moses (PGY9)
Lala, Salim (PGY6)
Voskresensky, Igor (PGY9)

**SURGICAL CRITICAL CARE**
Darrabie, Marcus (PGY8)
Kinnard, Christopher (PGY6)
Murray Casanova, Irina (PGY6)
Watson, Carrie (PGY6)

**ACUTE CARE SURGERY**

*Bold = Categorical*
Administrative Chief Resident
Bradley Schmit, MD

The responsibilities of the administrative chief resident include oversight of the general surgery call schedule (including vacation schedules), resident liaison to the Executive Education Committee, along with other chief residents provides assistance with monitoring of duty hours, and other administrative duties as assigned.

Educational Program at a Glimpse

Graduated Levels of Responsibility

Graduate medical education is based on the principle of progressively increasing levels of responsibility, in caring for patients, under the supervision of the faculty. The faculty is responsible for evaluating the progress of each resident in acquiring the skills necessary for the resident to progress to the next level of training. Factors considered in this evaluation include the resident’s clinical experience, judgment, professionalism, cognitive knowledge, and technical skills. These levels are defined as postgraduate years (PGY) and refer to the clinical years of training that the resident is pursuing. The requirement for training in General Surgery is five years of clinical rotations. At each level of training, there is a set of competencies that the resident is expected to master. As these are learned, greater independence is granted the resident in the routine care of the patient at the discretion of the faculty who, at all times, remain responsible for all aspects of the care of the patient. As a general outline, the PGY I year is devoted to learning the skills necessary to take care of patients on the floor and clinic and includes intensive care unit skills (VA Intensive Care Rotation). In the PGY II year, the resident has increasing clinical responsibilities and operative experience. The VA night float and Trauma rotation provide the PGY II the opportunity to function as a surgical consultant with chief resident and faculty supervision. The PGY III year is a year where the resident is the middle manager on the general surgery services and expands the basic surgical skills. The PGY IV and V years are chief years and when the young surgeon assimilates the clinical and operative skills necessary to practice the specialty. Additionally, the chiefs are expected to assume leadership roles in the administrative and educational objectives of the residency. General responsibilities for each level follow below.

PGY I - Individuals in the PGY I year are closely supervised by senior level residents and faculty. Examples of tasks that are expected of PGY I physicians include: perform a history and physical exam, start intravenous lines, draw blood, order medication and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and faculty, obtain informed consent, place urinary catheters and nasogastric tubes, assist in the operating room and perform other invasive procedures under the supervision of the faculty or senior residents at the discretion of the responsible faculty member. The resident is expected to exhibit dedication to the principles of professional preparation in surgery (see below American College of Surgeon Professional Code) that emphasizes the patient as the focus for surgical intervention. The first year resident must develop and implement a plan of study, reading and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. At all levels,
the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care.

**PGY II** - Individuals in the second post graduate year are expected to perform independently the duties learned in the first year and may supervise the routine activities of the first year residents. The PGY II may perform some procedures without direct supervision such as insertion of central lines, arterial lines, diagnostic peritoneal lavage, proctosigmoidoscopy, chest tube insertion or placement of PA catheters. Second year residents may manage critically ill patients including initial trauma care, ventilator management, resuscitation from shock, and anti-arrhythmic therapy. Residents at this level can perform surgical procedures under the direct supervision of faculty or senior level residents designated as teaching assistants. The PGY II should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in the practice of surgery and further ability to function independently in evaluating patient problems and developing a plan for patient care. The resident at the second year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member. The resident should take a leadership role in teaching the PGY I, and medical students, the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The PGY II should be able to incorporate ethical concepts into patient care and to discuss these with the patient, family and other members of the health care team.

**PGY III** - In the third year, the resident should be competent in the medical management of patients with virtually any routine or complicated surgical condition and of supervising the PGY I and PGY II in their daily activities. The resident is responsible for coordinating the care of multiple patients on the surgical team assigned. Individuals in the third postgraduate year may perform all routine diagnostic and therapeutic procedures including endoscopy with direct supervision. The PGY III can perform progressively more complex surgical procedures under the direct supervision of the faculty. It is expected that the third year resident be adept in the use of the literature and routinely demonstrate the ability to search selected topics and present these to the surgical team. At the completion of the third year, the resident should be ready to assume senior level responsibility as the chief resident on selected services.

**PGY IV** - Individuals in the fourth postgraduate year assume an increased level of responsibility as the senior resident on selected services and can perform the full range of complex surgical procedures expected of a general surgeon under the supervision of the faculty. The fourth year is one of senior leadership and the resident should be able to assume responsibility for organizing the service and supervising junior residents, interns and students. The resident should have mastery of the information contained in standard texts and be facile in using the literature to solve specific problems. The resident will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis. The PGY IV should begin to have an understanding of the role of the surgeon in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians.

**PGY V** - The fifth year surgical resident, under the supervision of the faculty, takes responsibility for the management of the major general surgical teaching services. Throughout the chief year, residents can perform most complex and high-risk procedures expected of a general surgeon with the approval of the attending surgeon. During the final year of training the resident should have
the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice of general surgery. The PGY V gives formal presentations at scientific assemblies and assumes a leadership role in teaching on the surgical service. The mores and values of the profession should be highly developed including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of surgery.

**ALL YEARS** - Residents at every level are expected to treat all other members of the health care team with respect and with a recognition of the value of the contribution of others involved in the care of patients and their families. The highest level of professionalism is expected at all times. Racial, ethnic or cultural slurs are never acceptable. Treat all others with the respect and consideration you would expect for yourself. Ego and personality conflicts are not conducive to good patient care. Long hours and the stress of surgical practice can precipitate conflict. The resident should be aware of the situations where this is likely to happen and try to compensate by not escalating the situation.

Each resident is expected to develop a personal program of reading. Besides the general reading in the specialty of surgery, residents should seek directed reading daily with regard to problems that they encounter in patient care or in the operating room. The resident is responsible for reading prior to performing or assisting in cases that the resident has not yet had the opportunity to see. Residents are expected to attend all conferences at the service and program level. The conference program is designed to provide a didactic forum to augment the resident’s reading and clinical experience.

**BLOCK DIAGRAM OF ROTATIONS**

**PGY I**
The PGY I residents will complete 13 rotations, each of 4 weeks duration. The possible rotations are listed below:

<table>
<thead>
<tr>
<th>Colorectal Surgery</th>
<th>Trauma</th>
<th>Pediatric Surgery</th>
<th>Transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Shands</td>
<td>Shands</td>
</tr>
<tr>
<td>MIS/Upper GI Surgery</td>
<td>Vascular Surgery</td>
<td>Burn Surgery</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Shands</td>
<td>Gainesville VA</td>
</tr>
<tr>
<td>Night Float</td>
<td>Pancreas/ Biliary</td>
<td>I.C.U.</td>
<td>Critical Care</td>
</tr>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Gainesville VA</td>
<td>Shands</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Plastic Surgery</td>
<td>Ambulatory Surgery</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Gainesville VA</td>
<td>Gainesville VA</td>
<td>Lake City VA</td>
<td>Shands</td>
</tr>
</tbody>
</table>

**PGY II**
The PGY II residents rotate about 6 or 7 weeks on each of the following services (unless otherwise specified):

<table>
<thead>
<tr>
<th>Pediatric Surgery</th>
<th>Vascular Surgery</th>
<th>Night Float - VA</th>
<th>Trauma Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Nights</td>
<td>Burns</td>
<td>Ambulatory Surgery - VA</td>
<td>Breast/Endocrine</td>
</tr>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Lake City VA</td>
<td>Shands</td>
</tr>
</tbody>
</table>
PGY III
The PGY III residents rotate for about 10 weeks on each of the following services (unless otherwise specified):

<table>
<thead>
<tr>
<th>Pediatric Surgery</th>
<th>Colorectal Surgery</th>
<th>MIS/PBS Surgery</th>
<th>Thoracic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Shands</td>
<td>Gainesville VA</td>
</tr>
<tr>
<td>SICU - Shands</td>
<td>Clinical Elective</td>
<td>General Surgery</td>
<td>Transplant Shands</td>
</tr>
</tbody>
</table>

PGY IV
The PGY IV/Senior Residents rotate for about 2.5 months on each of the following services (unless otherwise specified):

<table>
<thead>
<tr>
<th>Breast/Endocrine Surgery</th>
<th>Trauma (12 weeks)</th>
<th>Vascular Surgery</th>
<th>MIS/PBS</th>
<th>Community Surgery/ Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Gainesville VA</td>
<td>Shands</td>
<td></td>
</tr>
</tbody>
</table>

PGY V
The PGY V/Chief Residents rotate for about 2.5 months on each of the following services (unless otherwise specified):

<table>
<thead>
<tr>
<th>Colorectal Surgery</th>
<th>MIS</th>
<th>Transplant Surgery</th>
<th>Acute Care Surgery</th>
<th>PBS</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shands</td>
<td>Shands</td>
<td>Surgery</td>
<td>Shands</td>
<td>Shands</td>
<td>VA</td>
</tr>
</tbody>
</table>

**Transfer Protocol**
Transitions in patient care involve a face-to-face discussion between general surgery residents. There is a designated meeting place where these hand-offs occur. If a resident is concerned about a patient’s medical status they will sign out at the patient’s bedside. Chief residents will oversee and participate in all transfers. Residents will use the Department of Surgery Patient Census report to conduct transitions in patient care. The patient census instrument is available online and updated throughout the day and night so that it accurately documents patient management and progress.

Clinical assignments have been designed to minimize the number of transitions in patient care. Transfers are scheduled at 6am and 6pm to accommodate the shift change and take advantage of the brief overlap in schedules. This structured hand-over process has been developed to facilitate both continuity of care and patient safety. Residents are educated about conducting reliable and effective transfer of patient care during orientation. Over time senior residents ensure that junior residents demonstrate competence in communicating with team members in the hand-over process.

**Supervision**
All services must ensure that the attendings provide adequate supervision for all residents. There will be an on call schedule for the attendings on all services and residents should keep the attending informed of all events on the service. When in doubt, it is much better to communicate
up the chain of command rather than not. Residents should be supervised in a way that provides opportunity for the individual resident to assume increasing responsibility for patient care commensurate with their level of training, ability and experience.

**Supervisory Cascade**

The supervisory reporting chain varies by level of training. For each level there are certain expectations about the patient care events and situations that will trigger communication with the individual resident’s supervisors.

For the PGY-5 resident: At all times the supervising physician is the attending surgeon on call for the day. In general this is also the attending who will be operating with the chief resident. For patients in the ICU, the critical care attending on call for the day may also function as a supervising physician.

Because the chief resident is transitioning to independence, this resident always practices under indirect supervision. However, certain expectations exist regarding patient scenarios that will always trigger a call to the supervising physician. These include a patient who needs to go the OR, or a patient who is admitted to the ICU. Major adverse changes in a patient’s course, or the development of life-threatening complications should also trigger a call to the supervisor.

For the PGY-3 resident: From 6 AM to 6 PM the supervising physician for this resident is first the PGY-5 resident followed by either the attending surgeon on call or the ICU attending on call, depending on the location of the patient.

The PGY-3 resident will still require direct supervision for almost all operative procedures, either by the PGY-5 resident or the attending. In some limited circumstances, with advance notification from the attending surgeon, the PGY-3 resident may be allowed to perform operations under indirect supervision. Direct supervision is required of the PGY-3 resident for bedside procedures for which the resident has not demonstrated competence. For procedures that the resident has demonstrated that they can perform competently, indirect supervision is appropriate.

At this level, the majority of patient care activities are performed under indirect supervision, however in circumstances where the trainee is uncertain, a low threshold for seeking a higher level of supervision by the intermediate level trainee is a program expectation. Just as for the PGY-5 resident, certain expectations exist regarding patient scenarios that will always trigger a call to the supervising physician. These include, a patient who needs to go the OR, or a patient who is admitted to the ICU. Major adverse changes in a patient’s course, or the development of life-threatening complications should also trigger a call to the supervisor.

For the PGY-1 resident: At all times the supervisory chain of command is the PGY-3 or the PGY-5 resident first, and then the attending surgeon on call or the ICU attending on call. For patient care activities within their scope of practice, ARNP’s or PA’s may function as the supervisor in lieu of the PGY-3 resident.

At this early stage of training many activities require direct supervision. As stated in the ACGME common program requirements, direct supervision is required until competency is demonstrated for:
A. Patient Management Competencies
1. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and
2. Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
3. Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments

Following the demonstration of competency, indirect supervision for the above activities is acceptable. Just as with other levels of residents operating under indirect supervision, major adverse changes in a patient’s course, or the development of life-threatening complications should also trigger a call to the supervisor.

Direct supervision is always required for:
Management of patients in cardiac or respiratory arrest (ACLS required)

B. Procedural Competencies
1. Advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
2. Repair of surgical incisions of the skin and soft tissues
3. Repair of skin and soft tissue lacerations
4. Excision of lesions of the skin and subcutaneous tissues
5. Tube thoracostomy
6. Paracentesis
7. Endotracheal intubation
8. Bedside debridement
Clinical Rotations
Educational Goals and Learning Objectives

Each service has a number of faculty members, usually 2-5, with whom the resident will work. There is an attending designated as chief of each service who is ultimately responsible for assigning the duties of the residents rotating on that service and defining the educational activities of the service. In addition, it is the responsibility of the faculty to shape the educational experience of the residents on the rotation and to provide day-to-day guidance and feedback depending on the opportunities that present. What follows is a general description of the various services and expected competencies of residents assigned to these services. This is in no way a complete listing but should give each resident a general idea of expectations for each experience. A more comprehensive listing can be found in “Surgical Resident Curriculum” published by the Association of Program Directors in Surgery, a copy of which is in the program director’s office.

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Colorectal Surgery

This Colon and Rectal surgery service (CRS) cares for adult male and female patients of all ages and thus provides the resident staff a broad exposure to Colon and Rectal problems including benign and malignant diseases, and ano and rectal problems, including pelvic floor disorders. The patients come from a broad range of socioeconomic backgrounds and frequently have multiple co-morbidities that provide challenging complexity to their surgical management. There are 3 attending surgeons and one nurse practitioner, a senior nurse and one coordinator on the service. Resident staffing is composed of a PGY 1, PGY 3 and PGY 5 level that rotate on the service. Attending staff makes daily work/teaching rounds. The residents will participate in a weekly didactic, preop and complications conference and are expected to fully participate in all of the departmental conferences and educational offerings. The broad general competencies for surgical resident education as outlined by the ACGME apply to residents at all levels on this rotation:

Patient Care

Clinical Management of Patients with Colorectal Surgical Disease. The resident must demonstrate progressively detailed and complete knowledge and technical ability for the clinical management of colorectal surgical diseases as they progress from the PGY-1 year through the PGY-5 year by the following actions.

General Patient Care:

1) Pre-op assessment is accurate; identifies patients at risk for complications; requests appropriate pre-operative tests and consultation.
2) Recognizes, evaluates and manages post-operative problems and complications promptly and accurately, seeking advice promptly.
a. At the PGY-1 level, the resident should be able to recognize, manage and/or ask for help with post-operative complications such as wound infection, urinary tract infection, and pneumonia.

b. At the PGY-3 level, the resident should be able to manage the patient post-operatively with support and guidance from the chief resident or the attending. The resident should be able to recognize signs of anastomotic leak and be able to manage it.

c. At the PGY-5 level, the resident should be able to run the service, notice, anticipate and manage complications associated with disease process and from the surgery such as anastomotic leak, enterocutaneous fistula and medically complex patients. The resident should be able to lead the team and help the junior residents on the team.

3) Completes order writing and test ordering in a timely fashion.
4) Progress notes accurately reflect patient condition and progress.
5) Discharge summaries completed in timely fashion (i.e. 24 hours).
6) Dictations reflect understanding of patient problems and management.
7) Demonstrate basic skills.
8) Demonstrate technical mastery of appropriate cases:
   a. At the PGY-1 level, this includes simple operative and bedside procedures, such as basic manual skills in operating room, including knot-tying, handling of scissors, scalpel and electrocautery, basic suture techniques, including layered closures, running and interrupted suturing techniques, and subcuticular skin closures, and basic procedures, such as anorectal procedures, and simple operative excisions.
   b. At the PGY-3 level, this includes most colorectal procedures, uncomplicated routine laparoscopic bowel resections and colonoscopies.
   c. At the Chief Resident level, this includes routine and complex colorectal procedures, such as re-operative colon procedures, complex laparoscopic colon and pelvic resections.

Medical Knowledge
Disease Processes Included in Colorectal Surgery
The residents must gain progressively detailed and complete knowledge of the pathophysiologic processes associated with each of these disease processes, as well as the diagnosis and treatment of each, as they progress from the PGY-1 year through the PGY-5 year. They must be able to recite the anatomy, pathophysiology and relevant management for the diseases treated in colorectal surgery including:

1) Epidemiology, preventive screening, signs/symptoms, work-up, staging and current treatments for colon cancer and rectal cancer.
2) Epidemiology, signs/symptoms, findings, clinical evaluation, treatments and complications of diverticular disease.
3) Clinical presentation, histological findings, work-up, and current options for treatment of inflammatory bowel disease, ulcerative colitis, including indications for and complications related to restorative proctocolectomy.
4) Clinical presentations, work-up, histopathology, complications, and indications for operation in patients with Crohn’s disease.
5) Genetic basis, clinical course, evaluation and current treatment and counseling of patients with familial cancer syndromes: familial adenomatous polyposis (FAP), Gardner syndrome, Turcot syndrome, hereditary non-polyposis colorectal cancer (HNPCC).
6) Management and potential complications of ileostomy and colostomy.
7) Epidemiology, clinical presentation, histology, work-up and current treatment for other polyposis syndromes- Peutz-Jeghers polyps, Cronkhite-Canada syndrome, juvenile polyposis.
8) Causes, classification, complications, treatment options, and indications for operation for hemorrhoidal disease.
9) Pathogenesis, presentation, current treatments for anal fissures, anal fistulas, perianal and perirectal abscesses.
10) Symptoms, clinical findings, evaluation and current treatments for pelvic floor disorders such as fecal incontinence and rectal prolapse.
11) Symptoms, causes, work-up, and current treatments for large and small bowel obstruction, including volvulus.
12) Viral warts (condylomata.)
13) Pathogenesis, evaluation and treatment options for premalignant anal conditions, such as anal intraepithelial neoplasia (AIN I-III), and anal Paget’s disease.
14) Diagnosis and treatment options for malignant anal disease.
15) Etiology and treatment of hidradenitis suppurativa
16) Etiology, complications, and surgical treatment of pilonidal disease.

Other General Surgery and Critical Care for PGY-3 and PGY-5 residents:
1) Assess patient status and/or change in patient condition, and formulate a plan to treatment. Recognizes when deterioration of patient condition requires transfer to SICU.
2) Indications for, uses and characteristics of various suture materials, including absorbable and non-absorbable, in various clinical settings.
3) Appropriate use of prophylactic antibiotics in surgery.
4) Recognize and treat wound complications, including infection and hematoma.

At the PGY-1 level, the resident is expected to understand the indications for various types of colon and rectal procedures including ano-rectal procedures.

At the PGY-3 level, the resident is expected to understand; to appreciate major steps involved in various colon and rectal procedures; to recognize risks and benefits involved with various procedures and advise patients on what to expect with each procedure post-operatively.

At the PGY-5 level, the resident is expected to understand, to know the steps of colon and rectal surgery; to anticipate the pre-operative requirements and to order appropriate work up of each disease.

Practice-based Learning and Improvement
Residents at all levels must demonstrate particular familiarity with the scientific information pertinent to their patients’ care. In addition, they must be able to evaluate the level of evidence supporting that knowledge. The venues for acquiring, disseminating and demonstrating this knowledge are individual reading, and regular conference attendance/participation. The weekly Conference and the Morbidity and Mortality Conference, in particular, are designed to provide
venues for specific discussion of individual patient care issues, and critiques of the practice outcomes. Patients discussed at the Morbidity and Mortality Conference are presented by the resident most directly involved in the care related to the complication, who also leads discussion of this aspect of care. These activities are designed to promote habits of lifelong learning and improvement through reading, professional activities and reflecting on patient experiences.

All PGY levels are expected to attend all the conferences. PGY-3 and PGY-5 residents are expected to be able to present the patient at the tumor board conferences. All residents are expected to prepare and present patients at the pre-operative conferences each week. PGY-3 resident should be able to teach the medical students while the PGY-5 resident should be able to teach the junior residents. Additionally, the PGY-5 resident should keep up with current literature in patient care and be able to use technology to answer clinical issues.

**Interpersonal and Communication Skills**
The residents at all levels on the service are all required to consistently communicate with patients, families, and other health care professionals. The quality, quantity, and attitude of communication are all important, via both verbal and written routes. Written documentation is especially critical for documenting patient care for ongoing cooperative management. This is central to the care of both patients on the service, and patients who are evaluated and followed as consult patients. Active monitoring of the timeliness of medical record documentation must demonstrate compliance with Office of Clinical Affairs guidelines.

All levels of residents must:
1) Work in a cooperative manner with other health care personnel, being sensitive to their roles and abilities
2) Give and receive advice in a manner that is consistent with the harmonious operation of the health care team
3) Communicate with patients and their families, explaining recommendations to them in terms each individual can comprehend
4) Respect patients’ rights to privacy
5) Respect the sexual, moral, ethical, or religious characteristics of the patient and family, and other members of the healthcare team.
6) Understand the special psychological needs of the colorectal patient.

Additionally, PGY-3 and PGY-5 residents are expected to be able to answer questions from the family and be able to communicate with physicians from other services who are requesting consults or with whom the service has requested consult.

**Professionalism**
The residents on the service must each maintain the highest standards of ethical behavior, with a commitment to continuous, high quality patient care. The professional behavior extends to all patient care interactions, including patients on the service, and those evaluated as consults, and to all interactions with other healthcare professionals. The residents must demonstrate sensitivity to the diversity of ages, genders, cultures, and relationships.
The professionalism expected also encompasses the individual professional behavior necessary to maintain the function of the hospital and training program, including timely medical documentation, completion of licensing and credentialing requirements, documentation of work-hours, and adherence to the ACGME Duty Hours requirements.

The residents at all levels must demonstrate:
1) An appreciation of the ethical and legal aspects of colorectal surgery.
2) Honesty, reliability, and respectfulness in working with patients and colleagues.
3) Dress neatly and appropriately when working with patients in all settings.

**Systems-based Practice**
The residents must access the health system resources necessary to practice high-quality, cost-effective patient care. This includes understanding the roles of various specialists and other health care professionals in the care of their patients. The residents must fulfill their important role in the care of patients on other services that are evaluated and followed as consult patients. They should understand the ways that their recommendations and timely communication affect the function of the medical center.

The ability of the residents to utilize the health system resources is demonstrated in the daily care of the patient, and evaluated in daily attending contacts and conferences.

The resident at all levels must:
1) Demonstrate an understanding of how the health system functions to manage patients.
2) Discuss roles that support services, such as pharmacy, security, and social work, physical therapy and enterostomal therapy.
3) Coordinate patient care including obtaining tests and scheduling elective and emergency procedures.
4) Request and use consultations appropriately.

**Resident Responsibilities in Clinic:**

Dr. Tan’s Clinic begins at 8:30 am on Wednesday, Dr. Iqbal’s clinic begins 8:30 am on Monday and Thursday. All patients are seen by and/or in conjunction with attending staff.

Dr. Tan’s OR days are Monday and Thursday at the South Tower and 1st Friday and 3rd Tuesday of the month at FSC. Dr. Iqbal’s OR days are Tuesday and Friday at the South Tower and every 2nd (all day) and 4th (afternoon only) Wednesday at FSC.

**Documentation Format:**

All clinic/progress notes/letters should be done using the CRS template. They can be found under “ufp amb sur crs”. There are over multiple templates including one for progress note for floor, progress note for ICU and discharge summary. Orders are under bowel resection order set. All the patients who return to clinic for pre-op appointment needs a full H&P and not a short SOAP note in clinic. Some patients who are returning for post-op and pre-op must have a full H&P and not a simple SOAP post-op note. If you are not sure about a note, write a full H&P
note. Please use templates whenever possible so that we can have correct documentation regarding risks and benefits that were discussed.

At the time of discharge, patient’s problem list must include updated problems and diseases present on admission including smoking history and BMI. There should be reason why the patients stay in house (example: Patient was kept NPO on POD#1 and advanced to clear on POD#2. Patient was kept on clears awaiting return of bowel function and was advanced to regular diet on POD# 4). Just stating no complication and patient stayed until POD# 5 does not document fully why the patient stayed for that many days.

Please note that on this service a Progress note MUST be written even on the day of the discharge as decision is made on that day to discharge the patient. Writing a discharge summary is not adequate documentation for the day.

Especially on the inpatients, prior to discharge, please check and add the referring physicians, primary care outside of the hospital and if applicable who their gastroenterologist is for continue care after discharge.

**Pre-Operative Consults:**

Complete consult requisition and notify the Clinical Care Coordinator that patient requires cardiology consult (general medicine Pre-Op, Cardiology, Pulmonary, etc.)

**Patients Who Require a Cardiology Consultation:**

Patients with suboptimal disease management are referred to pre-operative cardiology consultation unless patient has a previous cardiologist.

**Patients who DO NOT Require a Consultation:**

1. Patients with well controlled hypertension
2. Patients with prior cardiac disease (post- CABG, etc.) that are asymptomatic
3. Patients with a history of heart palpitation but an otherwise normal (with appropriate documentation of stable disease per referring or primary care physician).

**Guidelines for Pre-operative Medications:**

Take: Cardiac medications, seizure meds, anti-hypertensive agents, bronchodilators, L-thyroxine steroids, immunosuppressives, eye drops for glaucoma (patient needs to tell Anesthesia)

DO NOT take: (unless told by surgery/anesthesia) Aspirin (stop 7 days in advance), NSAIDs, Vitamin E (stop 7 days in advance), Insulin, Oral hypoglycemic or other over the counter herbal medications, diuretics.

Birth control pills may increase the risk of DVT. Discuss with patient and individualize depending on the procedure.

Pre-operative antibiotic prophylaxis should be ordered at time on H&P, to be given in holding room one hour before procedure. Pre-operative orders should be printed out the night before and filled out. The antibiotic of choice is Ceftriaxone 2 grams and Metronidazole 500 mg
unless the patient has penicillin allergy. In which case, the antibiotic of choice is Ciprofloxacin 400 mg IV and Metronidazole 500 mg.

Enterag must be ordered pre-op for lap vs open small and large bowel resection patients who are not on narcotics previously. Order must be placed using “crs bowel resection order set.” Enterag is given until POD#5 or return of bowel function whichever is earliest.

**DVT Prophylaxis:**
Sequential Compression Device (SCD) is preferred and INDICATED if prior history of DVT, venous disease, Obesity, age> 60, long or laparoscopic procedure, patient with cancer.
SCD’s are not necessary for brief procedures
Heparin 5000 units’ subcutaneous injection prior to surgery
Hold anticoagulation (heparin/Lovenox) for patients who have epidural placed prior to surgery

**Cardiac Prophylaxis:**
Beta-blockers if no contraindications or on call to OR.

Revised by Dr. Tan on 5/31/16

**MIS/Upper GI Surgery**

**Patient Care:**
1) Residents will be expected to perform preoperative assessment of patients and demonstrate an understanding of the management options, indications, contraindications, and complications associated with the recommended procedure.
2) Residents should demonstrate understanding of and ability to order, integrate and interpret perioperative testing and evaluation of all organ systems as related to advanced GI surgery.
3) Residents will demonstrate intraoperative decision-making that minimizes complications and demonstrates an awareness of the limitations of his/her technical skills.
4) Residents will demonstrate knowledge of anatomy of the GI tract and the abdominal cavity, including as viewed through MIS access, both normal and abnormal.
5) Residents will demonstrate knowledge of a variety of approaches (both operative and non-operative) to a given GI tract disease and exhibit reasoning to arrive at the correct procedure for a given patient.
6) Residents will demonstrate expertise in interpreting anatomic and physiologic studies of the GI tract and abdominal cavity relevant to their areas of expertise.
7) Residents will demonstrate fundamental MIS competency relevant to their area of expertise. These would include some or all of the following:

**PGY1:**
- preoperative preparation (positioning, knowledge of necessary equipment, bowel prep); evaluations of cardiopulmonary system, age, body habitus
- exposure
- retraction
- tissue handling
- camera navigation
- two-handed manipulation
- port-site placement
- alternative access techniques
- use of angled scopes
- vascular control and algorithm for control of bleeding
- knot-tying ability, both hands, intracorporeal and extracorporeal
- decision to convert a laparoscopic procedure to an open operation

**PGY3:**
- laparoscopic cholecystectomy (anatomy, indications, intraoperative troubleshooting, postoperative care)
- laparoscopic and open hernia repair (anatomy, indications, intraoperative troubleshooting, postoperative care)
- suturing
- stapling
- intracorporeal anastomosis

**PGY 5:**
- suturing
- stapling
- intracorporeal anastomosis
- adhesiolysis
- running of bowel
- demonstrates knowledge of energy sources
- placement and fixation of prosthetic material

*Residents will also acquire skill in diagnostic upper flexible endoscopy.*

**Medical Knowledge:**
1) Residents will be expected to demonstrate understanding of the anatomy, physiology and pathologic conditions of the entire GI tract, abdominal cavity, abdominal wall, and solid organs in the abdominal cavity and retroperitoneum with strong emphasis to foregut pathology.
2) Residents will demonstrate an understanding of the surgical and nonsurgical options for managing pathologic conditions of the entire GI tract, abdominal cavity, abdominal wall, and solid organs in the abdominal cavity and retroperitoneum.
3) Residents are expected to be able to appropriately order, read, and interpret diagnostic tests and images.

**Practice-based Learning and Improvement**
1) Residents will remain diligent in updating their knowledge with regard to advances in allied health disciplines.
2) Residents will demonstrate an ability to access multiple resources for obtaining timely evidence to guide patient care decisions and be able to explain their decision-making rationale.
3) Residents will demonstrate ability to perform a detailed assessment of their patient care practice and be able to identify best practices and areas for improvement.

4) Residents will be engaged in the education and training medical students, where appropriate.

5) Residents will seek and accept constructive feedback concerning their practices.

6) Residents will use feedback from faculty and their own self-assessments to develop a plan for filling gaps in knowledge or skills.

7) Residents will learn the basics of practice management to include billing and coding for operative procedures, where relevant.

8) Residents will actively participate in bench, clinical, or basic science research as it applies to their situation.

**Interpersonal and Communication Skills**

1) Residents will provide concise and accurate communication of clinical information both in verbal and written form.

2) Residents will demonstrate effective communication with patients and family members in a manner that creates and sustains a professional and therapeutic relationship across a broad range of socioeconomic and cultural backgrounds.

3) Residents will demonstrate a caring attitude toward patients and families.

4) Residents will effectively explain working diagnoses and management.

5) Residents will demonstrate ability to effectively communicate with physicians, other health professionals and health related agencies about patients’ problems.

6) Residents will maintain comprehensive, timely and legible medical records.

**Professionalism**

1) Residents will display compassion and respect for all patients even under difficult circumstances.

2) Residents will treat all members of the health care team with respect regardless of their level of power or influence.

3) Residents will advocate for patients’ needs and desires even if they differ from the resident’s views.

4) Residents will take personal responsibility for the timely completion of all assigned work and medical records.

5) Residents will demonstrate the importance of teamwork by assisting colleagues in need.

6) Residents will demonstrate honesty in their interactions with patients and team members by practicing full disclosure of information with their patients, admitting and disclosing patient care errors, and admitting weaknesses as well as knowledge gaps.

7) Residents will demonstrate respect of patient confidentiality and the importance of best practices for insuring optimal care in the clinical setting.

**Systems-based Practice**

1) Residents will demonstrate understanding of new technologies and their role in the care of their patients.

2) Residents will demonstrate understanding of the integrative nature of health care and will coordinate the care of their patients utilizing the support of consulting physicians, allied health professionals, and ancillary staff.
3) Residents will develop appropriate discharge and disposition plans for patients by assessing the patients’ access to out-patient services, resources for paying for medications and tests, and by working cooperatively with the discharge planning service to obtain needed treatments and follow-up for their patients.

4) Residents will communicate the discharge plan with the patient’s referring physician to insure adequate follow-up care.

5) Residents will practice cost-effective medicine. Specifically, they will learn to avoid unnecessary tests and minimize length of stay while providing high quality care.

6) Residents will demonstrate understanding of the importance of institutional policy in promoting patient health through strict adherence to infection control policies and specific treatment protocols.

7) Residents will demonstrate understanding of documentation criteria for different levels of care.

Residents will develop an understanding of the nature and importance of regulatory requirements implemented by agencies such as the Joint Commission, CMS, and RRC.

No changes submitted Spring 2016

**Breast/Melanoma/Sarcoma/Endocrine Surgery**

This general surgery service cares for adult patients and provides the resident staff a focused exposure to both common and complex oncologic and benign surgical problems involving diseases of the breast, skin, soft tissue, and endocrine organs. There are 2 attending surgeons and one nurse practitioner on the service, as well as a nurse navigator for our breast cancer patients. Resident staffing is composed of one PGY 2 and one PGY 4 level that rotate on the service. Attending staff makes daily work/teaching rounds with the service residents. The residents also participate in a weekly didactic, pre-op and morbidity and mortality conference and are expected to fully participate in all of the departmental conferences and educational offerings.

Responsibilities and general learning objectives by level include but are not limited to the following:

**PGY 2** - The PGY2 level resident manages inpatients on the surgical wards under the direction of the senior resident and admitting attending. The PGY2 resident is responsible for initial history and physicals as well as the care of the patients throughout their hospital stay. It is expected that they become experienced in the inpatient care of surgical oncology patients on the ward. The PGY2 is also responsible for clinic duties at least once a week, with hopes to learn and establish professional relationships with our patients and to become proficient at the evaluation and work up of patients on the service. The PGY2 is responsible for giving a complete and thorough sign out to the night float. The PGY2 should go to the operating room when time permits and become comfortable with case-appropriate surgeries with maximum supervision. It is essential that they practice tying knots as well as suture techniques outside the OR. The more efficient they are at tying knots and using a needle holder the more they will get to do. The PGY2 should also be involved with teaching our medical students. Core competencies the resident should achieve on this rotation include:
Medical Knowledge

- The primary educational goal of this rotation will be the development of knowledge and skills in pre- and postoperative evaluation and management of surgical patients with diseases of breast, skin, soft tissue, and endocrine organs.
- Emphasis will be placed on perioperative risk assessment and pre-operative staging and evaluation.
- The resident will gain a working knowledge of the biology, pathophysiology, and anatomy of breast, skin, soft tissue, and endocrine organs.

Patient Care

- The resident will participate in formulating the treatment plan for all hospitalized patients.
- Be responsible for executing the treatment plan as formulated by the surgical staff.
- Participate in surgical procedures appropriate for skill level.
- The resident will participate in clinic, ward responsibilities permitting.

Practice-Based Learning and Improvement

- The resident will apply established principles of perioperative care to the management of ward patients.
- It is expected that the resident will understand the specific disease processes of surgical patients and their appropriate management.
- Become familiar with the service post-operative complication collection system and its application to continuous quality improvement.

Interpersonal and Communication Skills

- Communicate and collaborate effectively with colleagues other health care professionals.
- Counsel and educate patients and families.
- Effectively document practice activities.
- Teach and share knowledge with colleagues, residents, students, and other health care providers.
- Communicating the new diagnosis of cancer.

Professionalism

- Always place the needs of the patient first.
- Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
- Make sound ethical and legal judgments appropriate for a qualified surgeon.
- Demonstrate a commitment to continuity of patient care.
- Maintain an appearance appropriate to the health care setting.
- Relate to other health care providers with the dignity and respect. Demonstrate effective time management skills including punctuality, availability and prioritization of tasks.

Systems Based Practice

- Understand and apply the utility of communication with referring and collaborating physicians through well documented and timely notes.
- Work within the framework of the established policies and procedures of the UF-Shands medical system.
• Demonstrate knowledge of risk-benefit analysis.
• Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

**PGY4** : It is expected that PGY4 residents on the service focus on increasing their understanding and improve their ability to treat breast diseases, melanoma sarcoma and endocrine disorders. They must attend clinic at least once a week and should be present at a time when patients with cancer are being seen. The rotation is intended to serve as a transition to independent practice for the specific areas of focus. In this capacity the resident will assume responsibility for all aspects of the Breast/Soft Tissue/Endocrine service including administration, scheduling and patient care. The resident will have the opportunity to be the primary surgeon on a wide variety of complex general surgical cases and is expected to assume graduated responsibility as the teaching assistant for mid- and lower level residents. At the completion of the rotation it is expected that the resident will have demonstrated the knowledge, skill and judgment to practice independently. The resident will learn about breast imaging including mammography, ultrasound, ultrasound guided procedures including needle localization and biopsy, and breast MRI.

It is expected that the upper level residents become familiar in the care of all aspects of the care of complicated patients. It is expected that the PGY4 runs the service in an organized fashion! The attendings are not always aware of the resident vacation schedules and their availability from week to week. It is up to the PGY4 residents to keep the service functioning. The PGY4 resident should be extensively involved with teaching our medical students

• Ensure that the appropriate level residents are available to be in the OR on each day. Work this out in advance (as much as possible) so that the resident has appropriate time to read about the case and review films in advance. The attendings are noticing that many times the residents do not prepare prior to coming to the OR. Residents frequently cite as the cause for this: not knowing they were doing the case until a few minutes prior to the case. Sometimes there are not enough appropriate level residents to cover the OR. This should be communicated to the Attendings, in advance, so that necessary arrangements are made for residents from another service to cover. A second assistant is needed for thyroid cases and most low anterior/pelvic cases.

• Ensure that the appropriate level residents are available to be in clinic on each day. Every resident on the service should be clinic at least once a week. All clinics should be covered by at least one resident.

• The PGY4 should decide which cases they would like to scrub on. On occasion the attending will request the presence of a particular resident and this should be accommodated when possible.

• The upper level residents are responsible to make sure that the preoperative evaluations are completed and all problems are ironed out prior to (if possible) the day of surgery. This is not the responsibility of the medical students or interns.
• The upper level residents should communicate with Attendings on a daily basis regarding the progress of their patients.
• Ensure that rounds are done and work taken care of in order to reach the morning conferences such as Breast tumor board & M&M
• We must be active in our care of the IMC and ICU patients as leaving all the care to the Critical Care team does not lead to optimal patient outcomes.
• Teach the students please!

Medical Knowledge
• The resident must demonstrate a thorough knowledge of all aspects of breast, melanoma, sarcoma, and endocrine surgery.
• As the primary surgeon, the resident will perform a variety of complex general surgical procedures including mastectomy, axillary and inguinal node dissection, thyroidectomy, parathyroidectomy, adrenalectomy (laparoscopic), resection of soft tissue sarcoma (retroperitoneal and extremity), skin graft (split and full thickness).
• The chief resident will serve as teaching assistant for lower level residents on straightforward breast procedures as well as a variety of soft tissue procedures.

Patient Care
• The chief resident will supervise, coordinate and direct all aspects of patient care on the service in consultation with attending staff.
• At this level, independent decision making in patient care will be expected with the expectation that the resident has a high level of awareness his/her limitations in experience, knowledge, judgment and skill.
• Analysis of risk and benefit of surgical procedures and alternative treatments, particularly among patients with significant co-morbidities, will be stressed.
• The resident should be particularly focused on the recognition and management of postoperative complications in a high-risk patient population.
• Participation in the clinic will provide the resident with longitudinal exposure to the evaluation, care and management of surgical oncology and endocrine surgery patients.

Practice-Based Learning and Improvement
• The resident will apply established principles of perioperative care to the management of all service patients.
• It is expected that the resident will recognize and thoroughly understand the specific disease processes of surgical patients and their appropriate management.
• Investigate the medical literature for evaluation and management of specific surgical problems.
• Use the BMSE complication reporting system and its application to continuous quality improvement.
• Participate in multidisciplinary tumor boards for breast, melanoma, and sarcoma.

Interpersonal and Communication Skills
• As the leader of the general surgical team, the resident will communicate and collaborate effectively with colleagues other health care professionals
• Counsel and educate patients and families.
• Effectively document practice activities.
• Teach and share knowledge with colleagues, residents, students, and other health care providers.

Professionalism
• Always place the needs of the patient first.
• Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
• Make sound ethical and legal judgments appropriate for a qualified surgeon.
• Demonstrate a commitment to continuity of patient care.
• Maintain an appearance appropriate to the health care setting.
• Relate to other health care providers with the dignity and respect.
• Demonstrate effective time management skills including punctuality, availability and prioritization of tasks.

Systems Based Practice
• Understand and apply the utility of a timely and complete medical record.
• Work within the framework of the established policies and procedures of the UF-Shands medical system.
• Demonstrate knowledge of risk-benefit analysis.
• Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

Revised by Dr. Spiguel on 4/21/16

Pancreas/Biliary Surgery

This service sees the full spectrum of patients with pancreatic or biliary disorders, including complex problems and re-operative cases. There is a Chief Resident, 3rd year resident and first year resident on this service in addition to the 3 attendings.

PGY 1 - Manages inpatients on the adult surgical wards and intermediate care unit, does initial history and physicals as needed, sees patients in the clinic and establishes formal professional relationships, and participates in the operating room with maximum supervision. Since this is the first rotation for new residents in pancreaticobiliary disorders, the resident is expected to develop a familiarity with both benign and malignant disease. At the completion of the rotation the resident should be able to:

Medical Knowledge
• Discuss frequency/death rates of pancreatic, bile duct, gallbladder, ampullary and duodenal cancer in men and women in the United States.
• Describe trends of increasing, decreasing, and incidence for these neoplasms.

Explain the implications of the clinical behavior and response to adjuvant treatment. Discuss the mechanisms of cellular apoptosis and the potential feasibility for therapeutic applications. Identify genetic factors associated with neoplastic disease in regard to known proto-oncogenes.
• Define current theories of carcinogenesis for these tumors.
• Summarize the tenets of tumor biology, including the biochemical events of invasion and metastasis; describe the natural history of these lesions.
• Predict patterns of presentation of these malignant neoplasms.
• Describe the characteristics of the 7th AJCC staging systems and explain their use in evaluating malignant neoplasms.
• Outline the appropriate usage of tumor markers, tumor excretory metabolites, and diagnostic cytologic techniques for these tumors.
• Describe the principles of surgical technique for operative procedures designed for cure of malignant diseases and their application to endoscopic operative techniques.
• Summarize the nutritional requirements for postsurgical patients, and describe how they differ from those recommended for a healthy patient.
• Describe principles of current targeted molecular therapy (i.e. c kit oncogene and gleevac) in the treatment of solid tumors
• Discuss the economic and psychosocial issues associated with malignant disease, and analyze how they affect the management of patients with cancer, including:
  a) Ethics of cancer management
  b) Rehabilitation
  c) Home care resources
  d) Patient support groups
  e) Family support groups
  f) Enterostomal therapy
  g) Cost containment
  h) Pre-admission procedures and authorization
  i) Conservation of in-patient resources
  j) Special problems of the elderly
  k) Tumor registry data
• Identify available social service and community agency resources to address the issues listed in #14 above.
• Describe the risk factors and etiology for acute pancreatitis
• Discuss management of acute and chronic pancreatitis
• Describe the pathogenesis for biliary calculous disease.
• Discuss the diagnostic workup for jaundice.

Patient Care
• The resident will provide patient care that is compassionate, appropriate, and effective.
• Perform a complete history and physical examination on patients with benign or malignant disease.
• Formulate an appropriate differential cancer diagnosis, and record an independent, written diagnosis for each patient assigned.
• Formulate definitive treatment plan for biliary calculous disease with supervision.
• Understand the fundamental differences between between benign and malignant pancreaticobiliary diseases, and the implication for treatment
• Understand the fundamentals of biliary catheter utilization and their management.
• The resident will demonstrate knowledge of benign gallbladder disease with participation in operations to remove the gallbladder.
• Develop an ability to interpret CT scans of the abdomen and pelvis
• Demonstrate ability to perform complex wound care including the use of a VAC dressing.
• Demonstrate ability to manage drainage catheters.

**Practice-Based Learning and Improvement**
• The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
• Be committed to scholarly pursuits through the conduct and evaluation of research.
• Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.

**Interpersonal and Communication Skills**
• Communicate and collaborate effectively with colleagues other health care professionals.
• Counsel and educate patients and families.
• Effectively document practice activities.
• Teach and share knowledge with colleagues, residents, students, and other health care providers.
• Ensure that the chief resident is immediately aware of admissions, changes in clinical condition, critical lab values, and other important patient events.

**Professionalism**
• Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
• Make sound ethical and legal judgments appropriate for a qualified surgeon.
• Demonstrate a commitment to continuity of patient care.
• Assume responsibility for documentation.

**Systems-Based Practice**
• Demonstrate understanding of planning and utilizing OR resources
• Provide cost-effective care to surgical patients and families within the community.
• Demonstrate knowledge of risk-benefit analysis.
• Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

**PGY 3** - Participates in the middle management of both surgical ward and ICU patients, sees consults, and assists in the operating room with reduced supervision. When he/she is paired with the first year resident, he/she will assume a major responsibility of assisting with the orientation of the new resident. Sees patients in the clinic and establishes formal professional relationships. At the completion of the rotation the resident should be able to:

**Medical Knowledge**
• The resident will demonstrate in depth knowledge of the biologic behavior, histology, physiology and management principles of benign and malignant processes of the pancreas,
gallbladder and bile ducts, and carry out comprehensive medical and surgical management of such problems with supervision.

- Demonstrate proficiency in interpretation of CT scan studies in upper GI cancer patients and patients with pancreatitis.
- Summarize the indications and appropriate modalities for adjuvant therapy within the scope of pancreaticobiliary surgery, including chemotherapy, radiation therapy, immunotherapy, and gene therapy.
- Demonstrate a working knowledge of prior research milestones, current research efforts, and cancer research methodology.

**Patient Care**

- The resident will provide patient care that is compassionate, appropriate, and effective.
- Perform cholecystectomies
- Perform gastrointestinal surgical procedures including gastrojejunostomy and pseudocyst drainage
- Close wounds following major resections.
- Perform nutritional assessments and plan nutritional support programs.
- Manage patients in the intensive care unit in conjunction with the ICU team.
- Evaluate complex surgical patients in the clinic
- See new consults throughout the hospital and discuss and institute appropriate treatment plans.
- Participate in a multidisciplinary tumor board.

**Practice-Based Learning and Improvement**

- The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
- Be committed to scholarly pursuits through the conduct and evaluation of research.
- Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.

**Interpersonal and Communication Skills**

- Communicate and collaborate effectively with colleagues other health care professionals.
- Counsel and educate patients and families.
- Effectively document practice activities.
- Teach and share knowledge with colleagues, residents, students, and other health care providers.
- Ensure that the responsible attending physician is immediately aware of all new consults.

**Professionalism**

- Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
- Make sound ethical and legal judgments appropriate for a qualified surgeon.
- Demonstrate a commitment to continuity of patient care.

**Systems-Based Practice**

- Demonstrate understanding of planning and utilizing OR resources
- Provide cost-effective care to surgical patients and families within the community.
• Demonstrate knowledge of risk-benefit analysis.
• Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

**Chief Resident** - Works with the 1st year and 3rd year residents and other support personnel to manage pre and postoperative patients. Responds to consults and formulates plan to present to the attending. Is responsible for patients in the intensive care units. Participates in operative procedures with minimal supervision. Sees patients in the clinic and establishes formal professional relationships. Prepares material for conferences and helps to coordinate medical student education. At the completion of the rotation the resident is expected to:

**Medical Knowledge**

- Apply clinical screening for common malignancies. Recognize typical presentations and clinical manifestations for different types of neoplasms.
- Discuss the known facts relative to tumor suppressive genes and the implications of mutations.
- Stage specific neoplasms both clinically and pathologically, including the tumor, nodes, and metastasis system (TNM).
- Relate tumor staging to prognosis.
- Describe differences in presentation, treatment, and outcomes for malignancy in older patients.
- Compare each applicable treatment modality to the prognosis for tumors within the scope of general surgery.
- Apply post-treatment screening/surveillance for common malignancies.
- Discuss the known facts relative to tumor recurrence after resection of a primary lesion of the pancreas with regard to survival.
- Identify margins of resection and how this relates to local recurrence.
- Describe the indications for and actions of pharmacologic support in the postoperative state.

**Patient Care**

The resident will provide patient care that is compassionate, appropriate, and effective and:

- Demonstrate the capability for independent function in all aspects of patient management, including emergency and palliative care planning.
- Prepare and defend the preoperative assessment plan for the elderly patient in preparation for:
  - a. Pancreatic necosectomy
  - b. Pancreatic cyst jejunostomy
  - c. Pancreatic resection (Whipple Procedure and distal pancreatectomy)
  - d. Gallbladder or Liver resection
  - e. Duodenal preserving pancreatic head resection
  - f. Major laparoscopic procedures
- Stage specific neoplasms clinically and pathologically using the TNM system.
- Prepare patients medically for pancreaticobiliary surgery, including correction of nutritional and metabolic deficits.
- Demonstrate proficiency in interpretation of CT scan studies in GI surgery patients.
- Specify and prepare management plans for nutritional support in the elderly patient.
- Assess the need and institute appropriate monitoring both pre- and post- operatively.
- Use appropriate support from pharmacologic agents.
- Prepare an operative plan for treatment of benign or malignant disease.
• Demonstrate proficiency in the use and interpretation of operative and endoscopic ultrasonography.
• Demonstrate proficiency in laparoscopic staging and resection of the upper gastrointestinal cancer patient.
• Assume responsibility for managing the psychosocial aspects of neoplastic disease.
• Utilize appropriate social agencies and support groups in patient management.
• Assume teaching responsibilities for junior residents as assigned.
• Participate in a multidisciplinary tumor board.

**Practice-Based Learning and Improvement**
• The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
• Be committed to scholarly pursuits through the conduct and evaluation of research.
• Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.

**Interpersonal and Communication Skills**
• Communicate and collaborate effectively with colleagues other health care professionals.
• Counsel and educate patients and families.
• Effectively document practice activities.
• Teach and share knowledge with colleagues, residents, students, and other health care providers.
• Ensure that the responsible attending physician is immediately aware of admissions, significant changes in clinical condition, and critical lab values.

**Professionalism**
• Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
• Make sound ethical and legal judgments appropriate for a qualified surgeon.
• Demonstrate a commitment to continuity of patient care.

**Systems-Based Practice**
• Demonstrate understanding of planning and utilizing OR resources
• Provide cost-effective care to surgical patients and families within the community.
• Demonstrate knowledge of risk-benefit analysis.
• Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

**Chain of supervision:**
The supervisory reporting chain varies by level of training. For each level there are certain expectations about the patient care events and situations that will trigger communication with the individual resident’s supervisors.

For the PGY-5 resident: At all times the supervising physician is the attending surgeon on call for the day. In general this is also the attending who will be operating with the chief resident. For
patients in the ICU, the critical care attending on call for the day may also function as a supervising physician.

Because the chief resident is transitioning to independence, this resident always practices under indirect supervision. However, certain expectations exist regarding patient scenarios that will always trigger a call to the supervising physician. These include, a patient who needs to go the OR, or a patient who is admitted to the ICU. Major adverse changes in a patient’s course, or the development of life-threatening complications should also trigger a call to the supervisor.

For the PGY-3 resident: From 6 AM to 6 PM the supervising physician for this resident is first the PGY-5 resident followed by either the attending surgeon on call or the ICU attending on call, depending on the location of the patient. From 6 PM to 6 AM and on weekends when the PGY-3 is on call as the senior resident, the supervising physician is the attending surgeon or ICU attending on call depending on the patient circumstance.

The PGY-3 resident will still require direct supervision for almost all operative procedures, either by the PGY-5 resident or the attending. In some limited circumstances, with advance notification from the attending surgeon, the PGY-3 resident may be allowed to perform operations under indirect supervision. Direct supervision is required of the PGY-3 resident for bedside procedures for which the resident has not demonstrated competence. For procedures that the resident has demonstrated that they can perform competently, indirect supervision is appropriate.

At this level, the majority of patient care activities are performed under indirect supervision, however in circumstances where the trainee is uncertain, a low threshold for seeking a higher level of supervision by the intermediate level trainee is a program expectation. Just as for the PGY-5 resident, certain expectations exist regarding patient scenarios that will always trigger a call to the supervising physician. These include, a patient who needs to go the OR, or a patient who is admitted to the ICU. Major adverse changes in a patient’s course, or the development of life-threatening complications should also trigger a call to the supervisor.

For the PGY-1 resident: At all times the supervision chain of command is the PGY-3 or the PGY-5 resident first, and then the attending surgeon on call or the ICU attending on call. For patient care activities within their scope of practice, ARNP’s or PA’s may function as the supervisor in lieu of the PGY-3 resident.

At this early stage of training many activities require direct supervision. As stated in the ACGME common program requirements, direct supervision is required until competency is demonstrated for:

**Patient Management Competencies**

- initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and
- evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartmental syndromes
- evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications,
testing, and other treatments

Following the demonstration of competency, indirect supervision for the above activities is acceptable. Just as with other levels of residents operating under indirect supervision, major adverse changes in a patient’s course, or the development of life-threatening complications should also trigger a call to the supervisor. **Direct supervision is always required for management of patients in cardiac or respiratory arrest (ACLS required)**

**Procedural Competencies**

- advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
- repair of surgical incisions of the skin and soft tissues
- repair of skin and soft tissue lacerations
- excision of lesions of the skin and subcutaneous tissues
- tube thoracostomy
- paracentesis
- endotracheal intubation
- bedside debridement

No changes submitted Spring 2016

**Trauma Surgery**

Surgery residents from most levels will rotate on the Trauma Service. Residents are an integral part of the care from the Emergency Department to the ICU, to the operating room to the floor and then finally post-discharge in the outpatient clinic. The residents are part of the multidisciplinary team that has sit-down rounds twice weekly and walk round on a daily basis. Numerous opportunities are provided for resident presentation, work-up, management and didactic teaching opportunities exist on the service in three (3) trauma/emergency surgery/burn conferences and journal club. At the completion of the rotation the resident should:

Demonstrate complete understanding of the initial management of the injured patient including resuscitation, fluid management, airway management and all aspects of surgical critical care.

Demonstrate the ability to evaluate, manage and operate on the emergency surgical patient including the acute abdomen and all aspects of soft tissue infection.

**Patient Care**

**PGY 1**

1) Demonstrate recognition of shock in the initial assessment of the acutely injured patient.

2) Demonstrate appropriate pre- and post-operative management of acutely injured and acute surgery patients on the inpatient ward.

3) Demonstrate effective, safe performance of techniques to stop hemorrhage, close simple lacerations, and place gastric and bladder catheters.

**PGY 2**

1) Demonstrate appropriate primary survey and resuscitation of the acutely injured patient.
2) Demonstrate appropriate evaluation and management skills in the care of service patients in the surgical intensive care unit and in acute surgical consultation.
3) Demonstrate effective, safe performance of procedures of resuscitation and of adjunctive critical care procedures (e.g., tracheostomy, percutaneous gastrostomy tube placement, and open abdomen dressing change).

PGY 4
1) Demonstrate appropriate initial evaluation and management of the acutely injured patient.
2) Demonstrate appropriate coordination of care, to include use of consultants and radiological imaging, in the management of trauma and acute surgery patients.
3) Demonstrate appropriate operative management of patients with acute abdominal disease and traumatic injuries of the neck, torso, and soft tissues, to include operating room preparation and damage control transition.

Medical Knowledge

PGY 1
1) Articulate essential concepts for the initial assessment and management of acutely injured patients.
2) Describe the assessment, differential diagnosis, and initial resuscitation of patients with acute abdominal disease.
3) Discuss the basic science that drives pre-operative and post-operative care, to include fluids and electrolytes, pain management, and anticipated complications.

PGY 2
1) Discuss management concepts for patients with traumatic brain, spinal, chest, and severe musculoskeletal injuries.
2) Discuss the assessment and management of patients with gastrointestinal hemorrhage, abdominal catastrophe, and soft tissue infection.
3) Describe the basic science that drives resuscitation and management of the critically injured and acute surgically ill, to include blood transfusions, nutrition, and prophylaxis.

PGY 4
1) Explain the specific evidence-based management of acute traumatic injuries by organ system.
2) Review the specific assessment and operative management of patients with acute abdominal disease and gastrointestinal tract hemorrhage.
3) Review the basic science underlying the management of elderly, pregnant, and immunocompromised patients with acute traumatic injury and acute surgical disease.

Practice-Based Learning and Improvement

PGY 1
1) Describe successful management of post-operative problems for specific patients.
2) Discuss injury and disease characteristics related to specific ward patients.
3) Identify opportunities for care improvement in individual patient cases.
PGY 2
1) Describe evidence regarding management and prevention of specific surgical complications.
2) Explain evidence-based management of specific critically injured and ill patients in the surgical intensive care unit.
3) Appraise performance of procedures in trauma resuscitation and the intensive care unit.

PGY 4
1) Analyze trends and opportunities for process improvement by reviewing trauma and emergency surgery service statistics.
2) Review critical steps in the performance of operations in specific patients.
3) Analyze operative execution and outcome in light of the operative plan for specific patients.

Interpersonal and Communication Skills

PGY 1
1) Demonstrate clear and accurate written communication in ward progress notes and discharge summaries.
2) Demonstrate clear and accurate verbal communication in the care of service ward patients.
3) Demonstrates respectful and appropriate communication with patients, families, nurses, consultants, peers, and faculty.

PGY 2
1) Demonstrate clear and accurate written communication in intensive care unit progress notes and consultations.
2) Demonstrate clear, concise, and accurate verbal communication in the care of service intensive care unit and consultation patients.
3) Demonstrates respectful and purposeful communication with patients, families, nurses, consultants, peers, faculty, and consulting services.

PGY 4
1) Demonstrate clear, concise, and accurate written communication in operative notes.
2) Demonstrate clear, concise, accurate, and integrated verbal communication in the care of trauma and acute surgery patients.
3) Demonstrates respectful and purposeful communication with patients, families, nurses, consultants, peers, faculty, consulting services, and pre-hospital personnel.

Professionalism

PGY 1
1) Demonstrates equanimity in interactions with patients, families, and all members of the health care team.
2) Demonstrates appropriate appearance and affect for specific health care settings.
3) Demonstrates effective time management (punctual, available, tasks completed on time).
PGY 2
1) Demonstrates equanimity in interactions with patients, families, and all members of the health care team.
2) Demonstrates appropriate appearance and affect for specific health care settings.
3) Demonstrates effective time management (punctual, available, tasks completed on time).

PGY 4
1) Demonstrates equanimity in interactions with patients, families, and all members of the health care team.
2) Demonstrates appropriate appearance and affect for specific health care settings.
3) Demonstrates effective team management.

Systems-Based Practice

PGY 1
1) Explain the role of pre-hospital care in supporting evaluation and management of acutely injured patients.
2) Describe resources available to facilitate the recovery of patients following definitive management of traumatic injury and acute surgical disease.
3) Discuss behaviors that lead to traumatic injury and acute surgical disease.

PGY 2
1) Explain the role of a triage system in appropriate disposition of acutely injured patients to the trauma center.
2) Use appropriate outpatient management to promote recovery of patients from traumatic injury and emergent surgical disease.
3) Discuss interventions that can reduce the risk of traumatic injury and acute surgical disease.

PGY 4
1) Distinguish pitfalls in transitions from pre-hospital to hospital care and in inter-facility transfers for acutely injured and acute surgical patients.
2) Summarize system challenges for patient recovery following traumatic injury and severe surgical illness.
3) Differentiate programs that can reduce the incidence of trauma and acute surgical disease.

No changes submitted Spring 2016

Hepatobiliary and Transplantation Surgery

This service is the hepatobiliary transplantation service and performs kidney, liver and pancreatic transplantation. Other interests of the faculty include hepatobiliary, transplant-related general surgery and pancreatic for benign and malignant disease. There are 3 attending surgeons, PA’s
and coordinators on the service. Residents rotate at the PGY 1, PGY 3 and PGY 5 level. Responsibilities and general learning objectives include:

**PGY 1** - Performs initial history and physical, coordinates preoperative and postoperative care in conjunction with the senior resident, PA’s and attendings. Participate in clinics and attend various teaching conferences. Performs simple procedures under supervision. Participates in operative procedures that are appropriate for his/her level. Upon completion of the rotation the resident will have achieved the following core competencies:

**Medical Knowledge**

1) Know the anatomy, physiology of the liver and biliary tract.
2) Understand the pathophysiology of liver, kidney and pancreas failure.
3) Understand the pathophysiology of hepatocellular cancer in cirrhosis, biliary obstruction from stricture disease, portal hypertension and its sequelae.
4) Understand the indications and contraindications of liver, kidney and pancreas transplantation, the work-up, and perioperative management.
5) Be familiar with the general technical aspects of liver, kidney and pancreas transplantation.
6) Understand the indications and contraindications of liver surgery for benign and malignant disease, the work-up and perioperative management.
7) Be familiar with the general technical aspects of liver surgery for benign and malignant disease.
8) Describe general immunology principles and the body’s defenses against infection to include the function and interaction of the various classes of cellular elements, humoral defenses, and mechanical barriers.
9) Explain the rational use of antibiotics in surgical practice, and the special considerations in the transplant recipient.

**Patient Care**

1) The resident will provide patient care that is compassionate, appropriate, and effective.
2) Outline a basic plan for management of the liver, pancreas or kidney transplant candidate as it relates to organ failure, particularly on admission of transplantation.
3) Outline a basic plan for the management of the transplant recipient.
4) Understand dosage, titration of immuno-suppression and recognition and treatment of complications.
5) Outline a basic plan for the management of patient with hepatobiliary surgical diseases.
6) Become proficient in commonly performed bedside procedures under senior supervision such as central line, NGT.

**Practice-Based Learning and Improvement**

1) The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
2) Be committed to scholarly pursuits through the conduct and evaluation of research.
3) Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.
Interpersonal and Communication Skills

1) Communicate and collaborate effectively with colleagues and other healthcare professionals.
2) Counsel and educate patients and families.
3) Teach and share knowledge with colleagues, residents, students, and other healthcare providers.
4) Effectively document practice activities.

Professionalism

1) Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
2) Make sound ethical and legal judgment appropriate for a qualified surgeon.
3) Demonstrate a commitment to continuity of patient care.

Systems-Based Practice

1) Demonstrate understanding of planning and utilizing OR resources
2) Provide cost-effective care to surgical patients and families within the community.
3) Demonstrate a knowledge of risk-benefit analysis.
4) Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

PGY 3 - Works with the PGY 1 and physician extenders to manage pre and postoperative patients. Responds to consults and formulates plan to present to the attending. Participate in clinic and educations conferences. Is responsible for patients in the intensive care units. Participates in operative procedures including harvest as directed by the attendings. Prepares material for conferences and help to coordinate medical student education. Upon completion of the rotation the resident will have achieved the following core competencies:

Medical Knowledge:

1) Know the anatomy, physiology of the liver and biliary tract.
2) Understand in detail the pathophysiology of liver, kidney and pancreas failure.
3) Understand in detail the pathophysiology of hepatocellular cancer in cirrhosis, biliary obstruction from stricture disease, portal hypertension and its sequelae.
4) Understand in detail the indications and contraindications of liver, kidney and pancreas transplantation, the work-up, and perioperative management.
5) Understand in detail with the general technical aspects of liver, kidney and pancreas transplantation.
6) Comprehend surgery of the liver and biliary tract as it relates to:
   o Surgical anatomy of the liver and biliary tract.
   o Hepatic resections for benign and malignant liver lesions
   o Bile duct reconstruction or bypass for benign and malignant strictures.
   o Liver, pancreas and kidney transplantation
7.) Understand portal hypertension in terms of:
   - Anatomy and pathophysiology of the portal venous system
   - Evaluation, treatment, and resuscitation of hemodynamically significant upper gastrointestinal bleed
   - Medical and non-shunt surgical therapy
   - Non-selective, selective and percutaneous shunt therapy

8) Discuss the indications and contraindications of liver surgery for benign and malignant disease, the work-up and perioperative management.

9) Discuss with the general technical aspects of liver surgery for benign and malignant disease.

10) Describe general immunology principles and the body’s defenses against infection to include the function and interaction of the various classes of cellular elements, humoral defenses, and mechanical barriers.

11) Explain the rational use of antibiotics in surgical practice, and the special considerations in the transplant recipient.

**Patient Care**

1) The resident will provide patient care that is compassionate, appropriate, and effective.
2) Formulate a detailed plan for management of the liver, pancreas or kidney transplant candidate as it relates to organ failure, particularly on admission of transplantation.
3) Formulate a detailed plan for the management of the transplant recipient.
4) Manage the dosage, titration of immuno-suppression and recognition and treatment of complications.
5) Formulate a detailed plan for the management of patient with hepatobiliary surgical diseases.
6) Describe and assist in transplantation procedures including donor procedures.
7) Describe and assist in liver resections, bile duct resections and reconstructions.
8) Explain the use of immunosuppressive drugs including mechanism of action and newer trends in clinical care of transplanted organs.
9) Be proficient in identifying and managing complications in critically ill patients and transplant recipients.
10) Define the criteria for organ and tissue donation and discuss the legal and ethical implications of transplantation.

**Practice-Based Learning and Improvement**

1) The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
2) Be committed to scholarly pursuits though the conduct and evaluation of research.
3) Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.

**Interpersonal and Communication Skills**

1) Communicate and collaborate effectively with colleagues and other healthcare professionals.
2) Counsel and educate patients and families.
3) Teach and share knowledge with colleagues, residents, students, and other healthcare providers.
4) Effectively document practice activities.

**Professionalism**

1) Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
2) Make sound ethical and legal judgment appropriate for a qualified surgeon.
3) Demonstrate a commitment to continuity of patient care.

**Systems-Based Practice**

1) Demonstrate understanding of planning and utilizing OR resources
2) Provide cost-effective care to surgical patients and families within the community.
3) Demonstrate knowledge of risk-benefit analysis.
4) Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

No changes submitted Spring 2016

**Night Float – Shands**

The night float service at Shands is a rotation for the PGY 1 surgical resident who covers the Colorectal Surgery service, PBS service, MIS service, and the BMSE service. In addition, if patient acuity permits the resident will assist the on call team with trauma, transplantation and other acute patient care needs.

**Patient Care:**
- To competently and expeditiously assess a patient by history, physical examination, laboratory testing and imaging.
- To effectively communicate to the in-house or on-call senior resident the pertinent findings of a patient with an acute issue.
- As time permits, the resident should participate in trauma evaluations and operations.

**Medical Knowledge:**
- To impart clinical knowledge to effectively manage postoperative patients.
- To recognize the complications most likely to arise in the night float patient population.

**Interpersonal and Communication Skills:**
- The resident should obtain good hand-off information and keep the patient records and census information current such that an excellent sign-out to the day shift occurs.
- The resident should continuously seek out the ward nursing staff to assess patients and limit phone calls.

**Professionalism:**
To treat patients, staff and co-workers, especially those who may be on a long shift, with respect.
As needed, the resident should assist others services in emergency situations.

**Practice Based Learning and Improvement:**
- Follow-up of patients with complications should come through attendance at morbidity and mortality conference.

**System-based Practice:**
- To recognize the resources available in the healthcare system at night and utilize these services appropriately.
- For those patients that will be discharged, ready all necessary documents so that the patient can be discharged expeditiously.

No changes submitted Spring 2016

**Pediatric Surgery**

Pediatric general surgery is truly one of the last bastions of ‘general’ surgery, where the service deals with problems involving the head and neck, chest, abdomen, as well as multiple organ systems (airway, renal, GU, etc). The variability in the age also makes things interesting with very different conditions noted in newborns, as opposed to 18 year old patients.

This service does more than 2,000 operative procedures per year including routine and complex childhood and neonatal operations. The service currently has 3 attendings and 1 fellow, in addition to three ARNPs. Besides the usual pediatric surgical expertise, there is special interest in ECMO, trauma, burns, airway management and minimally invasive surgery.

The ultimate goal of the rotation is to have an ideal mix of service and clinical requirements to help teach the basic and important concepts of pediatric surgery. That balance is challenging to achieve and may be different for all residents.

Two PGY 1’s, a PGY2, and a PGY 3 are assigned to the service. Responsibilities and general learning objectives include:

**Pediatric Surgery PGY 1 Goals and Objectives:**

**PGY 1** - The first year resident manages the non-intensive care unit patients and is responsible for the coordination of preoperative and postoperative care. The intern will be expected to write notes, see and evaluate consults, learn how to interpret lab and radiologic data, and how to function as part of a team delivering care to patients. The mid-level providers are a huge asset that should be utilized whenever possible.

The intern will be covering either night or daytime duties. The schedule will be arranged to ensure compliance with the 16 and 80-hour work rules. The intern will get Monday off and that day will be used as the ‘switch’ day from Day to Night. Getting the chance to do surgery is a privilege as an intern and is dependent upon good performance. If that criterion is met, then the daytime
resident will be sent to perform outpatient surgery at least once a week on Friday depending on the schedule. Please see the reading list below to supplement your knowledge base and come to the conferences prepared. You will be sent the reading materials for those conferences ahead of time whenever possible. We have conferences on Monday mornings, Thursday morning and Friday mornings. Due to scheduling and the intern 101 classes, you will be able to only attend the Thursday conferences.

The intern must understand the anatomic and physiologic differences between children and adults and become adept at dealing with the pediatric patient and family. At the completion of the rotation the resident should be able to:

**Patient Care**
1. Use critical thinking when making decisions affecting the life of a patient and the patient's family.
2. Teach patients and their families about the patient's health needs.
3. Learn principles of routine postoperative care and postoperative critical care management.
4. Obtain a history and perform a directed physical recognizing the changing values of “normal” findings as the patient’s age changes.
5. Manage fluids and electrolytes, resuscitation, and ongoing fluid losses in each age group encountered.

**Medical Knowledge**
1. Manage surgical disorders based on a thorough knowledge of basic and clinical science.
2. Understand the unique congenital and acquired diseases and disorders that affect children.
3. Have a broad basic knowledge of underlying pathophysiology, genetic conditions, and environmental factors contributing to these problems.
4. Understand the anatomic and physiologic principles that guide successful operative repair of pediatric diseases, and develop technical skill in performing surgical procedures on children.
5. Summarize development of the newborn throughout childhood and be able to describe common congenital malformations.
6. Outline the basic diagnosis and management of more common surgical problems such as pyloric stenosis, appendicitis, hernia, malrotation, intussusception, and necrotizing enterocolitis.

**Practice-Based Learning and Improvement**
1. Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.
2. Utilize appropriate skill in those surgical techniques required of a qualified surgeon.
3. Learn the principles of stabilization, appropriate preoperative diagnosis, and preparation of the sick or injured child.
4. Increase expertise in care of infants and children.

**Interpersonal and Communication Skills**
1. Collaborate effectively with colleagues and other health professionals.
2. Teach and share knowledge with colleagues, residents, students, and other health care providers.
3. Understand how to work within the framework of a team
4. Timely organization and presentation of new patients to fellows and faculty

**Professionalism**
1. Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
2. Make sound ethical and legal judgments appropriate for a qualified surgeon.
3. Be committed to scholarly pursuits through the conduct and evaluation of research as is available to those interested.

**Systems-Based Practice**
1. Provide cost-effective care to surgical patients and families within the community.
2. Be prepared to manage complex programs and organizations.

Assessment of the residents will be based on their performance on the whole covering the six core competencies as well as technical skills. This will be judged from input with the fellow, the ARNP’s, office staff feedback and others.

Finally, we are **VERY** receptive to feedback from the residents and will respond to it. In the past we have made major changes to the rotation based on feedback that we received. Please feel free to let us know how we can improve your experience on Pediatric Surgery!

**Reading Materials: Pediatric Surgery Chapters from:**
Schwartz (http://www.accessmedicine.com/content.aspx?aid=5029784) or
Sabiston (http://www.mdconsult.com/books/page.do?eid=4-u1.0-B978-1-4377-1560-6..00067-6&isbn=978-1-4377-1560-6&uniqId=340643422-2#4-u1.0-B978-1-4377-1560-6..00067-6)

or Greenfield

The helpful links may be cut and pasted into a browser or clicked on and should take you to the electronic versions of these chapters. A PDF version of the Sabiston chapter is available as well.

**PGY 2 Pediatric Surgery Resident Goals and Objectives**

**PGY 2** – The second year resident on the Pediatric Surgery service will be on for a 4-6 week period. This time will be used to consolidate the understanding that was achieved as a PGY 1 intern on the service and in accordance with graduated learning and responsibility, he or she will be involved in higher level care in the team. This will be an excellent way for the resident to assess the increasing responsibility as well as operate. This will be a good opportunity during the second year for the resident to have a senior role on a team.

The goal of this rotation is to provide the PGY 2 resident with a good mix of cases that will allow them to improve their open surgery skills and to learn basic MIS techniques. This will be based on
the skill and comfort level of the resident. In certain situations, the fellow or PGY 4 will take the resident through cases to allow for participation in ‘index’ cases as well. Based on current case volumes, we anticipate the PGY 2 resident will perform 50-75 cases during this rotation. He or she will perform a mix of out and inpatient cases.

In addition, the PGY 2 resident will provide night time call coverage on Monday and Friday nights and at that point will function as a fellow or senior resident. This coverage will be by phone and will be from home. **This coverage will be on an “acting fellow” level for the month of July 2016, as there will no fellows during that time. The attendings will be sure to provide you with appropriate supervision.** In general, the PGY 2 will perform any operative cases during that time. They will be responsible for evaluating and assessing patients as well and discussing directly with the faculty. We will assess the residents capabilities based on their ability to communicate effectively, interact well with other services and perform as part of a team.

There will be a comprehensive education plan for the PGY 2 resident, and he or she will be expected to present a 20-minute talk to the team during the rotation. The resident will fully participate in the educational schedule of the service, which includes weekly lectures, case conferences, and multi-disciplinary conferences.

The PGY 2 also assists the PGY 1 in solving problems on the ward patients and will perform routine and complex procedures under faculty supervision. We expect the residents to easily complete their requisite number of cases, and if there is any issue, it should be brought to the attention of the faculty.

At the completion of the rotation the resident should be able to:

**Patient Care**
1. Use critical thinking when making decisions affecting the life of a patient and the patient's family.
2. Teach patients and their families about the patient's health needs.
3. Learn principles of routine postoperative care and postoperative critical care management.
4. Manage complex perioperative problems likely to be encountered including provision of appropriate nutritional support.
5. Counsel families on the surgical experience and options for management of surgical illnesses in this age group.
6. Manage injuries in this age group including multi-system trauma and burns

**Medical Knowledge**
1. Manage surgical disorders based on a thorough knowledge of basic and clinical science.
2. Understand the unique congenital and acquired diseases and disorders that affect children.
3. Have a broad basic knowledge of underlying pathophysiology, genetic conditions, and environmental factors contributing to these problems.
4. Understand the anatomic and physiologic principles that guide successful operative repair of pediatric diseases, and develop technical skill in performing surgical procedures on children.
5. Understand the prognosis and treatment of childhood tumors including Wilms, neuroblastoma, teratoma.

**Practice-Based Learning and Improvement**

1. Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.
2. Utilize appropriate skill in those surgical techniques required of a qualified surgeon.
3. Learn the principles of stabilization, appropriate preoperative diagnosis, and preparation of the sick or injured child.
4. Increase expertise in care of infants and children.
5. Successfully perform most surgical procedures in children likely to be encountered in the practice of general surgery.

**Interpersonal and Communication Skills**

1. Collaborate effectively with colleagues and other health professionals.
2. Teach and share knowledge with colleagues, residents, students, and other health care providers.
3. Demonstrate the ability to work effectively as part of a team – be able to both give and take orders and carry them out well.

**Professionalism**

1. Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
2. Make sound ethical and legal judgments appropriate for a qualified surgeon.
3. Engage in positive interactions with referring physicians and the team members.
4. Be committed to scholarly pursuits through the conduct and evaluation of research. These opportunities are available and we would welcome input and participation whenever possible.

**Systems-Based Practice**

1. Provide cost-effective care to surgical patients and families within the community.
2. Be prepared to manage complex programs and organizations.
3. Demonstrate the ability to learn from experience and apply this for future cases.

Assessment of the residents will be based on their performance on the whole covering the six core competencies as well as technical skills. This will be judged from input with the fellows, the ARNP’s, office staff feedback and others. The resident should get mid-term feedback and constructive criticism to improve for the remaining part of the rotation. *If not scheduled, the resident should ask to have mid-term feedback.*
Finally, we are **VERY** receptive to feedback from the residents and will respond to it. In the past we have made major changes to the rotation based on feedback that we received. Please feel free to let us know how we can improve your experience on Pediatric Surgery!

**Reading Materials: Pediatric Surgery Chapters from:**


or Greenfield

The helpful links may be cut and pasted into a browser or clicked on and should take you to the electronic versions of these chapters. A PDF version of the Sabiston chapter is available as well.

**SCORE resources for pediatric surgery**
Each topic below is associated with a link to specific learning objectives, selected readings, and quiz questions. Quiz questions, at this time in SCORE, are not able to be filtered beyond the broad subject of pediatric surgery.

- **Pediatric Trauma** ([http://www.surgicalcore.org/modulecontent.aspx?id=143135](http://www.surgicalcore.org/modulecontent.aspx?id=143135))

**Learning Objectives of the Senior General Surgery Resident on Pediatric Surgery**

**Overall Goals and Introduction:**

Pediatric Surgery is considered to be the last true bastion of General Surgery, with operations on almost every organ system, care for the injured and burnt child, management of the critically ill neonate and child, and advanced MIS cases. This rotation is designed to give the resident a firm
understanding of the scope of Pediatric Surgery, be taught the principles of care of children and how it differs from adults, as well as providing an incredibly rich and diverse operative experience.

The senior resident on the service will be treated as a Pediatric Surgery Fellow essentially as we have one fellow on service. Thus, the resident will take call at a fellow level twice a week and every other weekend as well (home call) and perform fellow level cases and care for critically ill patients when on call, including ECMO. The attending faculty on call will provide the supervision directly. The resident will be expected to perform index Pediatric Surgical cases including neonatal and MIS procedures.

**Operative experience** will be high in number and diversity. The Pediatric Surgery service performs approximately 2,200 cases per year with the diversity of cases as already stated. The senior resident should expect to end the 2-month rotation with between 100-150 procedures, which would ensure that the General Surgery case volumes would be enhanced and Pediatric specific numbers be excellent.

**Education** will be provided in the form of THREE Pediatric Surgery specific conferences a week (Monday AM, Thursday AM, and Friday AM). These will include Journal club discussions, lectures and interactive discussions, presentations BY the resident, M & M conference, Pediatric Tumor Board, and case management conferences. The senior resident will be expected to make one 20 minute presentation on a mutually agreed upon Pediatric Surgical topic. The education is going to be mapped directly to the Pediatric Surgery and General Surgery SCORE curriculum for maximal benefit.

**Research opportunities** are ALWAYS available to the resident who desires to be involved. The Pediatric Surgery service has a large number of clinical outcome based research projects that are being performed. These can be small or large series of patients and the projects will be tailored to the residents’ time availability and desire to be involved.

**Clinical Responsibilities:** The resident will be involved in the OR as well as outpatient clinics in addition to being responsible for running the service in conjunction with the fellow. The resident will be expected to attend one clinic a week (Tuesday or Thursday). There are currently 9 OR rooms a week (6 Shands North Tower, and 3 at Children’s Surgery Center) for our service that will ensure that every day will be very busy and productive.

**COMPETENCY BASED OBJECTIVES:**

1. **Patient Care:** This will be a great opportunity for the resident to care for children and neonates. This is a very different experience from the usual adult care. The resident will be expected to develop a deep understanding of the conditions in pediatric surgery. Specifically, the resident will:
   a) Obtain a detailed but specific history and directed physical exam recognizing the changing “normal” values as the patient ages.
   b) Manage complex patients in the intensive care unit – post, and pre operatively – learn to co manage patients with the critical care teams.
c) Manage the injured child and understand the differences in management of children vs. adults. Recognize patterns of injury consistent with child abuse.
d) Learn the principles of routine pre and postoperative care and be able to differentiate between Pediatric and Adult patients
e) Understand and provide nutritional support in the pre and post operative pediatric surgical patient.
f) Counsel families on the surgical experience, obtain consent, and explain surgical management in these patients.
g) Use critical thinking when making decisions affecting the life of a patient and the patient’s family.

2. Medical Knowledge: The senior resident will be assessed at the level of the fellow in terms of knowledge about specific conditions, but will not be expected to know the finer details of the operative care. The resident will be provided with extensive resources both physical and electronic to access the information. The SCORE curriculum will be used. Specifically, the senior resident will:
   a. Understand the unique congenital and acquired diseases and disorders that affect children
   b. Have a broad basic knowledge of the underlying pathophysiology, genetic conditions, and environmental factors contributing to pediatric surgical problems.
   c. Be able to understand the anatomic and physiologic principles that underlie and guide successful operative repair of pediatric diseases
   d. Be able to understand and explain the approach to surgical management of more complex procedures including head and neck lesions, thoracotomy, airway and GI endoscopy, anti-reflux procedures, congenital problems (CDH, EA, intestinal Atresia, imperforate anus).
   e. Understand the prognosis and treatment of childhood tumors including Wilms and neuroblastoma and be able to point out the differences in managing these tumors compared to adult ones.

3. Technical Abilities: The senior resident will be functioning at the level of the fellow and will be performing or participating in index pediatric surgical procedures including Cannulation for ECMO and management of congenital problems. Specifically, the resident will:
   a. Understand and apply the principles of gentle tissue handling and be able to point out the differences in adult and pediatric and neonatal technical skills.
   b. Further develop high-end MIS skills. The resident will understand the limitations of operating on babies and in a small space. They will learn intracorporeal sewing in that small space. Be able to use 3 mm instruments.
   c. Exceed the case requirements that are set for general surgery.
   d. Understand and apply the different techniques of endoscopy and bronchoscopy in neonates, infants, and children.
   e. Perform hand-sewn anastomoses in neonates and infants, and understand the differences in suturing this bowel together.
   f. Be expected to use surgical loupes and the headlight proficiently during an operation
4. Interpersonal and Communication: The senior resident on the service will be expected to communicate with the attendings and the other staff regularly as he or she will be running the service at many times. The resident will:
   a. Learn to collaborate effectively with other Pediatric providers in the NICU, PICU, and the floor as well as the Pediatric ED.
   b. Be able to synthesize and present information about patients and changing conditions effectively.
   c. Teach and share knowledge with other members of the team
   d. Communicate effectively with families and patients
   e. Maintain comprehensive, timely and legible medical records.

5. Practice Based Learning: The resident will:
   a. Increase expertise in care of neonates, infants and children
   b. Value life long learning as a necessary prerequisite to maintaining surgical knowledge and skill
   c. Review critical steps in the performance of operations, and understand the means to avoid complications
   d. Attempt to collaborate in quality and process improvement programs by helping to analyze outcomes and trends.
   e. Seek and accept constructive feedback concerning their practices
   f. Engage in active teaching of the medical students and interns on the service

6. Professionalism: The senior resident on the service will be the prime face of our division. He or she will be expected to:
   a. Respect the cultural and religious needs of patients and their families and provide care in accordance with those needs.
   b. Display compassion and empathy for patients and families even under difficult circumstances
   c. Treat all members of the team with appropriate respect and care regardless of their level of power.
   d. Take personal responsibility for the timely completion of all assigned work and notes in medical records
   e. Be up to date with the case logs and know if there are any surgical case deficiencies that need to be corrected prior to leaving the service
   f. Demonstrate integrity in their interactions with patients and families as well as team members by practicing full disclosure and acknowledgement of errors as well as knowledge gaps.
   g. Advocate for patients’ and families’ needs at all times
   h. Demonstrate respect for confidentiality and HIPAA compliance at all times

7. Systems based Practice: The senior resident on the service will be expected to:
   a. Demonstrate understanding of the integrative nature of health care and will coordinate the care of their patients utilizing the support of consulting physicians, allied health professionals, and ancillary staff.
   b. Demonstrate understanding of new technologies and their role in the care of their patients.
c. Develop appropriate discharge and disposition plans for patients by assessing the patients’ access to out-patient services, resources for paying for medications and tests, and by working cooperatively with the discharge planning service to obtain needed treatments and follow-up for their patients.

d. Communicate the discharge plan with the patient’s referring physician to insure adequate follow-up care.

e. Practice cost-effective medicine. Specifically, they will learn to avoid unnecessary tests and minimize length of stay while providing high quality care.

f. Demonstrate understanding of the importance of institutional policy in promoting patient health through strict adherence to infection control policies and specific treatment protocols.

g. Demonstrate understanding of documentation criteria for different levels of care.

h. Understand the various regulatory organizations and the effects that their laws have on the provision of care (JCAHO, RRC, provisions of the ACA, etc.)

Facilities:
The Senior general surgery resident will be treated and afforded the same privileges as a fellow. There will be 24/7 access to the office suite and the Fellow office will be their office as well for the two-month duration of the rotation. The resident will have a desk and computer that will be for his/her use exclusively. The office will have a large sofa for rest, in addition to access to the call room that has a clean bed and access to a shower / bathroom facility. A small refrigerator is available in the office, as well as access to the divisional coffee maker 24/7.

All major Pediatric Surgery textbooks will be available in the fellow/resident office, as well as electronic access to these texts 24/7 with a code purchased by the division.

Feedback and Evaluation:
The surgery resident will have mid rotation formal and formative feedback provided by the Program Director. This feedback will be provided in the form of the 7 competencies outlined, and will be ‘bi directional’ allowing for constructive criticism to improve the rotation for the resident as well. Issues such as technical skills will be addressed and improved during the rotation.

End of rotation feedback will be provided by the program director, which will be a summative statement from all the faculty, fellow, nurse practitioners, and nurses in the floor, clinic, and ICU’s. An attempt will be made to also provide 360 degree feedback whenever possible.

Finally, we are VERY receptive to feedback from the residents and will respond to it. In the past we have made major changes to the rotation based on feedback that we received. Please feel free to let us know how we can improve your experience on Pediatric Surgery!

Reading Materials: Pediatric Surgery Chapters from:
Schwartz (http://www.accessmedicine.com/content.aspx?aid=5029784) or

Sabiston (http://www.mdconsult.com/books/page.do?eid=4-u1.0-B978-1-4377-1560-6..00067-6&isbn=978-1-4377-1560-6&uniqId=340643422-2#4-u1.0-B978-1-4377-1560-6..00067-6) A PDF version of the Sabiston chapter is available as well.
Greenfield

Pediatric SCORE (maps to two volume Textbook of Pediatric Surgery)
The helpful links may be cut and pasted into a browser or clicked on and should take you to the electronic versions of these chapters.

SCORE resources for pediatric surgery
Each topic below is associated with a link to specific learning objectives, selected readings, and quiz questions. Quiz questions, at this point in SCORE, are not able to be filtered beyond the broad subject of pediatric surgery.

Biliary Atresia  http://www.surgicalcore.org/modulecontent.aspx?id=162913
Choledochal Cysts  http://www.surgicalcore.org/modulecontent.aspx?id=162963
Congenital Diaphragmatic Hernia Repair  
http://www.surgicalcore.org/modulecontent.aspx?id=163145
Cryptorchidism  http://www.surgicalcore.org/modulecontent.aspx?id=166707
Duodenal Atresia/Stenosis  http://www.surgicalcore.org/modulecontent.aspx?id=166603
Esophageal Atresia/Tracheoesophageal Fistula Repair  
http://www.surgicalcore.org/modulecontent.aspx?id=163331
Neuroblastoma  http://www.surgicalcore.org/modulecontent.aspx?id=166813
Pyloromyotomy  http://www.surgicalcore.org/modulecontent.aspx?id=151071
Tracheal/Esophageal Foreign Bodies  http://www.surgicalcore.org/modulecontent.aspx?id=139060
Wilms Tumor  http://www.surgicalcore.org/modulecontent.aspx?id=166769

Revised by Dr. Taylor on 4/27/16

Plastic Surgery at Shands

Learning Objectives

The Plastic and Reconstructive Surgery service at UF & Shands encompasses the entire field of our specialty. There are five Plastic Surgery faculty, two Plastic Surgery fellows and one surgical intern. Surgery is performed at Shands Teaching Hospital, Florida Surgical Center, Children’s Surgical Center and the Millennium Center. Clinic is held at the Millennium Center. The Plastic Surgery Service shares hand call with Orthopaedic Surgery and face call with Otolaryngology and Oral Surgery.
This rotation provides an introduction to plastic surgery for the first year surgical resident. The intern sees new consults with the fellow, physician extender and/or the attending on the floor, emergency room, and clinic. The intern will participate in the Craniofacial Clinical every Thursday afternoon. The intern is expected to develop a familiarity with the broad spectrum of plastic surgery elective, urgent, and emergent issues. At the completion of the rotation, the intern should be able to:

**Medical Knowledge**

1) demonstrate awareness of anatomy of the hand and upper extremity
2) demonstrate awareness of anatomy of face including cranial nerves in the head and neck
3) demonstrate awareness of different types of material available for wound closure (sutures, dressings, tissue adhesives)
4) demonstrate knowledge of breast reduction surgery
5) understand the different options available in breast reconstruction from implants to autologous tissue and everything in between
6) understand congenital anomalies in children including cleft lip/palate and vascular anomalies
7) understand the appropriate time-frame for postoperative follow up and suture removal
8) understand the need to obtain informed consent and “time-outs” prior to performing surgical procedures
9) understand risk factors for chronic wounds and indications for surgery
10) understand reconstructive options for ablative and traumatic wounds including grafts and flaps
11) understand the evaluation and management of the cosmetic patient

**Patient Care**

1) demonstrate ability to perform a hand exam
2) demonstrate ability to perform a head and neck exam
3) demonstrate ability to perform simple and complex wound closures
4) demonstrate the ability to administer local anesthesia prior to procedures on the hands and face
5) demonstrate knowledge of inpatients and consult patients
6) demonstrate ability to evaluate acute and chronic wounds
7) demonstrate ability to harvest split thickness skin grafts
8) demonstrate ability to read x-ray evidence of hand trauma
9) demonstrate ability to diagnose and manage acute facial trauma in the ER (lacerations and fractures)

**Practice-Based Learning and Improvement**

1) The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
2) Identify and discuss appropriate management of postoperative complications.
3) Understand the indications for denying elective surgery.
4) Be committed to scholarly pursuits through the conduct and evaluation of research.
5) Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.
6) Attend Plastic Surgery Journal Club – every third Wednesday of each month at 6:30PM
Interpersonal and Communication Skills
1) Demonstrate effective communication, both written and verbal, with other members of the healthcare team.
2) Counsel and educate patients and families.
3) Effectively document practice activities.
4) Teach and share knowledge with colleagues, residents, students, and other healthcare providers.

Professionalism
1) Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
2) Make sound ethical and legal judgments appropriate for a qualified surgeon.
3) Demonstrate a commitment to continuity of patient care.

Systems-Based Practice
1) Demonstrate understanding of planning and utilizing OR resources
2) Provide cost-effective care to surgical patients and families within the community.
3) Demonstrate knowledge of risk-benefit analysis.
4) Demonstrate an understanding of the role of different specialists and other healthcare professionals in overall patient management.

No changes submitted Spring 2016
Vascular Surgery

Learning Objectives
The Vascular Surgery service at UF Health - Shands provides exposure to a wide array of vascular surgery pathologies in a busy, university-based setting. It is a clinically mature, large-volume practice wherein the residents gain exposure to basic vascular principles, peri-operative care of the vascular patient, basic vascular procedures, as well as cutting-edge technology within vascular surgery. There are five full-time Shands vascular faculty and one full-time and one part-time physician-extender level practitioners who support both the service’s inpatient and outpatient activities. The educational conference schedule is integrated with the vascular service at the VA, and trainees at all levels are encouraged to attend. Although a significant proportion of the cases are tertiary vascular cases, the basic principles are applicable to all of vascular surgery. Residents rotate at the PGY I, II, and III levels, always supervised by one of our fellows, an upper level general surgery resident, or one of the faculty.

Competency-based responsibilities and general learning objectives are as follows:

PGY I – Shands Vascular Interns (N=2)
The first year resident is responsible for the daily activities and care delivery of patients on the floor. The two residents rotate weekly between a predominant night rotation and a day rotation. S/he is expected to see consults if asked, participate heavily in the routine post-operative care of the patients, plan for discharges, and manage the wounds on the service. The interns are always welcomed in the OR, either scrubbed or observing, and are encouraged to come to the OR as frequently as able. At the completion of the rotation the resident should be able to:

Patient Care:
• Perform a directed history and physical emphasizing the multiple problems likely to be seen in this population.
• Describe the preoperative work-up for patients with common vascular problems such as carotid disease, dialysis access, aortic aneurysms, and lower extremity ischemia including the use of the noninvasive laboratory and invasive techniques.
• Understand preoperative risk stratification and risk reduction in vascular patients.
• Manage the routine postoperative recovery of these patients and recognize complications such as limb ischemia, wound breakdown, and peri-operative organ dysfunction, including renal failure, pulmonary failure, and myocardial ischemia and arrhythmias.
• Appreciate the basic conduct of larger vascular operations, both endovascular and open, including the most common risks of each procedure performed.

Medical Knowledge:
• Formulate a picture of the distribution of a patient’s arterial disease based on physical exam and non-invasive testing.
• Explain the hemodynamics of the vascular tree and their implications for therapeutic decision-making.
• Understand the anatomy of the vascular system and be able broadly to interpret angiograms and CT scans as they apply to the blood vessels and associated organs.
• Understand identification and management of cardiovascular risk factors and “best medical management” for vascular disease.
• Distinguish between arterial, venous, and neurological disease presentations.

**Practice based learning and improvement:**
• Show consistent attendance at, preparation for, and active participation in all service conferences.
• Show prompt attendance and participation in service morbidity and mortality conference, when it does not conflict with previously scheduled Departmental PGY-1 specific conferences.
• Identify opportunities to improve patient care based on individual patients, but applicable to all similar service patients.

**Interpersonal and communication skills:**
• Demonstrate clear and accurate written communication in progress notes, consults, history and physicals, and discharge summaries.
• Demonstrate clear and accurate verbal communication to the PGY-2 and PGY-3, Vascular fellows, physician extenders, consultants, nurses, social workers, administrative professionals, and faculty in the care of service patients.
• Demonstrate respectful and appropriate communication with patients, families, and other support people or caregivers.

**Professionalism:**
• Demonstrate appropriate appearance and affect for specific health care settings.
• Maintain composure in all personal and patient-related activities.
• Demonstrate effective time management while on service (i.e. punctuality, availability, tasks completed on time, paperwork completed in timely manner).
• Demonstrate enthusiasm for and aptitude in teaching medical students that rotate on the service.

**System based practice:**
• Function as an integral member of the vascular surgical team within the larger surgical community and within the hospital structure as a whole.
• Explain the role of pre-hospital primary care in the prevention and management of cardiovascular disease and its risk factors (i.e., hypertension, diabetes, hyperlipidemia, smoking).
• Understand the resources (both inpatient and outpatient) available to facilitate the recovery of vascular patients following surgery – specifically, social work services, physical therapy and rehabilitation, wound care, smoking cessation, and hospice.
• Appreciate importance of public awareness of cardiovascular disease.

**PGY II – Shands Vascular Resident**
The PGY-2 on the service is expected to supervise the interns in the day-to-day problems on the service and to be a liaison between the faculty and fellows and other consulting services. S/he will have the opportunity to see and evaluate the consults initially, and is encouraged to formulate a plan before reporting it to the overseeing fellow. The PGY-2
helps coordinate the care of the vascular surgery inpatients who are in the ICU, and act as a liaison between the vascular (primary) service and the ICU service, but s/he is not expected to remain in the ICU at all times. The PGY-2 will participate in the OR to a varying degree, depending on complexity of the cases and number of concurrent operating rooms. Additionally, s/he will go to clinic one day each week. S/he reports directly to the fellow and faculty. At the completion of the rotation the resident is expected to:

**Patient Care:**
- Supervise the daily function of the clinical service and the two interns.
- Manage the pre-operative care of vascular patients.
- Identify urgent/emergent indications for surgery in vascular patients.
- Manage postoperative vascular patients and recognize and treat complications.
- Perform post-operative management of vascular patients in the ICU.

**Medical Knowledge:**
- Outline the indications, appropriate work-up and surgical options for patients with carotid stenosis, aortic aneurysms, claudication, acute and chronic limb threatening ischemia, venous insufficiency and other common vascular problems.
- Interpret non-invasive vascular testing, CT and MR imaging of the vascular system as well as diagnostic arteriography. Appreciate the role and limitations of each.
- Manage cardiovascular risk factors and “best medical management” for vascular disease, including antiplatelet agents, anticoagulants, lipid lowering agents, and beta-blockers.

**Practice based learning and improvement:**
- Show consistent attendance at, preparation for, and active participation in all service conferences.
- Show attendance and participation in Departmental morbidity and mortality conference.
- Implement changes to improve patient care through development, validation and revision of disease-based treatment algorithms.
- Assist in the management of the PGY-1 duty hour regulations and compliance.

**Interpersonal and communication skills:**
- Demonstrate clear and accurate written communication in ICU notes, consults, and operative dictations.
- Demonstrate clear and accurate verbal communication to other junior residents, physician extenders, consultants, nurses, social workers, administrative professionals, and faculty in the care of service patients.
- Demonstrate respectful and appropriate communication with patients, families, and other support people or caregivers.

**Professionalism:**
- Demonstrate appropriate appearance and affect for specific health care settings.
- Maintains composure in all personal and patient-related activities.
- Demonstrates effective time management while on service (i.e. punctuality, availability, tasks completed on time, paperwork completed in timely manner).
• Show enthusiasm for teaching the interns and students the basics of vascular patient care, vascular anatomy and physiology, and simple procedures, where appropriate.

System based practice:
• Function as an integral member of the vascular surgical team within the larger surgical community and within the hospital structure as a whole.
• Understand the resources (both inpatient and outpatient) available to facilitate the recovery of vascular patients following surgery – specifically, social work services, physical therapy and rehabilitation, wound care, smoking cessation, and hospice.
• Appreciate importance of public awareness of cardiovascular disease.

Technical Skill:
• Perform major and minor amputations and develop a working knowledge of the technique of vascular anastomoses; perform arteriovenous fistulae
  o Toe and metatarsal amputations
  o Major lower extremity amputations (BKA, AKA, guillotine)
  o Dialysis access
  o Assist with endovascular cases (angiography)
  o Attain proper intra-arterial access in the common femoral artery
• Understand the basic endovascular techniques in the treatment of aortic aneurysms, carotid disease, peripheral arterial disease, and IVC filters. Initiate a working knowledge of endovascular capabilities and limitations.

PGY III – Shands Vascular Resident
The Chief on the service is expected to supervise the interns in the day-to-day problems on the service and to be a liaison between the faculty and fellows and other consulting services. S/he will have the opportunity to see and evaluate the consults initially, and is encouraged to formulate a plan before reporting it to the overseeing fellow. The PGY-3 will participate in the OR to a varying degree, depending on complexity of the cases and number of concurrent operating rooms, with more autonomy and opportunity than the PGY-2, but always with direct supervision from a fellow and faculty. S/he will go to vascular surgery clinic one day each week. S/he reports directly to the fellow and faculty. At the completion of the rotation the resident is expected to:

Patient Care:
• Supervise the daily function of the clinical service and the two interns.
• Manage the pre-operative care of vascular patients.
• Identify urgent/emergent indications for surgery in vascular patients.
• Manage postoperative vascular patients and recognize and treat complications.
• Perform post-operative management of vascular patients in the ICU.

Medical Knowledge:
• Outline the indications, appropriate work-up and surgical options for patients with carotid stenosis, aortic aneurysms, claudication, acute and chronic limb threatening ischemia, venous insufficiency and other common vascular problems.

• Interpret non-invasive vascular testing, CT and MR imaging of the vascular system as well as diagnostic arteriography. Appreciate the role and limitations of each. The resident will be expected to formulate a surgical plan based on these interpretations.

• Manage cardiovascular risk factors and “best medical management” for vascular disease, including antiplatelet agents, anticoagulants, lipid lowering agents, and beta-blockers.

Practice based learning and improvement:

• Show consistent attendance at, preparation for, and active participation in all service conferences.

• Show attendance and participation in Departmental morbidity and mortality conference.

• Implement changes to improve patient care through development, validation and revision of disease-based treatment algorithms.

• Assist in the management of the PGY-1 and PGY-2 duty hour regulations and compliance.

Interpersonal and communication skills:

• Demonstrate clear and accurate written communication in consults.

• Demonstrate clear and accurate verbal communication to other junior residents, physician extenders, consultants, nurses, social workers, administrative professionals, and faculty in the care of service patients.

• Demonstrate respectful and appropriate communication with patients, families, and other support people or caregivers.

Professionalism:

• Demonstrate appropriate appearance and affect for specific health care settings.

• Maintains composure in all personal and patient-related activities.

• Demonstrates effective time management while on service (i.e. punctuality, availability, tasks completed on time, paperwork completed in timely manner).

• Show enthusiasm for teaching the interns and students the basics of vascular patient care, vascular anatomy and physiology, and simple procedures, where appropriate.

System based practice:

• Function as an integral member of the vascular surgical team within the larger surgical community and within the hospital structure as a whole.

• Understand the resources (both inpatient and outpatient) available to facilitate the recovery of vascular patients following surgery – specifically, social work services, physical therapy and rehabilitation, wound care, smoking cessation, and hospice.

• Appreciate importance of public awareness of cardiovascular disease.

Technical Skill:

• Perform basic vascular anastomoses and arterial exposure.
  o Hemodialysis access
  o Arterial reconstruction
  o Groin wound closure
Wire/catheter manipulation intra-arterial or intra-venous.

- Interpret Intravascular Ultrasound images (IVUS).
- Assist with endovascular therapy of aortic pathology.
- Understand the basic endovascular techniques in the treatment of aortic aneurysms, carotid disease, peripheral arterial disease, and IVC filters. Initiate a working knowledge of endovascular capabilities and limitations.

No changes submitted Spring 2016

Burns

**Overall Objective:** Demonstrate an understanding of the concepts of burn injury and its pathophysiology. Demonstrate the ability to apply these concepts to the evaluation, resuscitation, clinical management, and rehabilitation of the burned patient while working in a multidisciplinary patient care environment.

The Burn Team has many different levels of trainees participating on the burn service ranging from medical and physician assistant students to post-graduate burn fellows. This document pertains to first and second year residents. While their skills and educational objectives will vary, the burn service expectations are graduated and graded according to their level of responsibility and accountability. Since these objectives apply to junior level residents with relatively limited service time, most of the objectives apply to both PGY-1 and PGY-2 residents.

**Educational Opportunities and Expectations:**
- Burn Morbidity & Mortality Conferences
- Burn Service Orientation Manual
- Web-based Burn Education Course
- Herndon’s *Total Burn Care* and Wolf’s *Burn Care*
- *ABLS Now* on line course
- Other lectures, articles, pre-test and post test with content on patient care, medical knowledge, communication, and systems based practice
- In-patient care
- Burn Clinic
- Operating Room
- Bedside Procedures
- Weekly Multi-Disciplinary Burn Rounds

The overriding principle of the burn rotation is to view each of the educational opportunities through a graduated lens of medical experience and to then infuse each opportunity with at least one core competency.

Listed below are the core competencies, and how the educational opportunities and expectations provide the residents in training opportunities to meet the objectives of the core competencies.

For brevity sake, we did not enumerate each of the educational opportunities within each core competency, but instead are emphasizing some opportunities which may be unique to the Burn Service. The more granular detail is available in the Burn Fellow job description, the Burn Service...
Patient Care/Clinical Skills

Each resident is expected to round on every patient at least once per day and more as clinically necessary. The resident is expected to write daily progress notes and event notes which are compliant with hospital and national standards to reflect his/her physical examination, his/her medical decision making, and the complexity of care. The senior resident is expected to ‘carry’ more patients, and is expected to provide the junior resident with feedback.

Each PGY 1 is expected to develop the knowledge, evaluation skills, and technical skills to appropriately perform common bedside procedures such as extubation, enteral feeding tube insertion and harnessing, central venous catheter insertion, arterial catheter insertion, escharotomy, peritoneal catheter insertion, bronchoscopy, laryngoscopy. The PGY 1 is expected to know indications, patient, material, and staff preparation, the technical components of the procedure, complications (and how to both avoid them and recognize them), and routine post-procedural care.

The PGY 1 successful in this Core Competency will provide a complete evaluation and treatment plan to the attending burn surgeon for new patients, and daily updates for each established patient. This evaluation will be based upon sound judgment and scientific evidence. A key component of this Competency is timely completion of all medical notes and records.

All of the above is expected by the PGY-2 resident. They are also expected to evaluate and confirm the patient evaluations of other residents and students on the service and amend the information accordingly.

Patient Care/Surgical Skills

Each resident PGY 1 is expected to be able to identify patients, prepare them for an appropriate operative procedure, participate in the operation, and help direct post-operative care. Documentation of pre-operative note, operative note, and post-operative notes are included in this expectation. Use of specialty specific terminology and documentation is expected. Operative techniques such as fascial excision, tangential excision, split- and full-thickness skin graft acquisition, and graft fixation are expected skills.

The resident is expected to see selected patients in the outpatient setting and to help evaluate the need for admission, operation, or expectant care. To provide the resident with exposure to the entire temporal spectrum of wound healing, outpatient care will focus on patient follow up with which that particular resident had clinical responsibility.

The resident successful in this Core Competency will be appropriately confident and self-assured while performing surgical skills suitable to their level of training. The resident will be adaptable to dynamic conditions in the operating room and be a full participant in all patient safety related initiatives.

The PGY-2 resident should oversee the pre and post operative evaluation performed by junior residents. Also, this resident should participate in the teaching of surgical techniques to junior residents and have mastered the techniques of burn excision and split thickness skin grafting on a limited burn area by the end of the rotation.

Medical Knowledge

The resident is expected to read the Burn Service Orientation Manual, and to avail him/herself of the variety of PowerPoint Lectures on the Burn Center Education website. The
The resident is expected to take an orientation test, a pre-rotation test, and a post-rotation test and to show improvement.

The PGY 1 successful in this Core Competency will have a sound base of fundamental knowledge necessary to provide safe patient care. This medical knowledge is a complex integration of surgical critical care, nutrition, fluid and electrolyte management, infectious disease processes and is able to manage these complex relationships. The PGY 1 will be able to provide care for both pediatric and adult patients with multiple medical problems including diabetes, cardiac and renal disease, morbid obesity, autoimmune diseases, and a variety of severe exfoliative disorders.

The PGY-2 resident should have a higher level of medical knowledge with regard to the management of critically ill patients.

**Practice-Based Learning and Improvement**

The burn patient list and the Burn Morbidity and Mortality (M&M) conference represent an outstanding opportunity for the resident to critically evaluate their practice on a patient based level. Each PGY 1 is expected to assist the Burn Attendings and Fellows to monitor, acquire, record, and analyze M&M’s, near misses, and opportunities for improvement in the context of patient care delivery. S/he will present at least one case with which the resident was involved. Other cases are opportunities for self-directed learning and review of the literature with the fellow and/or attending guidance. This process also meets core curriculum objectives under the headings of Medical Knowledge and Communication.

The PGY 1 successful in this Core Competency will have developed the skills in burn registry use and evaluation to assess trends in patient outcomes. The resident will be facile at reading and interpreting relevant medical literature to understand and support their patient care decisions.

The PGY 2 is expected to having a higher level of skill in evaluation of patient care and the application of relevant medical literature.

**Interpersonal and Communication Skills**

There are many opportunities for the resident to meet the core competency objectives of Interpersonal and Communication Skills while the resident is fulfilling his/her expectations. Daily patient rounds and presentations are one example of communication and interpersonal skill building. Formal presentation at Burn M&M is a public speaking venue to an audience with a broad range of knowledge.

The effective burn team encourages multi-disciplinary contributions to burn care. Each patient receives care from nurses, nursing assistant, physicians, dieticians, burn rehabilitation, social work, psychiatric nursing, child life specialists, Chemical Dependency Service, and Social work. The resident is expected to be able to collect information from these team members and communicate them with the attending to help implement the total treatment plan. Many patients on the burn service have consults from other services. The resident is expected to gain the necessary

**Medical Knowledge** to effectively communicate patient condition and treatment plans with other disciplines.

The PGY 1 successful in this Core Competency will be able to present patient scenarios to audiences including the attending burn surgeon, consulting physicians, and to allied health professionals at conferences. The resident will respond to requests from the bedside nurse, the
hydrotherapy team, and the dressing team in a manner that ensures prompt and safe patient care which incorporates team member knowledge and expertise.

The PGY-2 resident should have more of a central role in the multidisciplinary team being knowledgeable of the overall long-term care plan for all servicer patients.

**Professionalism**

Since burn care is characterized by a multi-disciplinary team approach, there are many opportunities to develop an appropriate professional demeanor. Weekly Burn Service Multidisciplinary Rounds combine bedside teaching with multi-disciplinary service rounds where all members of the burn care team are expected to contribute to the care plan of the burn patient. Each discipline brings to the conversation their own unique perspective to the patient’s care. This experience provides an outstanding opportunity for the PGY 1 to comport him/herself with professionalism. The resident is expected to obtain the knowledge to appreciate and understand the team members’ contributions, and to develop the interpersonal and communication skills so that an effective plan of care can be developed and implemented.

The PGY 1 successful in this Core Competency will demonstrate respect, compassion, and integrity through his/her daily performance on the service. The PGY 1 will be a role model for whole-hearted participation in the multi-disciplinary burn care team. The PGY 1 will support and encourage the patient and family members during their difficult road to recovery.

The PGY-2 resident should have more of a team leader role in the multidisciplinary team as guided by the input from the attending physicians. He/She must be able to coordinate patient care activities with other members of the burn team as well as off service consultants in a manner that facilitates the overall care of the patient.

**Systems-Based Practice**

In addition to Burn M&M and Burn Multi-Disciplinary Rounds, the resuscitation from acute burn injury during the first 48 hours post-burn provides the resident with an outstanding opportunity to develop systems-based practice skills. The care of the burn patient for the first 24-48 hours of burn injury follows a rigorous multi-disciplinary printed protocol. The resident is expected to help guide the team to follow the protocol. Deviations from the protocol are opportunities for patient and practice-based learning and improvement, since perhaps this patient has a medically relevant reason to ‘fall-off’ the protocol. Deviations from protocol may be opportunities for a systems-based practice evaluation.

Weekly Burn Service Multidisciplinary Rounds are not just ‘work-rounds.’ They are also opportunities for each discipline to identify and share their perceptions of systems opportunities for improved care. Many systems-based care projects have come out of this meeting including universal pediatric drug screening for child abuse, infection and hygiene surveillance programs, and medication safety initiatives. The residents are often the ‘canaries in the coal mine’ as they give these issues a voice and presence in the Burn Treatment Center.

Burn M&M is not just a patient based discussion of the complication, but also an opportunity to critically review regularly reported metrics such as patient satisfaction, skin graft take, length of stay, antibiotic usage, and compliance with infection control.

The PGY 1 successful in this Core Competency will adhere to the carefully created and established patient care protocols. The PGY 1 will identify opportunities to support research projects by identifying patients eligible for participation in clinical trials.

The PGY-2 resident should have more of a team leader role in the multidisciplinary team as guided by the input from the attending physicians. He/She must be able to coordinate patient
care activities with other members of the burn team as well as off service consultants in a manner that facilitates the overall care of the patient.

**Teaching Skills**

The Burn Team has many different levels of trainees in various disciplines participating on the burn service, including medical and physician assistant students and postgraduate fellows. The PGY 1 successful in this Core Competency will identify and utilize appropriate opportunities to advance the skills and knowledge of the students on the service.

The PGY-2 resident should have more of a teaching role on the service providing junior residents and students with information pertaining to the care of surgical patients in general and burn injured patients in particular.

**Summary**

In summary, a rotation on the burn service allows the resident to maximize his/her educational opportunities. Each of the Educational Opportunities and Expectations provides a framework for the resident to meet the objectives contained within the Burn Core Competencies. Each resident is evaluated and provided feedback with the opportunity for modification of goals each month. This formal evaluation process will incorporates input from all members of the multi-disciplinary burn team as well as patients and families in a 360 degree model.

Surgery resident rotations on the Burn Service are provided at the **PGY 1 and 2** level. The rotation involves all aspects of care of the thermally injured patient. The residents participate in initial patient evaluation, admission to the Burn Center and all aspects of care throughout the hospital course. As an integral part of the Burn Care Team, the resident interacts with the multi-specialty ancillary staff and the Critical Care Medicine Service on a daily basis. The resident participates in all surgical procedures required by the burn patients and is available for outpatient burn clinic. At the completion of the burn rotation the resident should:

- Demonstrate an understanding of the concepts and pathophysiology of burn injury.
- Demonstrate the ability to apply these concepts to the evaluation, resuscitation, clinical management, and rehabilitation of the burned patient.
- Review the criteria for adequate evaluation of a burned patient, including historical aspects of the type of burn and subjective physical findings.
- Discuss an initial treatment plan for stabilization and fluid.
- Outline the principles of burn shock, immunologic alteration, and bacteriologic pathology of burned skin.
- Review the basic principles and controversies concerning the management of the burn wound, and describe a clinical plan for its care.
- Analyze the principles of systemic and local antibacterial agents in the burn wound.
- Explain the special circumstances created by electrical, chemical, and inhalation burn injury, and apply their relation to management.
- Describe the pathology and management of inhalation injury, noting its relation to mortality, morbidity, and time course of patient recovery.
- Assess the appearance of the burn wound in relation to its depth, bacteriologic condition, healing potential, and requirement for intervention.
- Describe the indications, techniques for harvest, application, immobilization, and care of split- and full-thickness skin grafts.
• Describe and explain the following terms:
  o Compartment syndrome
  o Burn eschar contraction
  o Fasciotomy and escharotomy incisions and techniques
  o Rhabdomyolysis
• Summarize the treatment of chemical burns to include pathology, sources, decontamination, and management
• Review and analyze the special circumstances, management, and rehabilitation of burns in the pediatric patient
• Summarize the activities of a specialized burn team or unit in the overall management of the burn patient to include the following:
  o Physical therapy
  o Occupational therapy
  o Psychological counseling
  o Recreational therapy
  o Burn nursing
• Provide emergency burn patient evaluation and monitoring. Determine the level of care and need for transfer to a burn facility
• Implement fluid resuscitation protocols for children and adults
• Select and apply appropriate dressings and antibacterials
• Manage systemic effects of the burn wound in the critically injured surgical patient, considering:
  o Sepsis
  o Gastrointestinal (GI) effects
  o Immunologic problems
  o Cardio-respiratory effects
• Manage treatment of inhalation injury;
  o Flexible laryngotraceoscopy
  o Ventilator management
• Manage wound therapy, including:
  o Eschar formation and slough
  o Re-epithelization
• Evaluate electrical burns, including:
  o Entrance and exit wound
  o Cardiac, vascular, neurologic, ophthalmologic effects
  o Deep tissue destruction
• Manage eschar contracture and edema control:
  o Techniques of escharotomy
  o Techniques of fasciotomy

Revised by Dr. Winston on 4/25/16

**VA Surgical Intensive Care Unit**

The VA CTICU and SICU comprise an 18-bed, multispecialty, open-model (primary teams remain the primary team while the patient is in the ICU) unit. The SICU resident provides
collaborative support as part of the Surgical Inpatient Care Section. The service is composed of an Intensivist (with three intensivists representing both medical and surgical backgrounds in rotation) and two (2) PGY-1 residents Monday-Friday 0600-1800h. A third-year medical student also participates during some rotations. Nighttime coverage is provided by the VA Night Float resident, except on Friday, when the SICU resident also serves as night float. The Intensivist provides in-house coverage on Saturday and Sunday, and on call coverage after-hours. Additional support is provided by two Clinical Pharmacists.

PGY-1 Resident- Functions in differing capacities depending on the patient’s primary team:

**General and Vascular Surgery** – The SICU resident essentially functions as a member of the surgical team and is responsible for management of the patients in the ICU. They are supported and guided by both the Intensivist and the surgical Senior Resident, Chief Resident and Attending. Being simultaneously a member of two teams can be complex and occasionally confusing, but prepares the resident for the collaborative management style encountered in private practice. It is emphasized that although the Resident often acts as a “go-between” the surgical and critical care teams, resolution of management disagreements between the two teams is ultimately the responsibility of the attendings and not the resident.

**Cardiothoracic Surgery** – The SICU resident provides after-hours coverage.

**Other services** – While these patients are managed by the Intensivist, the SICU resident is not usually directly involved in care. However, the resident will occasionally assist when this is educationally valuable, or to support the primary team as needed.

- The SICU Resident is responsible for knowing pertinent, up-to-date clinical data, assessing the status and active issues of the General and Vascular Surgery patients. He/she should also formulate the plan to address those issues—significant interventions are discussed with the Intensivist.
- The Resident will generally perform any procedures which are necessary, except certain specialist-level procedures such as awake bronchoscopy or interventional endoscopy.
- The complexity and multidisciplinary nature of ICU care demands clear and detailed communication of the patient care cognitive process in the medical record; the Resident will write the principal daily note on patients who are not also followed by a medical student.
- Finally, when workload in the ICU permits, the Resident is encouraged to participate in OR cases.

**Medical Knowledge**
1) Discuss the indications for initiating mechanical ventilation.
2) Develop a functional knowledge of ventilator settings and how to adjust the ventilator based on patient requirements.
3) Describe the discontinuation of mechanical ventilation, including weaning if necessary.
4) Interpret arterial blood gases.
5) The resident should be able to elaborate a differential diagnosis for common electrolyte and endocrine disorders in the ICU and select an appropriate therapeutic strategy.
6) Be familiar with the pharmacodynamics of common sedatives, neuromuscular blockers and cardiovascular medications used in the ICU setting.
7) Discuss the prevention and management of acute myocardial infarction and cardiogenic shock.
8) Discuss the prevention of central venous catheter infection, ventilator-associated pneumonia, thromboembolic disease and gastric stress ulceration.
9) Critically evaluate and demonstrate knowledge of pertinent scientific information.

Patient Care
The resident will provide patient care that is compassionate, appropriate, and effective.
1) Recognize changes in clinical status in critically ill surgical patients, initiate supportive measures and formulate a strategy for further evaluation.
2) The resident should be able to manage new onset sepsis, including volume resuscitation, vasoactive infusions and workup of the underlying cause.
3) Manage nutrition in critically ill surgical patients with both functional and nonfunctional gastrointestinal tracts.
4) Manage moderate sedation of the ventilated patient
5) Formulate definitive treatment plan for particular skin lesions by choosing a surgical or nonsurgical treatment modality (based on size, anatomical location, and physical condition of the patient) with supervision.

Practice-Based Learning Improvement
1) The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
2) Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.

Interpersonal and Communication Skills
1) Communicate and collaborate effectively with colleagues other health care professionals.
2) Address end-of-life issues, when appropriate, with patients and families.
3) Effectively document practice interventions, changes in clinical status, assessments and plans.
4) Teach and share knowledge with colleagues, residents, students, and other health care providers.

Professionalism
1) Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
2) Make sound ethical and legal judgments.

Systems-Based Practice
1) Provide cost-effective care to surgical patients and families within the community.
2) Demonstrate knowledge of risk-benefit analysis.
Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

No changes submitted Spring 2016

**Surgical Critical Care**

**Resident Goals and Objectives**

**PGY2**

The resident will be evaluated on the six core competencies required by the ACGME (described below), as pertains to the care of the ICU patient and the above listed goals and objectives. It is understood that the breadth of knowledge and experience gained will be proportional to the amount of time spent rotating in the ICU as well as the effort of the resident on rounds and in reviewing appropriate reading materials, including textbooks, the peer-reviewed literature, and web-based educational materials. Please note that the oral examination topics are most often drawn from the ACGME competencies.

ACGME Competencies:
The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. **Patient care** that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health:
   a. Perform an appropriate history and physical examination of the critically ill patient;
   b. Appropriateness and effectiveness of the medical plan is assessed on rounds;
   c. Competence in the placement of invasive monitors;
   d. Modified 360 degree evaluations are used to evaluate for compassionate care.

2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care:
   a. Workup of a patient with decreased urine output;
   b. Workup of a patient with hypotension;
   c. Workup and treatment of septic shock;
   d. Work-up of fever;
   e. Initiation of antibiotics;
   f. Choices of mechanical ventilatory modes for ARF;
   g. Ventilator weaning;
   h. Algorithm for difficult airway in the ICU;
3. **Practice-based learning and improvement** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care:
   
a. Learn how to use evidence-based medicine to improve patient care;
b. Become proficient at using the electronic medical record and the use of the Internet to look up medical information;
c. Evaluations of assigned lectures and rounds will be used for assessment.

4. **Interpersonal and communication skills** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals:
   
a. Understand the importance of effective communication;
b. Develop excellent communication skills with patients, patient families, peers, staff, and attendings;
c. Assessed for on rounds with attending physicians and residents, in interactions with nurses and staff, and in family interactions.

5. **Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds**
   
a. Understand the ethical principles of medicine and how these impact and influence the way we treat patients.
b. Understand the importance of timeliness in dictations, rounding, charting.
c. Understand the need for showing sensitivity to patients’ ethnicity, age, life-styles, and disabilities.
d. Learn how to practice medicine with integrity and honesty.
e. Assessed for on rounds with attending physicians and residents, in interactions with nurses and staff, and in family interactions.

6. **Systems-based practice, as manifested by actions that 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:**
   
a. Learn how to work with an interdisciplinary team in the care of the critical care patient including arranging care by consult teams.
b. Learn how to approach patient care problems from a systems-based approach rather than the “Band-Aid” approach.
c. Begin to develop a feel for providing cost-effective medicine without compromising patient care;
d. Appropriate resource utilization as determined by daily practice as well as discussion on rounds.

The resident will be able to recognize and treat:

I. The need for admission to the ICU care in postoperative or trauma patients
   A) Physiologic instability
      1. Neurologic
      2. Respiratory
      3. Hemodynamic
   
   B) Need for close monitoring
      1. Neurologic status
      2. High risk of post-op / ongoing bleeding
      3. Monitoring of flaps or grafts
      4. Poor physiologic reserve
         a. Neurologic
         b. Respiratory
         c. Hemodynamic

II. Fluid management principles in postoperative / trauma / burn patients
   A) ATLS / ABLS
   B) Maintenance requirements
   C) Replacement of blood loss
   D) Third space losses
   E) Burn injury resuscitation
      1. Resuscitation formulae (Parkland, Brooke)
      2. Titration of resuscitation
      3. Indication for invasive monitoring

III. Organ Dysfunction
   A) Neurologic System
      1. Confusion / agitation
      2. Seizures
      3. Hydrocephalus
      4. Vasospasm
      5. Increased ICP and herniation syndromes
   B) Cardiovascular System
      1. Hypotension
      2. Hypertension
      3. Arrhythmias
      4. Cardiac arrest (ACLS)
      5. Differential diagnosis and treatment of shock states
   C) Respiratory System
      1. Hypoxia
      2. Hypercarbia
3. ALI / ARDS
4. Airway Compromise – Understand different methods for securing the airway
   a. Endotracheal intubation with and without drugs
   b. Awake fiber optic intubation
   c. Laryngeal mask airway
   d. Indications for tracheostomy
      i. Cricothyrotomy
      ii. Surgical tracheostomy
5. Understand the various modes of ventilatory support

D) Renal System
1. Differential diagnosis and treatment of oliguria
2. Azotemia
3. Common electrolyte abnormalities
   i. Hyper / hyponatremia
   ii. Hyper / hypokalemia
   iii. Hyper / hypocalcemia
   iv. Hyper / hypophosphatemia
   v. Hypomagnesemia
4. Renal replacement therapy
5. Acid-Base Disorders

E) Hepatic System
1. Jaundice
2. Coagulopathy
3. Shock liver

F) Hematologic System
1. Anemia
2. Thrombocytopenia
3. Coagulopathy

G) Endocrine System
1. Adrenal insufficiency
2. Thyroid disorders
3. Diabetes Insipidus
4. Diabetes mellitus / and glycemic control
5. SIADH
6. Cerebral salt wasting syndrome

IV. Prevention and Management of Infectious Diseases
   A) Evaluation and workup of fever
   B) Antibiotic selection
      1. Initial choice
      2. Narrowing antibiotic focus based upon sensitivities
      3. Antimicrobial drug monitoring
      4. Duration of therapy
   C) Prevention and Treatment of common infections
      1. Ventilator-associated pneumonia (VAP)
      2. Catheter-related bloodstream infection
3. UTI
4. Wound infection
5. Peritonitis / Intra-abdominal abscess
6. Meningitis
7. Sepsis / septic shock
D) Surgical Prophylaxis

V. Nutritional Depletion
   A) Evaluation of nutritional status
   B) Enteral Nutrition
   C) Parenteral Nutrition

VI. The Indications for Blood Component Therapy
   A) Packed RBCs
   B) Platelets
   C) Fresh Frozen Plasma
   D) Cryoprecipitate
   E) Recombinant Factor VIIa
   F) Bleeding abnormalities
   G) Transfusion “triggers”

The resident will:

VII. Understand Indications and Techniques for Procedures in the ICU
   A) Capnography
   B) Arterial line
   C) Central venous line
   D) Pulmonary artery catheter
   E) Lithium dilution cardiac output (LiDCO)
   F) Esophageal Doppler Monitor
   G) Echocardiography
   H) Trans venous pacer
   I) External pacer
   J) Chest tube
   K) Bronchoscopy

VIII. Practice Preventive / “Proactive” Medicine
   A) DVT prophylaxis
   B) Stress ulcer prophylaxis
   C) Pulmonary toilet / bronchodilators / VAP prophylaxis
   D) Perioperative heart rate and blood pressure control
   E) Renal protection before dye load

IX. Understand Methods to Provide Sedation and Analgesia

X. Understand Appropriate Use and Monitoring of Neuromuscular Blockade

XI. Understand the Risks of Transporting a Critically Ill Patient

XII. Rapidly Recognize Postoperative Complications
   A) Postoperative hemorrhage
   B) Anastomotic lead
C) Wound infection  
D) Abscess  
E) Poor graft function  

XIII. Understand Management of Primary / Secondary / Tertiary Survey in Traumatic Injury  
A) Traumatic Brain Injury  
B) Head and Neck Injuries  
C) Thoracic Injuries  
D) Abdominal and Pelvic Injuries  
E) Extremity Injuries  
F) Pregnant Trauma patient  

XIV. Understand Critical Care Issues in Pregnancy  
A) Pre-eclampsia / Eclampsia  
B) Peripartum Hemorrhage  
C) Pulmonary and amniotic fluid embolism  
D) Peripartum cardiomyopathy  

Revised by Dr. Efron on 5/31/16  

Orthopaedics  

The residents may rotate on the orthopedic service at the PGY I level. The resident is assigned to the unique Orthopaedic Oncology service but also attends and participates in all of the conferences for the Department. The PGY I is exposed to a variety of soft tissue and bone neoplasms. There is also opportunity for exposure to sports and other orthopedic injuries while on the service. At the completion of the rotation the resident is expected to:  

1) Describe the gross anatomical structures of the skeletal system.  
2) Understand the basic physiology for different types of musculoskeletal disease including congenital, developmental, degenerative, neoplastic and traumatic.  
3) Discuss the use of imaging modalities in diagnosing such orthopaedic pathology as tumors, extremity injuries and spinal injuries.  
4) Outline the management of soft tissue and bone tumors.  
5) Participate in the operating room as directed.  
6) Explain the basics of physical therapy and rehabilitation to maximize functional recovery.  

No changes submitted Spring 2016  

VA General Surgery – Gainesville  

This general surgery service cares for adult male and female patients of all ages and thus provides the resident staff a broad exposure to both common and complex general surgical problems. The service in essence is the provider of general surgical care to the equivalent of a medium sized city. The patients come from a broad range of socioeconomic backgrounds and frequently have multiple co-morbidities that provide challenging complexity to their surgical management. There are 5 attending surgeons and two physician’s assistants on the service. Resident staffing is composed of a PGY 1, PGY 3 and PGY 5 level that rotate on the service. Attending staff makes daily work/teaching rounds. The residents will participate in a weekly didactic, preop and complications conference and are expected to fully participate in all of the departmental conferences and educational offerings. The broad general competencies for surgical resident education as outlined by the ACGME apply to residents at all levels on this rotation.
Broad surgical diseases and conditions commonly treated are:
- Abdominal pain
- Hernia, all types
- Biliary tract disease
- Hepatic mass evaluation
- Esophageal diseases
- Small intestinal obstruction
- Disease of the Appendix
- Benign and malignant neoplasms of the colon and rectum
- Diverticulitis
- Anal conditions
- Benign and malignant breast disease
- Melanoma

Focused surgical diseases and conditions commonly treated are:
- Bile duct neoplasms
- Hepatic neoplasms, benign and malignant
- Pancreatic neoplasms, benign and malignant
- Esophageal neoplasms, benign and malignant
- Splenic disorders

Service specific responsibilities and general learning objectives by level include but are not limited to the following:

**PGY 1** – The first year resident manages inpatients on the surgical wards under the direction of senior resident staff, performs initial histories and physicals as needed, sees patients in the clinic and establishes formal professional relationships, and participates in the operating room with maximum supervision. Core competencies the resident should achieve on this rotation include:

**Patient Care**

The resident is expected to:
1) participate in formulating the treatment plan for all ward patients;
2) be responsible for executing the treatment plan as formulated by the surgical staff;
3) participate in surgical procedures appropriate for skill level; and
4) participate in clinic, ward responsibilities permitting.

**Medical Knowledge**

The resident is expected to:
1) develop knowledge and skills in pre- and postoperative evaluation and management of general surgical patients;
2) understand the importance of and assess perioperative risk; and
3) acquire a working knowledge of the biology and pathophysiology of wound healing, fluid and electrolyte therapy, pain management, perioperative nutrition and surgical infection.
Practice-Based Learning and Improvement

The resident is expected to:

1) apply established principles of perioperative care to the management of ward patients;
2) understand the specific disease processes of surgical patients and their appropriate management; and
3) become familiar with the VA NSQIP system and SCIP measures and their application to continuous quality improvement.

Interpersonal and Communication Skills

The resident is expected to:

1) communicate and collaborate effectively with colleagues other health care professionals in an integrated health care system;
2) counsel and educate patients and families;
3) effectively document practice activities utilizing a comprehensive electronic medical record;
4) teach and share knowledge with colleagues, residents, students, and other health care providers.

Professionalism

The resident is expected to:

1) demonstrate a commitment to continuity of patient care;
2) maintain an appearance appropriate to the health care setting;
3) relate to other health care providers with the dignity and respect; and
4) demonstrate effective time management skills including punctuality, availability and prioritization of tasks.

Systems Based Practice

The resident is expected to:

1) understand and apply the utility of an electronic medical record;
2) work within the framework of the established policies and procedures of the VA medical system;
3) demonstrate knowledge of risk-benefit analysis; and
4) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

PGY 3- The third year resident is responsible for the day to day care of surgical inpatients, both in the ward setting and in the ICU. The resident is directly responsible for supervision of the Resident 1’s and students in the delivery of care to all service patients. In addition, the Resident 3 oversees the consult service and participates in clinic. The rotation will provide a significant primary operative experience with an emphasis on laparoscopy, hernia repairs of all types, biliary tract surgery, and intestinal resection. The resident is expected to participate in most surgical procedures either as a primary or assistant surgeon.

Medical Knowledge

The resident is expected to:

1) have a thorough understanding of general surgical disease processes and their management including but not limited to biliary tract disease, hernias, inflammatory/infectious bowel disease, GI tract
malignancy, benign and malignant esophageal disease, anorectal disorders, benign and malignant pancreatic disease, burns and soft tissue problems and sepsis; and
2) take advantage a significant operative experience that will enhance technical skill and judgment with a wide variety of general surgical problems.

**Patient Care**

The resident is expected to:

1) demonstrate independent decision making in the care of patients balanced by an awareness of the limitations of his/her judgment, experience knowledge and skill;
2) analyze risks and benefits of surgical procedures and alternative treatments, particularly among patients with significant co-morbidities; and
3) focus on the prevention, recognition and management of postoperative complications in a high-risk patient population.

**Practice Based Learning and Improvement**

The resident is expected to:

1) apply established principles of perioperative care to the management of all service patients;
2) thoroughly understand the specific disease processes of surgical patients and their appropriate management;
3) become familiar with the VA NSQIP system and its application to continuous quality improvement; and
4) utilize the VA-based Skills Laboratory for development of basic and advanced laparoscopic techniques.

**Interpersonal and Communication Skills**

The resident is expected to:

1) communicate and collaborate effectively with colleagues other health care professionals in an integrated health care system;
2) counsel and educate patients and families;
3) effectively document practice activities utilizing a comprehensive electronic medical record;
4) teach and share knowledge with colleagues, residents, students, and other health care providers; and,
5) assume a leadership role in the evaluation, management and coordination of care.

**Professionalism**

The resident is expected to:

1) demonstrate a commitment to continuity of patient care;
2) maintain an appearance appropriate to the health care setting;
3) relate to other health care providers with the dignity and respect; and
4) demonstrate effective time management skills including punctuality, availability and prioritization of tasks; and
5) serve as an example of professional behavior to peers, juniors and students.
Systems-Based Practice

The resident is expected to:

1) understand and apply the utility of an electronic medical record;
2) work within the framework of the established policies and procedures of the VA medical system;
3) demonstrate and apply knowledge of risk-benefit analysis; and
4) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

PGY 5- The rotation is intended to serve as a transition to practice for the Chief Resident. In this capacity the resident will assume responsibility for all aspects of the General Surgery Service including administration, scheduling and patient care. The resident will have the opportunity to be the primary surgeon on a wide variety of complex general surgical cases and is expected to assume graduated responsibility as the teaching assistant for mid- and lower level residents. At the completion of the rotation it is expected that the resident will have demonstrated the knowledge, skill and judgment to practice independently.

Medical Knowledge

The resident is expected to:

1) demonstrate a thorough knowledge of all aspects of general surgery commensurate with passage of the American Board of Surgery Qualifying and Oral examinations;
2) act as the primary surgeon in a variety of complex general surgical procedures including esophagectomy, pancreatectomy, complicated colorectal resections and advanced laparoscopy; and
3) serve as teaching assistant for lower level residents on straightforward biliary tract and gastrointestinal procedures as well as a variety of soft tissue and anorectal procedures.

Patient Care

The resident is expected to:

1) supervise, coordinate and direct all aspects of patient care on the service in consultation with attending staff;
2) Exercise independent decision making in patient care with the expectation that the resident has a high level of awareness of his/her limitations in experience, knowledge, judgment and skill;
3) analyze risks and benefits of surgical procedures and alternative treatments, particularly among patients with significant co-morbidities;
4) focus on the recognition and management of postoperative complications in a high-risk patient population; and,
5) actively participate in the clinic to provide longitudinal exposure to the evaluation, care and management of general surgical patients.

Practice-Based Learning and Improvement

The resident is expected to:

1) apply established principles of perioperative care to the management of all service patients;
2) recognize and thoroughly understand the specific disease processes of surgical patients and their appropriate management;
3) investigate the medical literature for evaluation and management of specific surgical problems;
4) use the VA NSQIP system and its application to continuous quality improvement;
5) monitor and report morbidity and mortality with analysis of trends and application to practice patterns; and
6) utilize the VA-based Skills Laboratory for improvement of basic and advanced laparoscopic techniques.

Interpersonal and Communication Skills

The resident is expected to:
1) As the leader of the general surgical team, the resident will communicate and collaborate effectively with colleagues other health care professionals
2) Counsel and educate patients and families.
3) Effectively document practice activities.
4) Teach and share knowledge with colleagues, residents, students, and other health care providers.

Professionalism

The resident is expected to:
1) demonstrate a commitment to continuity of patient care;
2) maintain an appearance appropriate to the health care setting;
3) relate to other health care providers with the dignity and respect; and
4) demonstrate effective time management skills including punctuality, availability and prioritization of tasks; and
5) serve as an example of professional behavior to peers, juniors and students.

Systems Based Practice

The resident is expected to:
1) understand and apply the utility of an electronic medical record;
2) work within the framework of the established policies and procedures of the VA medical system;
3) demonstrate and apply knowledge of risk-benefit analysis; and
4) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management

Revised by Dr. McDonald on 4/27/16

VA Night Float

The PGY-2 resident assigned to the VA night float rotation will be the first call resident on the General, Vascular and Cardiothoracic services at the VA hospital most nights of the week. As such the primary responsibility of the resident will be to provide perioperative care to patients in both the ICU and general care settings. In addition the night float resident will serve as the emergency surgical consultant to both the emergency room and the remainder of the non-surgical services in the hospital after hours. In this role the resident will function as a surgical “hospitalist” for the VA hospital, with appropriate support from more senior residents and the attending physicians in General, Vascular and Cardiothoracic surgery.

The goals of this rotation and the learning objectives for the rotation by core competency are outlined below:
Medical Knowledge

1) The primary educational goal of this rotation will be to master the physiology and pathophysiology required to manage perioperative patients in a critical care environment. The focus will be on cardiovascular, pulmonary and gastrointestinal physiology. The resident will master the pharmacology of agents used to treat common post operative conditions.

2) The resident will also master the microbiology of common perioperative infections, especially nosocomial infections seen in the ICU. The resident will also master the pharmacology of antimicrobials required to treat these infections.

3) The resident will master the physiology of resuscitation and learn the signs and symptoms of emergency surgical conditions encountered in the emergency room and in hospitalized patients.

4) The resident will gain knowledge of the initial evaluation and management of common urgent and emergent General, vascular and cardiothoracic conditions.

Patient Care

1) The resident will begin to develop independent decision making skills in perioperative and critical care, with a careful awareness of their own limitations in experience, knowledge and judgement.

2) The resident will master the skills required to perform bedside procedures commonly utilized in the management of critically ill surgical patients such as arterial line placement, central line placement, Swan-ganz catheter placement, tube thoracostomy, and emergent airway skills.

3) The resident will develop the clinical acumen to recognize and manage common perioperative complications such as are encountered in a high-risk surgical patient population.

4) The resident will learn to begin to independently diagnose and manage commonly encountered urgent and emergent general, vascular and cardiothoracic conditions in the emergency room and inpatient setting.

Practice Based Learning and Improvement

1) The resident will apply evidence-based, established principles of perioperative care to the management of intensive care unit patients. The resident will learn, with appropriate faculty guidance how to identify and correct deficiencies in their personal fund of knowledge

2) The resident will learn to assess the effectiveness of interventions performed in the intensive care unit on improving perioperative care.

3) The resident will gain a practical understanding of the role of aggressive perioperative care in preventing complications in surgical patients and improving the quality of surgical care.

4) The resident will gain familiarity with the VA NSQIP system and it’s role in continuous quality improvement.

Interpersonal and Communication Skills

1) The resident will learn to effectively communicate and collaborate as a member of a multidisciplinary health care team.

2) The trainee will learn to effectively document practice activities performed off hours in the patient’s medical record.

3) The resident will learn the skills required to effectively transfer or hand off care of complex surgical patients to other providers in a way that enhances patient care.

4) The resident will learn to effectively communicate to supervising residents and attending physicians changes in a patient’s status which may require a change in management plan.
5) The resident will learn to effectively communicate changes in patient condition with patients and their families. The resident will learn to obtain informed consent for emergency procedures from patients and their families.

**Professionalism**

1) Always place the needs of the patient first
2) Demonstrates equanimity in interactions with patients, families, and all members of the health care team.
3) Demonstrates the ability to make sound ethical decisions in patient care.
4) Demonstrate a commitment to quality patient care.

**System-Based Practice**

1) Understand the utility of, and effectively utilize the electronic medical record to provide quality patient care.
2) Work within the framework of established policies a procedures of the VA medical system and the individual surgical sections to provide effective night-time care to surgical patients
3) Demonstrate an understanding of the role of different specialists and other health care professionals in providing nighttime care to surgical patients. Effectively utilize other specialists to provide emergent consultative care to surgical patients.

Revised by Dr. McDonald on 4/27/16

**VA Vascular Surgery**

The Vascular Surgery service at Malcom Randall VAMC provides the primary vascular surgical operative experience for the general surgery residents. There are three full-time VA vascular faculty members who share responsibility for the service. There are also two physician-extender level practitioners who support both the service’s inpatient and outpatient activities. The educational conference schedule is largely integrated with the vascular service at Shands Hospital, but there are several VA-specific learning opportunities for the residents on this rotation. Residents are exposed to all of the common problems encountered in the practice of vascular surgery, and see a broad scope of “bread-and-butter” vascular surgery. Residents rotate at the PGY I and IV level with the PGY IV acting as Chief Resident. Competency-based responsibilities and general learning objectives are as follows:

**PGY I – VA Vascular Intern**

The first year resident does patient work-ups, sees patients in clinic, cares for the patients on the ward and responds to consults. The PGY I is expected to participate in the operating room as workload permits and to perform such procedures as amputations, debridements and skin grafts. At the completion of the rotation the resident should be able to:

**Patient Care**

1) Perform a directed history and physical highlighting the multiple problems likely to be seen in this population.
2) Describe the preoperative work-up for patients with common vascular problems such as carotid disease, aortic aneurysms, and lower extremity ischemia including the use of the noninvasive laboratory and invasive techniques.
3) Understand preoperative risk stratification and risk reduction in vascular patients.
4) Manage the routine postoperative recovery of these patients and recognize complications such as myocardial ischemia, wound breakdown, pulmonary problems, and limb ischemia.

5) Perform simple operative procedures under supervision (i.e. wound debridement, digital amputations, some major amputations, and diagnostic arteriography).

6) Appreciate the basic conduct of larger vascular operations, both endovascular and open.

Medical Knowledge

1) Formulate a picture of the distribution of a patient’s arterial disease based on physical exam and non-invasive testing.

2) Explain the hemodynamics of the vascular tree and their implications for therapeutic decision-making.

3) Understand the anatomy of the vascular system and be able to interpret angiograms and CT scans as they apply to the blood vessels and associated organs.

4) Understand identification and management of cardiovascular risk factors and “best medical management” for vascular disease.

5) Distinguish between arterial disease and venous disease presentations.

Practice-based Learning and Improvement

1) Show consistent attendance at, preparation for, and active participation in all service conferences.

2) Show attendance and participation in service morbidity and mortality conference.

3) Identify opportunities to improve patient care based on individual patients, but applicable to all similar service patients.

Interpersonal and Communication Skills

1) Demonstrate clear and accurate written communication in progress notes, consults, and discharge summaries.

2) Demonstrate clear and accurate verbal communication to Chief Resident, physician extenders, consultants, nurses, social workers, administrative professionals, and faculty in the care of service patients.

3) Demonstrate respectful and appropriate communication with patients, families, and other support people or caregivers.

Professionalism

1) Demonstrate appropriate appearance and affect for specific health care settings.

2) Maintain composure in all personal and patient-related activities.

3) Demonstrate effective time management while on service (i.e. punctuality, availability, tasks completed on time, paperwork completed in timely manner).

4) Demonstrate enthusiasm for and aptitude in teaching medical students that rotate on the service.

Systems-based Practice

1) Function as an integral member of the vascular surgical team within the larger surgical community and within the hospital structure as a whole.

2) Explain the role of pre-hospital primary care in the prevention and management of cardiovascular disease and its risk factors (i.e. HTN, diabetes, dyslipidemia, and smoking).

3) Understand the resources (both inpatient and outpatient) available to facilitate the recovery of vascular patients following surgery – specifically, social work services, physical therapy and rehabilitation, wound care, smoking cessation, and palliative care/hospice.

4) Appreciate importance of public awareness of cardiovascular disease.
PGY IV – VA Vascular Chief

The Chief on the service is expected to manage the day-to-day problems and appropriately schedule patients for operation with the supervision of the faculty. The Chief performs or assists the junior residents in all operations under the direct supervision of the attending. The Chief prepares pre-operative conference cases and is expected to have an evidence-based treatment plan. The Chief also prepares for morbidity and mortality conference and should critically analyze and present all deaths and complications on the service during their rotation. At the completion of the rotation the resident is expected to:

Patient Care

1) Orchestrated preoperative evaluation, risk stratification, optimization of risk factors and timing of intervention in vascular patients.
2) Appreciate when non-operative management is appropriate.
3) Identify urgent/emergent indications for surgery in vascular patients.
4) Perform the operative approach to the major vessels and perform vascular anastomoses to large and small vessels – to include aortic aneurysm repair, carotid endarterectomy, lower extremity thromboembolectomy, lower extremity revascularization, and operations in the management of chronic venous insufficiency.
5) Perform diagnostic arteriography and understand the basic principles of endovascular techniques in the treatment of aortic aneurysms, carotid disease, and peripheral arterial disease.
6) Manage postoperative vascular patients as well as recognize and treat complications.
7) Perform post-operative management of vascular patients in the ICU.

Medical Knowledge

1) Outline the indications, appropriate work-up and surgical options for patients with carotid stenosis, aortic aneurysms, claudication, acute and chronic limb threatening ischemia, venous insufficiency and other common vascular problems.
2) Distinguish between treatment of asymptomatic and symptomatic presentations of vascular disease (i.e. carotid stenosis, aortic aneurysms, peripheral arterial disease).
3) Interpret non-invasive vascular testing, CT and MR imaging of the vascular system (including 3D reconstruction), and diagnostic arteriography and incorporate each into therapeutic decision-making. Appreciate the role and limitations of each.
4) Manage cardiovascular risk factors and “best medical management” for vascular disease, including antiplatelet agents, anticoagulants, lipid lowering agents, angiotensin-converting enzyme/receptor inhibitors and beta-blockers.

Practice-based Learning and Improvement

1) Show consistent attendance at, preparation for, and active participation in all service conferences.
2) Show attendance and participation in service morbidity and mortality conference.
3) Implement changes to improve patient care through development, validation and revision of disease-based treatment algorithms.

Interpersonal and Communication Skills

1) Demonstrate clear and accurate written communication in ICU notes, consults, and operative dictations.
2) Demonstrate clear and accurate verbal communication to junior residents, physician extenders, consultants, nurses, social workers, administrative professionals, and faculty in the care of service patients.
3) Demonstrate respectful and appropriate communication with patients, families, and other support people or caregivers.

**Professionalism**

1) Demonstrate appropriate appearance and affect for specific health care settings.
2) Maintains composure in all personal and patient-related activities.
3) Demonstrates effective time management while on service (i.e. punctuality, availability, tasks completed on time, paperwork completed in timely manner).
4) Show enthusiasm for teaching the junior residents and students the basics of vascular patient care and vascular anatomy and physiology.

**System-based Practice**

1) Function as an integral member of the vascular surgical team within the larger surgical community and within the hospital structure as a whole.
2) Explain the role of pre-hospital primary care in the prevention and management of cardiovascular disease and its risk factors (i.e. HTN, diabetes, hyperlipidemia, and smoking).
3) Understand the resources (both inpatient and outpatient) available to facilitate the recovery of vascular patients following surgery – specifically, social work services, physical therapy and rehabilitation, wound care, smoking cessation, and hospice.
4) Appreciate importance of public awareness of cardiovascular disease.

Revised by Dr. Scali on 4/7/16

**VA Plastic Surgery**

This service sees the full spectrum of Plastic and Reconstructive surgery patients for the North Florida/South Georgia Veteran population. There is one fellow on the service, one PGY 1 resident, three plastic surgery faculty attendings, and an ARNP to assist with the management of the patients. The clinic and OR are staffed by UF/VA plastic surgery faculty. The plastic surgery service covers hand surgery for the NF/SG VA system and shares facial trauma coverage with the ENT section.

This rotation provides an introduction to plastic surgery for the first year general surgery resident. The intern sees new consults with the fellow and the attending in the clinic, ER, and wards. He performs histories and physicals prior to surgery, participates in procedures, and follows up with the patient in the clinic. The new resident is expected to develop a familiarity with the broad spectrum of plastic surgery elective, urgent, and emergent issues.

Broad and focused surgical diseases and conditions commonly treated are:

- nerve compression (broad); carpal tunnel vs cubital tunnel (focused)
- hand fractures (broad); treatment for metacarpal vs phalangeal (focused)
- skin cancer (broad); basal cell vs melanoma vs squamous cell (focused)
- dupuytren's disease (broad); surgical vs nonsurgical indications (focused)
- tendonitis (broad); trigger finger vs deQuervain's vs epicondylitis (focused)
- arthritis (broad); carpometacarpal (focused)
- breast pathology (broad); macromastia and acquired defect reconstruction (focused)

At the completion of the rotation, the resident should be able to:
PGY 1

Medical Knowledge

- demonstrate awareness of anatomy of the hand and forearm
- demonstrate awareness of anatomy of facial and motor nerves in the head and neck
- demonstrate awareness of different types of material available for wound closure (sutures, dressings, tissue adhesives)
- understand the indications for ordering nerve conduction studies both pre and postoperatively
- understand the criteria for sending patients to hand therapy
- understand the different types of splints and indications for using them
- understand the indications for dupuytren’s surgery
- demonstrate ability to recognize degenerative joint disease on x-rays
- understand the indication for use of fluoroscopy in the ER and OR
- understand the threshold to reperfusion after placing upper extremity tourniquets
- diagnose upper extremity compartment syndrome
- learn indications for referral to Moh’s surgery
- understand the appropriate time-frame for postoperative follow up and suture removal
- understand the different options available in breast reconstruction from purely implant-based to purely autologous
- understand the need to obtain informed consent and “time-outs” prior to performing surgical procedures
- demonstrate knowledge of breast reduction surgery and the indications for the same
- understand risk factors for chronic wounds and indications for surgery

Patient Care

- demonstrate ability to perform a hand exam
- demonstrate ability to perform simple and complex wound closures
- demonstrate ability to read x-ray evidence of hand and finger fractures and dislocations
- demonstrate the ability to administer local anesthesia prior to minor surgery on the hands and face in the clinic, OR, and ER
- demonstrate ability to diagnose and treat skin cancers on the head, neck, and hand both in the office and OR
- demonstrate ability to evaluate hand trauma patients in urgent care and in the ER
- demonstrate ability to surgically and medically treat hand and digit infections in urgent care, ER, and OR
- demonstrate ability to place digit, forearm, and arm tourniquets
- demonstrate ability to perform primary closure and skin grafts to cover acquired defects in the digits and face secondary to trauma or oncologic resection
- demonstrate ability to diagnose and manage acute facial trauma in the ER (lacerations and fractures)
- demonstrate ability to diagnose and treat hand and finger burns

Practice-Based Learning and Improvement

- The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
- Identify and discuss appropriate management of postoperative complications.
- Understand the indications for denying elective surgery.
- Be committed to scholarly pursuits through the conduct and evaluation of research.
• Value lifelong learning as a necessary prerequisite to maintaining surgical knowledge and skill.

**Interpersonal and Communication Skills**

• Demonstrate effective communication, both written and verbal, with other members of the healthcare team.
• Counsel and educate patients and families.
• Effectively document practice activities.
• Teach and share knowledge with colleagues, residents, students, and other healthcare providers.

**Professionalism**

• Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
• Make sound ethical and legal judgments appropriate for a qualified surgeon.
• Demonstrate a commitment to continuity of patient care.

**Systems-Based Practice**

• Demonstrate understanding of planning and utilizing OR resources
• Provide cost-effective care to surgical patients and families within the community.
• Demonstrate knowledge of risk-benefit analysis.
• Demonstrate an understanding of the role of different specialists and other healthcare professionals in overall patient management.

No changes submitted Spring 2016

**VA Thoracic and Cardiovascular (TCV) Surgery**

This service performs coronary revascularization, valve replacement and lung cancer resections. There are 2 faculty members who are primarily at the VA and other faculty who participate on a daily basis in conjunction with two physician extenders. There is a first or second year cardiothoracic resident, and PGY III general surgery resident on the service. General learning objectives and responsibilities include:

I. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health

Team members are expected to develop and execute patient care plans, demonstrate technical ability, use information technology, and evaluate diagnostic studies.

**PGY-3:**
1. Arrive at an acceptable plan of management for the thoracic surgical patient, demonstrating knowledge in the operative and non-operative management of the disease process.

2. Demonstrate appropriate initial evaluation and management of the early postoperative cardiac and thoracic surgery patient, including postoperative bleeding, low cardiac output syndrome, ventilator management, postoperative arrhythmias, etc.

3. Appropriate evaluation of outpatient consultations.


II. Medical knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of the knowledge to patient care

Team members are expected to know current medical information and critically evaluate scientific information.

PGY-3:
1. Discuss management concepts for patients with coronary artery disease, aortic stenosis, aortic incompetence, mitral incompetence, and thoracic malignancy.

2. Demonstrate knowledge of pharmacology, indications, and complications of drugs commonly used for treating the cardiothoracic surgical patient.

3. Demonstrate knowledge of preoperative preparation of the thoracic surgical patient including pulmonary function tests, arterial blood gas analysis, etc.

4. Discuss the assessment and management of patients with atrial fibrillation, thoracic air leak, and postoperative infection.

III. Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care.

Team members are expected to demonstrate the ability to practice lifelong learning, analyze personal practice outcomes, and use information technology to optimize patient care.

PGY-3:
1. Investigate literature surrounding clinical cases and develop effective self-directed learning strategies for continuing education. Attend all organized didactic opportunities while on the service.

2. Explain evidence-based management of specific complications in the cardiothoracic surgical intensive care unit.

IV. Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals

All team members are expected to communicate with other health care professionals, counsel and educate patients and families, maintain appropriate records documenting practice activities and outcomes, and function as a team member and/or leader.

PGY-3:
1. Demonstrate clear and accurate written communication in intensive care unit progress notes and consultations.
2. Demonstrate clear, concise, and accurate verbal communication in the care of intensive care unit and consultation patients.

3. Inform patients and families about their condition at an appropriate, empathetic, and understandable level.

V. Professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds

Team members are expected to maintain high standards of ethical behavior by maintaining preoperative, operative, and postoperative continuity of care, demonstrating sensitivity to age, gender, culture and other differences, and demonstrating honesty, dependability, and commitment.

PGY-3:
1. The ability to give and receive advice in a manner that is consistent with the harmonious operation of a health care team.

2. Exhibit appropriate personal and interpersonal professional behaviors

VI. Systems-based practice as manifested by actions that 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

Team members are expected to practice cost-effective care without compromising quality, promote disease prevention, demonstrate risk-benefit analysis, and know how different practice systems operate to deliver care.

PGY-3:
1. Utilize resources (laboratory, diagnostic imaging, and consultation) effectively to balance patient care and learning needs

No changes submitted Spring 2016

Lake City VA Hospital

Ambulatory Surgery - This general surgery service cares for outpatient adult male and female patients of all ages and thus provides the resident staff a broad exposure to common ambulatory general surgical problems. The rotation also provides the Resident 2 an extensive experience with upper and lower gastrointestinal endoscopy that will more than satisfy the residency training requirements. There are 3 attending surgeons and one nurse practitioner on the service. Resident staffing is composed of PGY 1 and PGY 2 level housestaff that rotate on the service. The residents will evaluate patients in the outpatient clinic and perform a wide variety of ambulatory surgical procedures. They will also assist in the Gainesville VA general surgery clinic, provide call coverage at the Gainesville VA Hospital and are expected to fully participate in all of the departmental conferences and educational offerings. The broad general competencies for surgical resident education as outlined by the ACGME apply to residents on this rotation:

PGY 1 – The first year resident evaluates ambulatory general surgical problems in the clinic under attending supervision, schedules and performs surgeries and provides follow-up care. Core competencies the resident should achieve on this rotation include:

Patient Care
The resident is expected to:
1) participate in formulating the treatment plan ambulatory surgical patients.
2) be responsible for preparing patients for ambulatory surgery including scheduling preoperative evaluation and risk assessment; and,
3) participate and perform surgical procedures appropriate for skill level including inguinal and primary abdominal wall hernia repair, excision of superficial melanomas and other skin and subcutaneous lesions and common anorectal operations such as hemorrhoidectomy, sphincterotomy and fistulotomy.

Medical Knowledge

The resident is expected to:
1) develop knowledge and skills in pre- and postoperative evaluation and management of ambulatory general surgical patients;
2) understand and implement perioperative risk assessment;
3) gain a working knowledge of the biology and pathophysiology of wound healing;
4) develop significant knowledge in the recognition and management of inguinal and primary abdominal wall hernias, common anorectal disorders, skin malignancies including melanoma and benign soft tissue lesions; and,
5) acquire basic operative skills that include knowledge of sterile technique and operating room safety, suture material and instrument types, knot tying (including one hand, two hand, instrument and application of knots under tension)

Practice-Based Learning and Improvement

The resident is expected to:
1) apply established principles of perioperative care to the management of ambulatory surgical patients;
2) understand the specific disease processes of surgical patients and their appropriate management; and,
3) become familiar with the VA NSQIP system and its application to continuous quality improvement.

Interpersonal and Communication Skills.

The resident is expected to:
1) communicate and collaborate effectively with colleagues other health care professionals in an integrated health care system;
2) counsel and educate patients and families;
3) effectively document practice activities utilizing a comprehensive electronic medical record; and,
4) teach and share knowledge with colleagues, residents, students, and other health care providers.

Professionalism

The resident is expected to:
1) demonstrate a commitment to continuity of patient care;
2) maintain an appearance appropriate to the health care setting;
3) relate to other health care providers with the dignity and respect; and
4) demonstrate effective time management skills including punctuality, availability and prioritization of tasks.
Systems Based Practice

The resident is expected to:
1) understand and apply the utility of an electronic medical record;
2) work within the framework of the established policies and procedures of the VA medical system;
3) demonstrate knowledge of risk-benefit analysis; and
4) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

PGY 2 – The rotation will provide the second year resident with the primary endoscopic experience during the residency. In addition, the resident will evaluate ambulatory general surgical problems in the clinic under attending supervision, schedule and perform surgeries and provides follow-up care. Core competencies the resident should achieve on this rotation include:

Medical Knowledge

The resident is expected to:
1) acquire a thorough understanding of the indications for upper and lower gastrointestinal endoscopy;
2) be able to perform upper and lower gastrointestinal endoscopy with minimal supervision and understand the indications and techniques for biopsy, and polypectomy;
3) gain an extensive understanding of benign and malignant diseases of the esophagus, stomach, duodenum and colon including esophageal reflux and carcinoma, gastric and duodenal ulcer gastric carcinoma, neoplasms of the colon and inflammatory bowel disease;
4) enhance knowledge and skills in pre- and postoperative evaluation and management of ambulatory general surgical patients.
5) place emphasis on perioperative risk assessment; and,
6) become thoroughly familiar with the recognition and management of inguinal and primary abdominal wall hernias, common anorectal disorders, skin malignancies including melanoma and benign soft tissue lesions.

Patient Care

The resident is expected to:
1) participate in formulating the treatment plan ambulatory surgical patients;
2) be responsible for preparing patients for ambulatory surgery including scheduling preoperative evaluation and risk assessment.;
3) participate and perform surgical procedures appropriate for skill level including inguinal and primary abdominal wall hernia repair, excision of superficial melanomas and other skin and subcutaneous lesions lesions and common anorectal operations such as hemorrhoidectomy, sphincterotomy and fistulotomy; and,
4) perform upper and lower gastrointestinal endoscopy.

Practice Based Learning and Improvement

The resident is expected to:
1) apply established principles of perioperative care to the management of all service patients;
2) understand the specific disease processes of surgical patients and their appropriate management;
3) become familiar with the VA NSQIP system and its application to continuous quality improvement; and,
4) use the VA Skills Lab to enhance his/her endoscopic techniques.

**Interpersonal and Communication Skills.**

The resident is expected to:
1) communicate and collaborate effectively with colleagues other health care professionals in an integrated health care system;
2) counsel and educate patients and families;
3) effectively document practice activities utilizing a comprehensive electronic medical record; and,
4) teach and share knowledge with colleagues, residents, students, and other health care providers.

**Professionalism**

The resident is expected to:
1) demonstrate a commitment to continuity of patient care;
2) maintain an appearance appropriate to the health care setting;
3) relate to other health care providers with the dignity and respect; and,
4) demonstrate effective time management skills including punctuality, availability and prioritization of tasks.

**Systems Based Practice**

The resident is expected to:
1) understand and apply the utility of an electronic medical record;
2) work within the framework of the established policies and procedures of the VA medical system;
3) demonstrate knowledge of risk-benefit analysis; and,
4) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

Revised by Dr. McDonald on 4/27/16

**Community Surgery**

**St Vincent’s Medical Center/North Florida Surgeons**

The goal of the community surgery rotation is to provide the resident with the experience general surgery practice in a busy non-university hospital. An additional role of the service is to provide the residents with an experience caring for surgical patients without the traditional complete team of residents. The service consists of a PGY-4 resident, and involves the resident working in a practice of five general surgeons in an urban community hospital without a surgical residency.

PGY-4: Participates in the care of surgical patients in the North Florida Surgeons practice. The resident will attend clinic one day each week ideally with a different attending each week and assist with inpatient care and operative management of surgical patients under the supervision of the members of the practice. The resident should take call at least one night each week and participate in emergency surgical care with the attending on call. During the rotation the resident is expected to master the following skills:
Medical Knowledge
- The resident will demonstrate mastery of the knowledge required to manage common general surgery problems such as biliary tract disease, inguinal and ventral hernia, indwelling vascular access, soft tissue lesions, bowel obstruction.
- The resident will demonstrate the knowledge required to assist or perform a broad array of surgical procedures including but not limited to procedures on the biliary tract, hernia surgery, bowel resection and obstruction, breast procedures, skin and soft tissue procedures and endocrine surgery procedures.

Patient Care
- The resident will learn to coordinate and direct all aspects of patient care on as delegated by the attending staff.
- At this level independent decision making, as delegated by the attending staff, will be expected in patient care with the expectation that the resident has a high level of awareness his/her limitations in experience, knowledge, judgment and skill.
- Analysis of risk and benefit of surgical procedures and alternative treatments, particularly among patients with significant co-morbidities, will be stressed.
- The resident will demonstrate the surgical skills necessary to perform a broad array of general surgical cases with the assistance and supervision of the attending staff.

Practice-Based Learning and Improvement
- The resident will apply established principles of perioperative care to the management of all service patients.
- Investigate the medical literature for evaluation and management of specific surgical problems.
- The resident will demonstrate the ability to carry out an evidence based practice in compliance with current quality improvement mandates

Interpersonal and Communication Skills
- The resident will communicate and collaborate effectively with colleagues other health care professionals.
- Counsel and educate patients and families.
- Effectively document practice activities.
- Teach and share knowledge with colleagues, residents, students, and other health care providers.

Professionalism
- Always place the needs of the patient first.
- Respect the cultural and religious needs of patients and their families, and provide surgical care in accordance with those needs.
- Make sound ethical and legal judgments appropriate for a qualified surgeon.
- Demonstrate a commitment to continuity of patient care.
- Maintain an appearance appropriate to the health care setting.
- Relate to other health care providers with the dignity and respect.
- Demonstrate effective time management skills including punctuality, availability and prioritization of tasks.
Systems Based Practice

- The resident will acquire familiarity with the rules of coding and billing. The resident will acquire familiarity with precertification and other processes of insuring that patients are appropriately evaluated and vetted prior to scheduling patients for operations.
- The resident will learn the basics of practice management and the necessary ancillary personnel necessary to run a surgical practice.
- Demonstrate knowledge of risk-benefit analysis in surgical decision-making.
- Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

No changes submitted Spring 2016

SHANDS RESEARCH LABORATORY

As it is currently configured, two to three categorical residents each year will be in the laboratory for one or two years. Two of the residents will enter the laboratory after the second year and one after the third year. This is subject to change due to funding and the availability of laboratories to place the resident. The chairman and program director will discuss the laboratory year with the categorical residents during the first and second year and make every effort to match the resident’s wishes with the needs of the program, but this is not guaranteed. Occasionally residents may desire two or three years in the laboratory but this also is not guaranteed and is subject to funding and manpower needs. Residents must make their wishes known to the program director early in the second half of the first year and complete an application by October 1 of their PGY2 year.

The laboratory experience is no different from any other rotation and has its own responsibilities and general learning objectives. These include:

1) Complete dedication to the laboratory experience as directed by the laboratory director. The laboratory year is not any less intense than any of the clinical years and, to be productive, the resident must be willing to put in the effort. It is expected that the residents in the laboratory will behave in a collaborative manner with other residents and faculty in the department and be willing to assist at any task assigned. This will include occasional call nights and some unscheduled clinical duties. The resident is to learn and apply the scientific method under the direction of the laboratory attending. This should include identifying a problem, formulating a hypothesis, performing a literature review, designing and performing experiments, analyzing data, writing results and presenting results at regional and national meetings.

2) The resident should become proficient in a number of laboratory skills. These may include tissue culture, small animal and primate surgery, molecular biology, immunochemistry, protein purification, statistical and data analysis, and other skills that may be applied to a variety of problems.

3) It is anticipated that the resident will submit abstracts for presentation, prepare manuscripts for peer reviewed publication and discuss their findings with other members of the department and College.

4) It is expected that the resident, at the end of the laboratory experience, will be able to identify a relevant question, formulate a hypothesis, describe a method to answer the question, be able to analyze the results of that inquiry and communicate these findings. The resident should also be able to identify external funding sources and prepare an application for peer review. This process will benefit the resident regardless of whether or not the resident pursues research as a career.

No changes submitted Spring 2016
ACGME CORE COMPETENCIES

The ACGME has determined that all physicians graduating from an accredited program should be proficient in six areas of specialized skills. The surgery program at the University of Florida provides the needed educational experiences through various rotations, conferences and other instruction to meet these requirements. The evaluation system is designed to determine the resident’s progress in attaining proficiency in these areas.

The specific language from the program requirements is included below:

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:
   a. demonstrate manual dexterity appropriate for their training level.
   b. be able to develop and execute patient care plans.

2. Medical Knowledge about established and evolving biomedical, clinical, and cognate (eg. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

   Surgical residents are expected to:
   a. 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 following tables summarize the Departmental teaching and assessment methods for the 6 ACGME core competencies:

**ACGME Core Competencies (Educational Methods)**

<table>
<thead>
<tr>
<th>COMPETENy</th>
<th>Attending Rounds</th>
<th>Operating Room</th>
<th>Clinic</th>
<th>Skills Laboratories</th>
<th>M &amp; M Conference</th>
<th>Grand Rounds</th>
<th>Chair’s Conference</th>
<th>PGY Level-specific Courses</th>
<th>Service Specific Conference</th>
<th>Resident’s as Teachers</th>
<th>On-Line Module (Compliance/HIPAA Training)</th>
<th>ACLS/ATLS Courses</th>
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## ACGME Core Competencies (Assessment Methods)

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<tr>
<th>COMPETENCY</th>
<th>On-Line Faculty Evaluation</th>
<th>360° Evaluation</th>
<th>Mock Orals</th>
<th>ABSITE</th>
<th>ACGME Case Log</th>
<th>Skills Evaluation</th>
<th>M &amp; M Conference</th>
<th>Scholarly Activity</th>
<th>Records Completion</th>
<th>Duty Hours Compliance</th>
<th>Committee Participation</th>
<th>Conference Attendance</th>
<th>Student Teaching Evaluations</th>
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As Fellows of the American College of Surgeons, we treasure the trust that our patients have placed in us because trust is integral to the practice of surgery. During the continuum of pre-, intra-, and postoperative care we accept responsibilities to:

- Serve as effective advocates for our patients' needs.
- Disclose therapeutic options, including their risks and benefits.
- Disclose and resolve any conflict of interest that might influence decisions regarding care.
- Be sensitive and respectful of patients, understanding their vulnerability during the perioperative period.
- Fully disclose adverse events and medical errors.
- Acknowledge patients' psychological, social, cultural and spiritual needs.
- Encompass within our surgical care the special needs of terminally ill patients.
- Acknowledge and support the needs of patients' families.
- Respect the knowledge, dignity, and perspective of other health care professionals.

Our profession is also accountable to our communities and to society. In return for their trust, as Fellows of the American College of Surgeons, we accept responsibilities to:

- Provide the highest quality surgical care.
- Abide by the values of honesty, confidentiality, and altruism.
- Participate in lifelong learning.
- Maintain competence throughout our surgical careers.
- Participate in self-regulation by setting, maintaining, and enforcing practice standards.
- Improve care by evaluating its processes and outcomes.
- Inform the public about subjects within our expertise.
- Advocate strategies to improve individual and public health by communicating with government, health care organizations, and industry.
- Work with society to establish just, effective, and efficient distribution of health care resources.
- Provide necessary surgical care without regard to gender, race, disability, religion, social status or ability to pay.
- Participate in educational programs addressing professionalism.

As surgeons, we acknowledge that we relate to our patients when they are most vulnerable. Their trust, and the privileges we enjoy, depends upon our individual and collective participation in efforts that promote the good of both our patients and society. As Fellows of the American College of Surgeons we commit ourselves and the College to the ideals of professionalism.

Adapted from http://www.facs.org/fellows_info/statements/stonprin.html#anchor116209
Residents are expected to attend all conferences at the departmental level. At a minimum, this means 85% of the conferences. Attendance is recorded and will be part of the resident’s evaluation as part of the ACGME Professionalism core competency. Residents should also attend the conferences of the service to which they are assigned. The conference program is designed to provide a didactic and interactive forum to augment the resident’s reading and clinical experience. Failure to attend conferences limits the resident’s ability to be exposed to the wide breadth of problems seen in surgical practice. Residents must be on time for conferences and it is requested that residents turn down the volume on their beepers or put them on vibrator mode if possible so that there is the least disruption to the speaker when the resident is paged. Residents will be called upon to present at conferences periodically and should spend the necessary time to be well prepared.

**DEPARTMENTAL CONFERENCES**

**Morbidity and Mortality Conference** – Wednesday morning at 6:45 AM in the Room 6120. All residents are required to attend. The format is case presentations by chief residents on the general surgery services, plastic surgery and vascular surgery and includes special presentations of interesting cases. The yearly schedule is available on the Department of Surgery intranet. (http://education.surgery.ufl.edu/Current/confMorbidityMortality13_14.aspx).

**Grand Rounds** - Wednesday morning at 7:15 AM in Room 6120. All residents are required to attend Surgery Grand Rounds. Format includes lectures, case presentations and visiting professors. The yearly schedule is available on the Department of Surgery intranet. (http://education.surgery.ufl.edu/GrandRounds/GrandRounds.asp).

**SERVICE CONFERENCES**

**Breast Conference** - Monday at 7:15am in the Radiology Conference Room (G101). Residents and students on the Breast service are required to attend, as well as Oncology, Radiation Oncology and Radiology faculty and residents. Breast cancer patients, their treatment plan and pathology are discussed. Second-year residents are expected to present all surgical patients, write tumor board notes, and assist in carrying out the plan created in tumor board.

**BMSE Pre-Op Conference** – Tuesday at 12pm in Woodward Conference Room

**GI Tumor Board** – Thursday at 7am at 1115 Davis Cancer Pavilion. This multidisciplinary case-based conference discussed the complex management of patients with GI tumors. Divisions represented include Pancreas/Biliary/Colorectal Surgery and Transplant/Hepatobiliary Surgery, as well as faculty and residents from the Departments of Radiology, Radiation Oncology, and Medical Oncology.

**Colon and Rectal Surgery Pre-op conference** - Tuesday at 7am at South Tower Room 5011. This conference will start with 20 minutes of didactic lecture on CRS topic by the Attending Surgeons. The remainder of time is spent on review of M&M and cases for the following week. This is attended by the faculty, residents and ancillary staffs on CRS.

**Colon and Rectal Surgery Journal Club** – will meet once every 10 weeks to review papers on CRS. This is attended by faculty and residents interested in reviewing latest journal articles.

**MIS Pre-Op Conference** – Tuesday at 4pm in the conference room on the second floor adjacent to the surgeon lounge
Pancreas Conference – Friday at 7am in the Woodward Conference Room

Trauma M&M - Friday at 7am in 5 East Conference Room

Trauma Multidisciplinary Rounds – Monday at 7:30am and Friday at 8am in 5 East Conference Room

Trauma Quality Meeting – The third Tuesday of each month

TCV Fellow Meeting – First Monday of month; Monthly meeting with Division Chief

TCV M&M – Biweekly Tuesday at 7:15am in TCV Conference Room NG-36

TCV Journal Club - Biweekly Tuesday at 7:15am

TCV Resident Education Conference – Thursday at 7:15am TCV Conference Room NG-36

TCV/Pulmonary Conference – Friday at 7:30am Shands G101

TCV/Cardiology Case Conference – Friday at 7:30am Cardiology Library

Vascular Case Conference – Friday at 7am in the Vascular Conference Room (NG-37). This interactive preoperative conference provides the chief resident on the VA Vascular service (PGY-IV) and the junior resident on the Shands Vascular service (PGY-II) a chance to present upcoming cases and discuss the surgical management options. The faculty then question the presenters in an interactive, oral board format.

Vascular Surgery M&M – The fourth Friday of every month at 7am in NG-37

Vascular Educational Conference – The first and third Monday, and the second and fourth Thursday of each month from 4-6pm in NG-37. This can include the journal club, Rutherford conference, vascular lab, research conference or VQI depending on the schedule made at the beginning of each month. Residents on the vascular services at the VA and Shands are required to attend. The Rutherford conference is a text-book based discussion that covers an entire vascular surgery curriculum over a 2 year cycle. The research conference is a roundtable discussion about ongoing and potential research topics within the Division of Vascular Surgery. The VQI is a report and discussion about the quality initiatives within the Division. The journal club is a discussion of the current Journal of Vascular Surgery. The vascular lab is didactic, instructional, and “hands on” for non-invasive vascular lab testing.

Pediatric Surgery Basic Science/Journal Club/Clinical Conference – Monday and Friday at 7am in M-603

Pediatric Surgery Multidisciplinary Conference – Monday at 7:30am and Friday at 8am in M-603

Pediatric Surgery Tumor Board – Every other Thursday at 5pm in the Radiology Conference Room

Pediatric Surgery Divisional M&M – Every other Friday at 7am

Plastic Surgery Thursday Conference – Every 1st, 2nd, 4th and 5th Thursday at 5pm in room N6-1

Plastic Surgery Divisional M&M- Divisional Morbidity and Mortality conferences occur once a month during Monday Conference. Specific dates will be noted on the curriculum calendar on the Plastic Surgery Website.

Plastic Surgery Friday Conference – Every 2nd and 4th Friday at 7am, includes a Pre-Op Conference with Oral Board Preparation
Craniofacial Clinic Conference - This conference meets every Thursday from 1pm – 5pm and allows for a thorough group discussion of all patients seen in clinic that day. Treatment plans are discussed in a multidisciplinary fashion.

Hepatobiliary Conference – Monday at 7:00am at the 1st floor conference room in the Med Plaza Cancer Center. Residents and students on the Hepatobiliary/Transplant service are required to attend. Patients with hepatobiliary and pancreatic malignancies are reviewed with input from hepatobiliary and pancreatic surgeons, medical oncologists, hepatologists, pancreatologists, radiation oncologists, and interventional radiologists.

Transplant Teaching Conference – Friday at 12pm

Transplant Pre-op Conference – Friday at 7:30am

VA General Surgery Conference – Tuesday at 7:00AM in the 2 East Conference Room. Residents and students on the General Surgery Service at the Gainesville VA are required to attend. The format is case presentations of upcoming operative procedures and VA surgical database morbidity and mortality review.

RESIDENT COURSES

Surgery 101 - Principles of Surgery This is a mandatory course for all PGY 1 residents and meets weekly to review assigned reading from SCORE. This intense reading program will cover the entire surgical text with the first 2 basic science sections address through self-study prior to matriculation. Each unit will be accompanied by an examination. In this course and all others in the training program a passing score of 70% is required for each unit.

Surgery 201 This course is directed at expanding the general surgical knowledge of PGY 2 residents and utilizes the SCORE curriculum throughout the year. In this course, six major areas of study will be emphasized. These areas include gastrointestinal surgery, oncology and endocrine surgery, pediatric surgery, trauma and critical care, transplantation, vascular and cardiovascular surgery. The resources used for this text will be varied and course directors will assess participants’ fund of knowledge on a weekly basis.

Surgery 401 The PGY 3 and 4 residents will participate in this weekly course which aims to critically examine the surgical literature through weekly review of overviews of selected readings. This intensive program will require dedicated reading and critical interpretation of the literature. Course directors will be responsible for the assessment of trainees.

Surgery 501 This PGY 5 course meets biweekly to review current journal articles and critically examine new topics in the literature. Faculty participants will be chosen at the discretion of the Chief Residents. This course utilizes the Clinical Scenarios in Surgery text.

VISITING PROFESSORS

Chief Residents Visiting Professor – Selected by the chief residents, this visiting professor is asked to lecture the department during Grand Rounds, then accompanies the residents on formal teaching rounds for selected patients. The afternoon is dedicated to resident education, including a case conference with the chief residents and junior residents.

Woodward Visiting Professors - In honor of Dr. Edward R. Woodward, the founding Chairman of the Department of Surgery at the University of Florida College of Medicine from 1958 to 1982. Two distinguished
surgeons per year are invited to be the Woodward Visiting Professors. The visiting professor is asked to lecture the department during Grand Rounds, then accompanies the residents on formal teaching rounds for selected patients. The afternoon is dedicated to resident education, including a “Stump the Professor” session with the distinguished guest and the residents.

**Dragstedt Visiting Professor** - In honor of Dr. Lester R. Dragstedt, a Research Professor with a joint appointment in the Department of Surgery and Physiology, following his retirement as Professor and Chairman of the Department of Surgery at the University of Chicago in 1959. Dr. Dragstedt was professor emeritus in the Department of Surgery at the University of Florida College of Medicine at the time of his death. In honor of its namesake, this visiting professorship is geared more to the basic sciences.

**TEXTBOOK**

The Department of Surgery provides all residents with access to SCORE. In addition, you’ll find electronic access to the *Sabiston Textbook of Surgery* and several other excellent surgical textbooks at the Health Science Center Library. General surgery residents may purchase other standard textbooks as well. The soft cover review books are not a substitute for reading in the major text but may be useful for directed study before the In-Training Exam. The resident is expected to develop a personal program of reading. Besides the general reading in the specialty of surgery, residents should do directed daily reading with regard to problems that they encounter in patient care or in the operating room. The resident is responsible for reading prior to performing or assisting in cases that the resident has not yet had the opportunity to see. The resident should have thorough mastery of the material in the standard text by the end of the third year. In addition, the resident should begin the habit of reading one of the general surgery journals. *Annals of Surgery* or *Surgery* have articles of general interest to the practicing surgeon and the resident, especially in the senior years, should become familiar with the current advances in the field. Faculty will identify appropriate reading materials for Surgery 401 based on the 2-year curriculum.

**IN-TRAINING EXAMINATION**

The American Board of Surgery administers a yearly exam to surgery residents. The examination always takes place on the last Saturday in January. The test is multiple choice and is part clinical and basic science in content. The best way to prepare for the exam is to read the standard text. There are several surgery question and answer books available that may also help you to study. Individuals who score below the 30th percentile are less likely to pass the Qualifying Examination.
AWARDS

Resident Awards

**Bierstedt Award** - Awarded to a first year resident who exemplifies outstanding qualities as an intern in the categories of integrity, compassion, intellectual curiosity and diligence. This award is voted on by all residents and faculty in the Department.

**Outstanding Teaching Resident** - Awarded to a general surgery resident in recognition of academic excellence in service to housestaff, students and faculty. This award is voted on by the general surgery residents and faculty.

**Edward R. Woodward Surgical Resident Award** - Awarded to the general surgery resident who embodies outstanding qualities in scholastics, teaching and patient care. This award is voted on by the faculty.

**Hugh A. Walters, MD Humanitarian Award** – The Department of Surgery has established the Hugh A. Walters, MD Humanitarian Award. This will be used to support humanitarian efforts in surgical education and an annual award to be given to a surgical resident who embodies Dr. Walters’ qualities of compassionate care and selfless dedication to excellence.

Faculty Awards

**Lester R. Dragstedt Physician-Scientist Award** - Awarded to the attending surgeon who exemplifies Dr. Dragstedt’s idea of the surgeon-physiologist. This award is voted on by the Chief Residents with input from their fellow general surgery residents.

**Outstanding Faculty Award** - Awarded to a general surgery faculty member in recognition of academic excellence in service to housestaff and students. This award is voted on by Chief Residents with input from fellow general surgery residents.

**Edward Copeland Faculty Award** – Awarded to a general surgery faculty member in honor of the ultimate gentleman surgeon representing academic excellence, leadership, and lifetime mentorship.

COUNSELING AND SUPPORT SERVICES

**Where to get help** - The UF GME website includes important information special services and discounts for housestaff, training opportunities, benefits, and other useful information. The Residency Assistance Program (RAP) offers confidential services for residents and their family. The physician may also call the Housestaff Affairs Office for further information and referral.

Residents who feel the need for counseling should discuss this with the appropriate faculty member (mentor), the program director or, if they wish to remain anonymous to the Program, the Office of Housestaff Affairs. Confidentiality will be preserved and is of the highest priority. Referrals through the Office of Housestaff Affairs can be made to individuals within the University and outside the University.

COMMUNICATION

Each resident will be assigned an e-mail account during orientation. This will be the primary mode of communication between the program director and the residents. Important information about meetings, policies and educational issues will be sent to you on an almost daily basis. It is critical that the program have a working
email address for you and that you check that mailbox frequently. Of course, for critical or sensitive issues, the resident should feel free to directly contact the program director or mentor at any time.

**DUTY HOURS**

Graduate education in surgery requires a commitment to continuity of patient care. This continuity of care must take precedence without regard to the time of day, day of the week, number of hours already worked or on-call schedules. At the same time, patients have a right to expect a healthy, alert, responsible, and responsive physician dedicated to delivering effective and appropriate care. Different rotations may require different work hours and patterns. Residency training in surgery is a full-time responsibility; activities outside the program must not interfere with the resident’s opportunity to rest, relax and study. On average, residents will be on in hospital call no more than every third night and will have 1 day in 7 free of duties.

**ACGME Duty Hour Requirements**

1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

**On-call Activities**

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
3. No new patients may be accepted after 24 hours of continuous duty.
4. **At-home call (or pager call)** is defined as a call taken from outside the assigned institution.
   a) The frequency of at-home call is not subject to the every-third- night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
   b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
   c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
Residents are required to complete the electronic time card so that their duty hours are reported and monitored by the program. They should visit the on-line time card no less than every 3 days in order to keep the electronic timecard current and accurate. If the timecard indicates non-compliance with the above stated duty hour requirements, the resident will be asked to justify the episode. It is the responsibility of each resident, with the support of the Program Director and faculty, to commit to the practice on compliance with regard to duty hours. Any resident who does not consistently submit a timecard, or who violates duty hour requirements without meaningful justification, will be put on academic probation. The notice of academic probation will stay in the resident’s academic file and become part of his/her permanent record.

**EVALUATION**

An effective evaluation system is critical to the individual resident’s development and to improving the program. Assessment of both the individual and the system of education is meant to provide valid data about the performance of each and to provide information that can be used to improve the educational experience. The system is consistent with the Goals and Objectives of the various experiences and consistent with the ideas imbedded in the ACGME Outcomes Project. It provides for multiple assessment approaches, multiple observations over time and multiple observers providing input. It is absolutely critical that faculty and residents participate in this process. There can be no progress unless the individuals involved in the training program are committed to continuous improvement of the educational experience.

**Resident Evaluation** – All resident evaluations are conducted via New Innovations. Evaluations are e-mailed to the faculty for completion on each resident who rotates through that service. Evaluations will also be solicited from peers in the residency and from other health care professionals who work with the residents. Eventually, patients will be asked to evaluate the residents as well. Residents will also receive evaluations on the quality of their presentations, participation at conferences, and on special assignments through the year. The in-training examination is considered an important measure of medical knowledge and practice-based learning. Once completed, the evaluations are made available to the residents to review on-line. All residents are required to periodically review their evaluations and discuss any issues with the faculty or program director. A record will be kept of this review and residents who do not review their evaluations will be counseled by the program director. The faculty as a whole meets twice yearly to review the evaluations and to discuss resident and program issues. Comments from the chief residents are solicited and used in these meetings. Twice yearly, the program director or members of the Executive Education Committee will meet with the resident and prepare a written summary of that meeting. A final, summative evaluation of each resident that finishes the program will be done and placed in the permanent record. This will include a review of the resident’s performance during the final period of training and will verify that the resident can practice independently.

**Faculty** – All faculty evaluations are completed via New Innovations. Individual faculty evaluations are provided to the resident on-line. Residents must evaluate the faculty at the completion of each rotation. Results are tabulated and provided to the faculty member, chair and program director in aggregate, towards the end of the academic year.

**Clinical Rotations** – At the end of each rotation, the resident must evaluate the rotation via New Innovations (residency management program). These are discussed at the semi-annual faculty meetings and used to improve the educational content of the program. Periodic meetings between the residents and program director also allow for feedback on rotations and faculty.

**SAMPLE EVALUATIONS**

Faculty Evaluation of Resident
Burn PGY 1

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<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Above Average</th>
<th>Exceptional</th>
<th>Cannot Assess</th>
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Patient Care

The resident provides patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Needs Improvement: The resident is unable to obtain sufficient information to care for patients without major assistance.

Meets Expectations: The resident is able to recognize and manage basic surgical conditions, such as thermal, chemical, and electrical burns, smoke inhalation injury, and other soft tissue wounds, with some assistance.

Above Average: The resident is able to diagnose and manage basic surgical conditions, such as thermal, chemical, and electrical burns, smoke inhalation injury, and other soft tissue wounds, independently and complex conditions with assistance.

Exceptional: The resident is able to independently diagnose and manage complex surgical conditions.

The resident demonstrates ability to recognize and manage complications.

Needs Improvement: The resident is unable to recognize common complications such as oliguria, hypotension, or fever.

Meets Expectations: The resident can recognize and manage common complications with direct supervision.

Above Average: The resident can recognize and manage common complications with minimal assistance.

Exceptional: The resident can recognize and manage complex complications such as sepsis and multiple organ failure with minimal assistance.

The resident demonstrates an appropriate level of manual dexterity and technical skill in the operating room and when performing bedside procedures.

Needs Improvement: The resident is unable to perform basic patient care and surgical procedures expected of a graduating medical student.

Meets Expectations: The resident can perform bedside procedures with supervision and can perform common essential operations with significant assistance.

Above Average: The resident can perform bedside procedures independently and common essential operations with some assistance.

Exceptional: The resident can perform common essential operations with minimal assistance and complex operations with moderate assistance.

Medical Knowledge

The resident demonstrates knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Needs Improvement: The resident's medical knowledge of basic surgical disease is less than expected of a medical student.

Meets Expectations: The resident has superficial knowledge of basic surgical diseases and conditions, such as thermal, chemical, and electrical burns, smoke inhalation injury, and other soft tissue wounds.

Above Average: The resident has significant knowledge of basic surgical diseases, such as thermal, chemical, and electrical burns, smoke inhalation injury, and other soft tissue wounds, including uncommon presentations and some knowledge of focused surgical diseases.

Exceptional: The resident has deep knowledge of basic surgical diseases and significant knowledge of focused surgical diseases.

The resident demonstrates knowledge of surgical procedures and operations.

Needs Improvement: The resident has insufficient knowledge of common essential operations to obtain informed consent.

Meets Expectations: The resident can describe the indications, complications and steps necessary to perform some common essential operations and procedures.

Above Average: The resident can describe indications, complications and steps necessary to perform most common essential operations.
Exceptional: The resident can describe the indications, complications and steps necessary to perform all common and most uncommon essential operations.

**Systems Based Practice**
The resident demonstrates 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.

**Needs Improvement:** The resident is unable to coordinate in-hospital care of patients.

**Meets Expectations:** The resident has a basic knowledge of how hospitals run and non-physician resources, such as social workers or physical therapists, available to care for a patient. The resident can follow patient care protocols.

**Above Average:** The resident can arrange for outpatient services, such as home health care. The resident can recognize patients who deviate from patient care protocols.

**Exceptional:** The resident efficiently arranges disposition planning of patients. The resident recognizes areas where improvement opportunities exist in care protocols.

**Practice Based Learning and Improvement**
The resident demonstrates 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.

**Needs Improvement:** The resident does not demonstrate the ability to learn from their own experience.

**Meets Expectations:** The resident changes his or her care behaviors in response to feedback from supervisors. The resident is an active participant in service M&M.

**Above Average:** The resident independently changes his or her care behavior in response to feedback from supervisors. The resident is a leader in service M&M.

**Exceptional:** The resident systematically assesses their own surgical outcomes and changes their own practice as a result. The resident identifies patterns in service M&M.

The resident demonstrates self-directed learning.

**Needs Improvement:** The resident does not demonstrate self-directed learning.

**Meets Expectations:** The resident demonstrates that he or she completes assigned learning assignments.

**Above Average:** The resident independently seeks out common resources, such as SCORE or textbooks, to answer questions about their patients. The resident seeks faculty input for technical skill improvement.

**Exceptional:** The resident actively uses evidence medicine tools to answer questions about patients. The resident independently practices technical skills to improve operative performance.

**Professionalism**
The resident demonstrates a commitment to carrying out professional responsibilities and an adherence to ethical principles.

**Needs Improvement:** The resident displays undesirable behaviors such as disrespect, dishonesty, or failure to take responsibility for patient care.

**Meets Expectations:** The resident is polite and respectful to families and other providers, is committed to continuity of care, completes clinical responsibilities promptly, and is honest.

**Above Average:** The resident maintains composure even in stressful conditions, shows compassion toward families, and asks for help when appropriate.

**Exceptional:** The resident actively ensures continuity of care is maintained, accepts responsibility for errors, and initiates corrective actions.

**Interpersonal and Communication Skills**
The resident demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

**Needs Improvement:** The resident displays undesirable behaviors such as disrespectful communications with other health care providers. The resident's patient hand-offs are inadequate.

**Meets Expectations:** The resident communicates respectfully with other care providers. The resident engages in effective face-to-face hand-offs.
**Above Average:** The resident promotes effective inter-professional communication by active listening and approachability. The resident provides exceptional hand-offs and consultation services.

**Exceptional:** The resident actively ensures that all team members are kept up-to-date on patient status changes independently. The resident's communication with referring physicians is proactive and complete.

The resident practices appropriate communication in the Operating Room.

**Needs Improvement:** The resident does not communicate effectively in the Operating Room. The resident cannot obtain informed consent.

**Meets Expectations:** The resident is capable of basic communication in the Operating Room. The resident can obtain informed consent for basic procedures.

**Above Average:** The resident can lead a time out and communicate his or her needs during a surgical procedure. The resident can obtain informed consent for most procedures.

**Exceptional:** The resident communicates anticipated needs during a case. The resident efficiently leads an Operating Room team during routine cases.

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**RESIDENT EVALUATION OF ROTATION**

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<th>Strongly Disagree</th>
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<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

This rotation provided excellent educational content for my level of training.
Comments

This rotation allowed for appropriate operative experience for my level of training.
Comments

Faculty teaching on this rotation met my expectations.
Comments

This rotation has the right balance of education and service.
Comment

Educational goals and learning objectives for this rotation were clearly communicated to me.
Comments

I received timely and useful feedback regarding my progress on this rotation.
Comments

This rotation complies with the ACGME duty hour requirements.

Enter the average number of hours you trained per week on this rotation.
Comments

If you worked more than 80 hours, please explain why you think this occurs.
Comments

What is the best thing about this rotation?
Comments
What is the worst thing about this rotation?

Comments

RESIDENT EVALUATION OF FACULTY

PATIENT CARE

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

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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- The faculty member is an effective role model for residents.

Comments

- The faculty member teaches residents how to be a more effective surgeon.

Comments

MEDICAL KNOWLEDGE

Faculty 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.

- The faculty member demonstrates appropriate medical knowledge in his or her care of patients.

Comments

- The faculty member helps the resident expand their medical knowledge.

Comments

PRACTICE-BASED LEARNING AND IMPROVEMENT

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

- The faculty member practices and role models evidence-based patient care.

Comments

- The faculty member systematically analyzes his or her practice and actively engages in practice improvements.

Comments

INTERPERSONAL AND COMMUNICATION SKILLS
Faculty must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

- The faculty member is a role model of effective communication with patients, families, and other health care providers.

Comments

- The faculty member effectively communicates with residents.

Comments

PROFESSIONALISM

Faculty must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

- The faculty member demonstrates compassionate and ethical patient care. They are an effective role model for professional behavior.

Comments

- The faculty member demonstrates effective teaching of professional behavior including accountability to patients and appropriate documentation.

Comments

SYSTEMS-BASED PRACTICE

Faculty 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.

- The faculty member demonstrates the ability to work effectively and efficiently within the larger health care system in a collaborative fashion.

Comments

- The faculty member is actively engaged in identifying systems errors and implementing potential systems solutions.

Comments
MEDICAL LICENSURE – USMLE/COMLEX EXAMINATION POLICY

In order to successfully practice medicine in the United States and become Board Certified, a resident must pass all three parts of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). Graduate Medical Education Programs must assure that their graduates are eligible to practice medicine.

For purposes of this policy, COMLEX Step 3 may be substituted for USMLE Step 3 in every instance. Residents currently in training programs at the PGY-2 or higher level will have one year from the date of implementation to pass USMLE Step 3. Residents in all core residency training programs sponsored by the University of Florida College of Medicine Gainesville must pass the USMLE Step 3 examination by the completion of the PGY-2 year. Failure to pass USMLE Step 3 by the conclusion of the PGY-2 year may result in suspension from training without pay until USMLE Step 3 is successfully passed. No resident may receive a salary increase to the PGY-3 level without prior passage of USMLE Step 3, but may, at the discretion of the program director, be promoted to the PGY-3 level clinically. Alternatively, programs may elect to non-renew residency training contracts for residents who have not successfully completed USMLE Step 3 by March 1 prior to the PGY-3 year. International Medical Graduates who first enter US GME training at the fellowship level (i.e. have not completed core residency training) are exempt from this policy. Other individual exceptions to this policy may be granted on appeal to the Designated Institutional Official.

- This policy is a minimum standard applicable to all training programs sponsored by the University of Florida. Individual programs may implement more stringent policies as desired.
- Residents in all core residency programs must register for and take USMLE Step 3 for the first time no later than September of their PGY-2 year.
- Residents who fail USMLE Step 3 on the first try must successfully pass this examination by the conclusion of the PGY-2 year. At the discretion of the individual program director, residents who have not passed USMLE Step 3 by March 1 prior to the PGY-3 year are at risk for non-renewal of their residency training contracts.
- No resident may receive the step increase in salary for the PGY-3 year without passing USMLE Step 3.
- International Medical Graduates beginning fellowship training without prior completion of a core residency program are exempt from this policy.
- Residents transferring into core programs from other institutions who have not already passed USMLE Step 3 will have one calendar year from the time of arrival to successfully pass USMLE Step 3.
- American Medical Graduate applicants to any Fellowship program sponsored by the University of Florida College of Medicine MUST have passed USMLE Step 3 prior to beginning training or receive approval from the DIO for an exemption.
- International Medical Graduates who have completed a core residency program in the United States applying to any Fellowship program sponsored by the University of Florida College of Medicine MUST have passed USMLE Step 3 prior to beginning training or receive approval from the DIO for an exemption.
- In order to graduate and receive a certificate of residency training, all housestaff MUST have documentation of successfully passing USMLE Step 3.
- Adverse academic actions associated with this policy may be appealed according to the GME Grievance and Appeals policy.
- Exceptions to this policy may only be granted by the Designated Institutional Official.
Moonlighting Policy

No moonlighting is allowed while residents are completing their clinical training. However, non-clinical residents are required to work up to two (2) clinical shifts per month during academic development time. Pre-approved moonlighting by lab residents is limited to four (2) days per month. Details below.

Clinical Work by Residents during Academic Development Time

In order to help preserve clinical skills and to help address patient care coverage issues with the new duty hours regulations, residents during academic development time will be asked to perform some limited clinical duties during the period of academic development time.

Guidelines:

Each resident during academic development time will be required to work up to two clinical shifts (13 hours each) per month during the period of full time academic development time. Residents will not receive extra compensation for these clinical duties, they represent part of their academic responsibilities. Some examples of the types of duties required include:

   1. Trauma Junior coverage
   2. VA in house coverage
   3. Vascular surgery in house coverage
   4. Pediatric surgery in house coverage
   5. Transplant coverage
   6. In other areas as needed

During this period of academic development time, the Department will continue to provide malpractice coverage for these residents.

In addition to the two required clinical shifts, lab residents will be allowed to perform clinical moonlighting if pre-approved by the program director. All moonlighting performed by lab residents must be disclosed to the program director prior to engaging in clinical activities. Un-approved moonlighting could result in disciplinary action being taken against the trainee up to or including probation or dismissal from the program. Moonlighting activities will be limited to two additional days of clinical activity per month. Total clinical activity will be limited to four days of clinical activity per month. Approval to moonlight will be granted under the following conditions:

   1. The resident is in good standing in the program.
   2. There are no outstanding professionalism issues.
   3. The resident maintains an adequate academic performance as defined by ABSITE scores at or above the 45 percentile.
   4. The resident demonstrates adequate productivity in their research as defined by their research mentor.
VACATION AND LEAVE OF ABSENCE POLICY

**Intent:**
The sponsoring institution must provide written institutional policies on residents’ vacation and other leaves of absence (with or without pay) to include parental and sick leave; these policies must comply with applicable laws. This policy must ensure that each ACGMEaccredited program provides its residents/fellows with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident’s/fellow’s eligibility to participate in examinations by the relevant certifying board(s).

**Description:**
Residents/fellows shall be entitled to leave with pay for the purpose of vacation and sick leave, depending upon the length of appointment, during the training period July 1 through June 30, as described in this section. Leave will be granted and charged in one day increments for each workday of leave requested and approved. If specialty board regulations for vacation and sick leave accrual and usage differ from that outlined in this policy, the program director will provide the DIO written notice of the applicable specialty board regulation and seek approval for a modification of this policy for program participants. The maximum time a resident or fellow can be away from a program in any given year shall be determined by the requirements of the specialty board involved. Each program will have a policy that addresses the effect of leave on promotion, eligibility to participate in examinations by the relevant certifying board and length of training. If the leave taken exceeds that which is allowed by a program, the resident may be required to extend his/her training to fulfill Board requirements.

The College of Medicine recognizes a variety of categories of leave:

**Vacation Leave:**
Requests for vacation leave shall be submitted to, and approved by, the program director prior to the date the vacation leave is taken. Vacation leave may be advanced to residents/fellows proportionate to that person’s expected period of service. This advanced leave cannot exceed the amount that could be earned during the remainder of the program year. Vacation leave that has been granted to, but not earned by, the resident/fellow at the time of separation from the academic department will require an appropriate reduction for the value thereof in the final stipend payment. Vacation leave accruals are normally based on an annual rate of fifteen (15) vacation days for all residents/fellows, provided this does not exceed that allowed by the appropriate specialty board. Residents/fellows may be permitted to carry over unused leave to a new program year, as consistent with department policy; however, carryover must be approved by the program director and no more than twenty-five (25) vacation days can be accumulated. All unused leave is considered non-payable leave, and there is no entitlement for lump-sum payment for unused leave upon separation or completion of training.

**Sick Leave:**
All residents/fellows shall accrue sick leave at the rate of 10 days per year of full time employment, if consistent with board requirements. Residents/fellows shall be entitled to utilize sick leave for: time off from work because of exposure to a contagious disease that may endanger others; personal visits to doctors or dentists; and for personal illness, which includes disability caused, or contributed to, by pregnancy. Additionally, sick leave may be used in reasonable amounts for illness, injury, or death within the resident’s/fellow’s immediate family, pending program directors approval. In instances of a serious medical condition of a resident/fellow or a member of the resident’s/fellow’s family, the resident/fellow may be eligible for an extended medical leave of absence under the Family and Medical Leave Act (FMLA) or UF’s Extended Leave of Absence program. Please see the section on FMLA, below, for more information.

Sick leave may be advanced to residents/fellows proportionate to expected service. This advance leave cannot exceed the amount of the leave that could be earned during the remainder of the program year. Sick leave that
has been granted, but not earned, by the resident/fellow at the time of separation from the academic department will require an appropriate reduction for the value thereof in the final stipend payment. Residents/fellows may be permitted to carry over sick leave to a new program year, as consistent with department policy; however, carryover must be approved by the program director and an excess of fifteen days (15) sick leave days cannot be accumulated. All unused sick leave is considered non-payable leave, and there is no entitlement for lump-sum payment for unused sick leave upon separation or completion of training.

FMLA Entitlement:
The Family and Medical Leave Act (“FMLA”) provides certain employees with up to 12 workweeks of unpaid, job-protected leave per year and requires group health benefits to be maintained during the leave as if the employees continued to work instead of taking leave.

Leave Entitlement
The University will grant an eligible employee up to a total of 12 workweeks of unpaid leave in an FMLA Benefit Year for one or more of the following reasons:

- For incapacity due to pregnancy, prenatal medical care, or childbirth;
- Placement of a child with the employee for adoption or foster care, and to care for the employee’s newly adopted child or a child newly placed in the foster care of the employee.
- To care for the employee’s family member with a serious health condition.
- The employee’s serious health condition.

Employees may choose to use accrued paid leave instead of unpaid leave for any portion of the 12 workweeks.

All residents/fellows are eligible for up to 12 workweeks of FMLA leave once they have worked at the University at least 12 months (need not be consecutive) or at least 1,250 hours during the 12 months prior to the start of the FMLA leave. Breaks in employment do not affect this total. It is a cumulative total of the number of months the resident/fellow has been employed by the University.

FMLA Benefit Year
The University of Florida uses as its FMLA Benefit Year the UF fiscal year, which is the twelve-month period from July 1 through June 30.

Serious Health Condition
Serious health condition means an illness, injury, impairment, or physical or mental condition that involves:

- any period of incapacity or treatment connected with inpatient care in a hospital, hospice, or residential medical care facility; or
- a period of incapacity requiring absence of more than three calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider; or
- any period of incapacity due to pregnancy, or for prenatal care; or
- any period of incapacity (or treatment therefore) due to a chronic serious health condition; or
- a period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective; or,
- any absences to receive multiple treatments (including any period of recovery therefrom) by, or on referral by, a health care provider for a condition that likely would result in incapacity of more than three consecutive days if left.

Family Member
The federal definition of “immediate family member,” for purposes of FMLA leave requests, is an employee’s spouse, children (son or daughter), and parents. The University’s definition for “immediate family member”
includes an employee’s spouse, domestic partner, great-grandparent, grandparent, parent, brother, sister, child, grandchild, or great-grandchild, or the grandparent, parent, brother, sister, child, grandchild, or great-grandchild of the employee’s spouse or domestic partner, or the spouse or domestic partner of any of them. Immediate family member also includes individuals for whom the employee is the current legal guardian.

While use of sick leave and extended medical leaves of absence are available for employees to use for the care of family members who meet the University’s definition of immediate family member, those absences will not be designated as qualifying as FMLA leave unless the employee’s family member also meets the federal definition of immediate family member.

Requesting FMLA
A resident/fellow must provide his/her program at least 30 days advance notice before FMLA leave is to begin if the need for the leave is foreseeable based on an expected birth, placement for adoption or foster care, or planned medical treatment for a serious health condition of the employee or of a family member. If 30 days’ notice is not practicable, notice must be given as soon as practicable.

The resident/fellow will confirm with the University’s Office for Human Resources Services whether he/she is eligible for leave under FMLA. If he/she is, the University’s Office for Human Resources Services will provide the resident/fellow notice of his/her rights and responsibilities and will specify any additional information that may be required to be submitted. If the resident/fellow is not eligible for FMLA leave, the notice from the University’s Office for Human Resources Services will provide a reason for the ineligibility.

Completed FMLA paperwork must be turned into either the program director or the University’s Office for Human Resources Services. FMLA paperwork can be obtained through the GME Office or [http://hr.ufl.edu/benefits/leave/fmla/](http://hr.ufl.edu/benefits/leave/fmla/)


Parental Leave:
Residents/fellows may take up to 6 weeks paid leave using accrued sick leave and vacation leave to care for a new child by birth or adoption. Sick/vacation leave may be advanced, proportionate to expected service. Please see the above vacation and sick leave policies.

The official parental leave period may begin two weeks before the expected date of the child’s arrival and must occur with 12-months of the child’s birth. Residents/fellows who plan to utilize parental leave are expected to notify their program director as soon as they know they will need to use parental leave, to facilitate appropriate scheduling. Complicated pregnancy or delivery will be handled in accordance with the FMLA and disability policies.

The total time allowed away from a program in any given year, or for the duration of the program, will be determined by the requirements of the specialty board involved. Any absences must be made up in accordance with specialty board policy.

Domestic Violence Leave:
Under Florida law, employers must provide employees up to 3 days of leave in a twelve month period if the employee or a family or household member is a victim of domestic violence. The UF fiscal year of July 1 to June 30 will be considered the 12-month period.

Activities Covered by the Leave
Under Florida law, the University must provide leave for the following specific activities:
• Seeking an injunction for protection against domestic violence or repeat violence, dating violence, or sexual violence;
• Obtaining medical care or mental health counseling or both for the employee or a family or household member to address injuries resulting from domestic violence;
• Obtaining services from victims services organizations such as a domestic violence shelter or rape crisis center;
• Making the employee’s home secure from the perpetrator of domestic violence or finding a new home to escape the perpetrator;
• Seeking legal assistance to address issues arising from domestic violence or attending or preparing for court related proceedings arising from the act of domestic violence.

Advanced Notice
Except in cases of imminent danger to the health or safety of an employee, or to the health or safety of a family or household member, a resident/fellow seeking domestic violence leave from work must provide his/her program director advanced notice of the leave.

Type of Leave
Residents/fellows are required to use accrued paid leave, if available, for domestic violence leave. Paid leave time can be advanced to the resident/fellow at the discretion of the program director. In the event that the resident/fellow does not have sufficient paid leave days to cover the domestic violence leave, the leave time will be unpaid.

Employer Responsibilities
The University, GME Office, and program director must keep all information relating to the domestic violence leave confidential and exempt from disclosure. Documentation of domestic violence leave is to be maintained in the GME Office and kept separate from the employee’s official personnel file. Under no circumstances can the University or the program take any disciplinary action against the resident/fellow related to the use of domestic violence leave.

Bereavement Leave:
Residents/fellows shall submit requests for bereavement leave their program director, who may grant up to 5 days off for the funeral of an immediate family member. The program shall provide 2 days of paid bereavement leave. If a resident/fellow requests, and is granted, more than 2 days of bereavement leave, the resident/fellow may use his/her sick or vacation leave time.

The University’s definition for “immediate family member” includes an employee’s spouse, domestic partner, great-grandparent, grandparent, parent, brother, sister, child, grandchild, or great-grandchild, or the grandparent, parent, brother, sister, child, grandchild, or great-grandchild of the employee’s spouse or domestic partner, or the spouse or domestic partner of any of them. Immediate family member also includes individuals for whom the employee is the current legal guardian.

Military Leave:
Absences for temporary military duty (e.g., two-week annual training) will not be taken from sick or vacation leave but will be considered leave with pay for up to 17 days. If activated from reserve to active duty status, the resident/fellow will receive thirty (30) days full pay before going on leave without pay. Insurance policies will remain in effect for dependents during the period of active duty for one year. Additional extensions of insurance require approval from the Graduate Medical Education Office. Any absences must be made up in accordance with the applicable specialty board policy. [http://hr.ufl.edu/benefits/leave/military-leave/](http://hr.ufl.edu/benefits/leave/military-leave/)

Jury Duty Leave:
Jury duty leave must be approved by the resident’s/fellow’s program director in advance.

Residents/fellows who are summoned to jury duty will be granted paid leave for all hours required for such duty. The University will not reimburse the employee for meals, lodging, and travel expense while serving as a juror.

If jury duty does not require absence for the entire workday, the resident/fellow should return to work immediately upon release by the court. Any absences must be made up in accordance with applicable specialty board policy.

**Documentation**
A department may require the resident/fellow to provide proof of jury duty.

**Court Appearance Leave:**
A resident/fellow subpoenaed as a witness in a court or administrative hearing, not involving personal litigation or service as a paid expert witness, shall be granted court appearance leave. If the court appearance does not require absence for the entire workday, the resident/fellow should return to work immediately upon release by the court.

**Approval**
Court appearance leave must be approved by the department. Upon receipt of a subpoena, a resident/fellow must notify his/her program director. If a resident/fellow is subpoenaed, his/her department is obligated to provide paid leave, unless the subpoena is related to personal litigation. “Personal litigation” is defined as a lawsuit in which the resident/fellow is the plaintiff or the defendant. For subpoenaed appearances related to personal litigation, the resident/fellow must use vacation leave or leave without pay. A department is obligated to provide housestaff with time off from work for subpoenas related to personal litigation but is not obligated to approve paid leave.

**Educational Assignment:**
Residents/fellows shall be eligible for absences pertaining to educational programs and training; provided such absences are allowed by the appropriate board and agreed to, in writing, by the program director. This leave should not be charged as either vacation or sick leave.

**Licensure Examination Leave:**
Residents/fellows taking American specialty board and state licensure examinations will be authorized leave at the discretion of the program director. The amount of absence authorized will not exceed the time actually required for taking the examination and for travel to and from the place of examinations. One licensure and one specialty exam leave period shall be paid as an added resident/fellow benefit. Any additional absence will be charged to vacation leave or leave without pay if vacation leave is not available.

**Holidays** – Residents/fellows shall be entitled to observe all official holidays designated by the University of Florida, except when they are on duty or call for clinical responsibilities. Residents/fellows on Veteran’s Administration Medical Center (VAMC) rotations shall be entitled to observe all official holidays designated by the federal government for VAMC employees, except when they are on duty or call for clinical responsibilities. When on duty or call for clinical responsibilities on designated holidays, the assignment will be considered as part of the residency and will not result in extra remuneration. The official University holiday schedule can be found at: [http://hr.ufl.edu/benefits/leave/holidays/](http://hr.ufl.edu/benefits/leave/holidays/)

**Extended Leave Policy:**
“Extended leave” encompasses forms of leave with or without pay that last longer than 15 consecutive workdays. Extended leave may be provided for medical (self and family), parental, military, and personal
reasons. Programs are encouraged to partner with the GME Office to assist with management of extended leave by residents/fellows.

Please note: When resident/fellow uses vacation leave and compensatory leave to cover an absence of more than 15 consecutive workdays for personal reasons, in keeping with the University’s vacation and compensatory leave policies, residents/fellows will not be considered to be on an “extended leave,” so long as the resident/fellow has sufficient vacation and compensatory leave to remain in full-pay status. The University of Florida’s extended leave of absence policy incorporates, at a minimum, that which is required by the federal Family and Medical Leave Act of 1993 (“FMLA”)

Leave of Absence without Pay Not Covered by FMLA or Disability Leave:
This policy should be followed by the Departments when a resident/fellow requests a LEAVE OF ABSENCE WITHOUT PAY (LWOP):

1. The resident must submit, in writing, the request for leave of absence without pay. The letter should be addressed to the Chair of the Department and must contain the following information:
   a. The purpose of the leave of absence.
   b. The period of leave to be taken without pay.
   c. The number of annual leave hours being requested.
   d. A date of expected return. This date can be adjusted, either with the resident returning earlier or extending further LWOP. If an extension is needed, the resident must write a new letter indicating the new date of return.
   e. A statement acknowledging the resident’s understanding that the department will cover the insurance benefits for up to two months, after which time COBRA laws will apply.
   f. A statement acknowledging the residency program will be extended as required by the applicable specialty board.
2. After the letter has been officially accepted by the Department, the Chair shall submit a letter to the GME Office, referencing both the resident’s/fellow’s request letter and the Chair’s approval.
3. Once the GME Office approves the LWOP, a letter approving the LWOP will be sent to the resident.
4. The department should submit to the Office of Educational Affairs/Graduate Medical Education (DEA/GME) a Job Action Form and a coding sheet with the Status Code 11- Extended Leave of absence. The effective date of leave without pay (Effective: from to ). The “from” date is the date the resident has exhausted sick and/or annual leave. The “to” date is the expected date of return. The DEA/GME will send a copy of the Job Action Form to fringe benefits.
5. Six weeks after the effective date of the LWOP, the department should call the DEA/GME to inform them when the department will stop paying benefits. (See section 8, Insurance Benefits, below). The DEA/GME will notify payroll and fringe benefits of the status change.
6. Upon the resident’s/fellow’s return from LWOP, the department will complete and submit to the DEA/GME a Job Action Form and coding sheet with the Status Code 01- Active (Effective: from to ). The “from” is the actual date of the resident’s/fellow’s return. The “to” date is the date the academic year ends. The DEA/GME will send a copy of the 255 to fringe benefits.
7. Payroll. No salary shall be paid to the resident for those days or weeks that are not covered by vacation/sick leave.
8. Insurance Benefits: If LWOP is approved and uncompensated leave is taken, insurance benefits will be covered by the Department for up to two months. Prior to the two months ending, the Program Director/Chair should request submit a written request for coverage of benefits for up to six-months by the College of Medicine. The letter should be
addressed to Timothy Flynn, M.D., Fringe Benefits Committee Chairman, and a copy sent to the ADGME/ADEA. If College of Medicine does not approve coverage of benefits for up to six-months, then, after two months of benefits covered by the Department, the resident will be responsible for payment of insurance premiums for the remaining period. After the coverage of benefits by the Department and College ceases, the resident may purchase benefits for up to 18 months, consistent with the COBRA provisions.

**Travel** - There are appropriate opportunities for residents to travel to meetings. These include attendance at educational seminars and presentation of original data in a peer review program. However, funds are limited and the residents’ primary responsibility is to the educational and service requirements of the program. The following guidelines are the policy of the Department:

1) Resident travel to all meetings must be approved by the program director and Chairman.
2) Chief residents can attend a meeting of their choice. All requests much be approved by the program director. Travel reimbursement is limited to $1200 for eligible travel-related expenses. When more than one resident travels to the same meeting residents are encouraged to split the cost of lodging whenever possible.
   - Meal expenses may not exceed $36.00 per day (these are State standard numbers). All other expenses are the responsibility of the resident. In general, total time away from Gainesville should not exceed five (5) days and residents should limit their time away to attend only the essential part of the meeting.
   - Residents may travel to other meetings in addition to their one guaranteed meeting to present data in peer-reviewed programs. Prior to submission of abstracts, the resident must obtain approval from the faculty member with whom they have worked and also the approval of the program director and Chairman. The resident should know the source of funding for travel prior to the submission of the abstract. In the absence of funding, the resident will be financially responsible. Every effort should be made to have travel funded by other than departmental sources. Travel time should be the minimal amount of time necessary to present the paper.
3) Residents in the clinical years who travel to meetings must also have the approval of the service chief of the rotation to which they are assigned and the Program Director.

Chief residents requiring time away for fellowship interviews or job interviews will be allowed 7 days of time off (not affecting vacation time) to conduct such interviews. The 7-day interview policy will be offset by any sick time or maternity/paternity leave used by the resident. If additional time off is needed for interviews, residents will subtract that time from their unused vacation time. Preliminary residents that require time off for interviews will use their vacation time to conduct their interviews.

For more details about leave, including extended leave, please refer to the following website:

**OUTSIDE EMPLOYMENT**

Housestaff may not accept outside employment (moonlighting) during the regular work year. During vacation, members of the house-staff may engage in contracts of their choosing as long as they do not violate the Florida Practice Act. Should housestaff become engaged in contracts related to medical practice they will not be considered nor represent themselves as University of Florida employees for that purpose. The program director must approve any locum tenens arrangements. Professional liability insurance must be obtained by the housestaff member for such activity. The housestaff member will not be protected from liability claims for outside employment by the Insurance Trust Fund during this period of time. Housestaff shall be permitted to participate in extracurricular, educational, professional activities with approval by the program director and by the Dean of the College of Medicine, for which those participating individuals may be compensated. These shall be referred to as “Paid Educational Experiences” and include such activities as giving lectures to PA students. Violation may lead to immediate dismissal of the house officer.
MENTORS

Each general surgery and preliminary surgery resident will be assigned a faculty member who will act as advisor/mentor. Later on, a resident may elect a new mentor that shares similar career interests or is otherwise a better fit for the trainee. Ideally, each resident should have three to four formal meetings per year. The mentor is responsible for providing a written report of these meetings.

NEEDLE STICK

All exposures to blood or body fluids should be taken seriously. Although the risk of HIV transmission is low, transmission of hepatitis is all too common, especially Hepatitis C. You should report all exposures to the housestaff office so that the appropriate Workman’s Compensation forms can be filed. For needle sticks and the possibility of HIV exposure, time to treatment is critical. UF Needle Stick Hotline (1-866-477-6824) is the first contact during regular hours or if after hours, the victim is triaged to the nearest ER. The full policy and instructions can be found at: http://osa.med.ufl.edu/about/needle-stick-hotline-program/.

Sexual Harassment Policy

SEXUAL HARASSMENT IS NOT TOLERATED AT THE UNIVERSITY OF FLORIDA

Policy Statement

It is the policy of The University of Florida to provide an educational and working environment for its students, faculty, and staff that is free from sex discrimination and sexual harassment. In accordance with federal and state law, the University prohibits discrimination on the basis of sex, including sexual harassment. Sex discrimination and sexual harassment will not be tolerated, and individuals who engage in such conduct will be subject to disciplinary action. The University encourages students, faculty, staff, and visitors to promptly report sex discrimination and sexual harassment.

Non-Discrimination Policy

Scope

This policy applies to visitors, applicants for admission to or employment with the University, students, and employees of the University who allege sex discrimination, including sexual harassment, by University employees, students, visitors, or contractors.

Definition

Sexual Harassment is a form of sex discrimination that can occur when:

- The submission to unwelcome physical conduct of a sexual nature, to unwelcome requests for sexual favors, or to other verbal conduct of a sexual nature is made an implicit or explicit term or condition of employment or education; or
- The submission to or rejection of unwelcome physical conduct of a sexual nature, unwelcome requests for sexual favors, or other verbal conduct of a sexual nature is used as a basis for academic or employment decisions or evaluations; or
- Unwelcome physical acts of a sexual nature, unwelcome requests for sexual favors, or other verbal conduct of a sexual nature have the effect of creating an objectively hostile environment that interferes with employment or education on account of sex.

Reporting

Anyone who believes that he or she has been subjected to a violation of this policy or related retaliation is strongly encouraged to promptly report such behavior to the Director of Employee Relations or any university official, administrator, supervisor, manager, or faculty member.
• Except for student-on student sexual harassment, students are strongly encouraged to report such incidents to the Director of Employee Relations. For student-on-student sexual harassment incidents, reports should be directed to the Dean of Students, Office of Student Conduct and Conflict Resolution.

• Incidents should be reported as soon as possible after the time of their occurrence to allow the university to take appropriate remedial action. No employee or student should assume University of Florida officials knows about a situation or incident.

• Any university official (administrator, supervisor or manager) who has knowledge of or receives a written or oral report or complaint of a violation of this policy must promptly report it to the Director of Employee Relations, and may be disciplined for failing to do so.

• Any faculty member, teaching assistant or staff member with knowledge of sexual harassment of a student must promptly report the incident to the Director of Employee Relations, and may be disciplined for failing to do so.

• Other persons who suspect a violation of this policy should report it to an appropriate person in their department / unit or to the Title IX Coordinator.

Contact Information:

John Rouse
University Title IX Coordinator
Assistant Director, Office of Institutional Equity & Diversity
Human Resource Services
903 W. University Avenue
PO Box 115010
Gainesville, FL 32611-5010
352-392-1072
jsrouse@ufl.edu


PROMOTION/PROBATION/TERMINATION

Promotion to the next level of training is determined by the faculty’s assessment of the resident’s ability to assume the responsibilities of the new level. This is based in part on the resident’s demonstrated achievement of the milestones listed in the goals and objectives for each rotation and each year, in part on the resident’s performance on the American Board of Surgery Annual In-Training examination, and in part on the faculty’s overall assessment of the resident’s progress in relation to the expected competencies at any given year level. Promotion and retention are also dependent on continued appropriate moral, ethical and professional conduct by the resident.

If the faculty determines that a resident’s progress is not satisfactory, the faculty may vote to terminate the resident, place the resident on probation or require that the resident repeat the year. If the faculty decides to terminate the resident, the resident will be notified by the program director and will be given the right to appeal as outlined in the due process policy. If the decision is to place the resident on probation, the program director will send the resident a letter outlining the resident’s deficiencies and suggesting remedial action. The program director will set the terms of probation and the circumstances that will result in lifting the probation or proceeding to termination. Probation is meant to be a very serious warning to the residents that their performance does not meet the standards set by the faculty of the Department of Surgery. Serious violations of hospital policy, acts that endanger patient safety, or breaches of accepted moral or ethical standards may result in summary termination at the discretion of the program director.
All residents must pass step 3 of the USMLE by March 1st of their PGY2 year to be promoted in the program. If a resident fails to pass step 3 by March 1st of their PGY2 year they will not be promoted to PGY3. This delay in academic progress may be grounds for non-renewal of contract for the upcoming academic year.

**GRIEVANCES – DUE PROCESS POLICY**

Grievance procedures and due process: The program director must ensure the implementation of fair policies and procedures, as established by the sponsoring institution, to address resident grievances and due process in compliance with the Institutional Requirements.

The position of the resident presents the dual aspects of a student in graduate training while participating in the delivery of patient care.

The University of Florida College of Medicine is committed to the maintenance of a supportive educational environment in which residents are given the opportunity to learn and grow. Inappropriate behavior in any form in this professional setting is not permissible. A resident’s continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident’s academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

**Grievances** - A grievance is defined as dissatisfaction when a resident believes that any decision, act or condition affecting his or her program of study is arbitrary, illegal, unjust or creates unnecessary hardship. Such grievance may concern, but is not limited to, the following: academic progress, mistreatment by any University employee or student, wrongful assessment of fees, records and registration errors, discipline (other than non-renewal or dismissal) and discrimination because of race, national origin, gender, marital status, religion, age or disability, subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida and the College of Medicine.

Prior to invoking the grievance procedures described herein, the resident is strongly encouraged to discuss his or her grievance with the person(s) alleged to have caused the grievance. The discussion should be held as soon as the resident becomes aware of the act or condition that is the basis for the grievance. In addition, or alternatively, the resident may wish to present his or her grievance in writing to the person(s) alleged to have caused the grievance. In either situation, the person(s) alleged to have caused the grievance may respond orally or in writing to the resident.

If a resident decides against discussing the grievance with the person(s) alleged to have caused such, or if the resident is not satisfied with the response, he or she may present the grievance to the Chair. If, after discussion, the grievances cannot be resolved, the resident may contact the Associate Dean of Graduate Medical Education (ADGME). The ADGME will meet with the resident and will review the grievance. The decision of the ADGME will be communicated in writing to the resident and constitute the final action of the University.

**Suspension** - The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the Chair or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be informed of the reasons for the suspension and will be given an opportunity to provide information in response.
The resident suspended from patient care may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident within thirty (30) days of the date of suspension.

Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision-making or appeal process. The resident will be afforded due process and may appeal to the ADGME for resolution, as set forth below.

Non-renewal - In the event that the Program Director decides not to renew a resident’s appointment, the resident will be provided written notice which will include a statement specifying the reason(s) for non-renewal. This should be done at least 4 months prior to the end of the resident’s current agreement.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed non-renewal decision. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that non-renewal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

Dismissal - In the event the Program Director of a training program concludes a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair in writing of this decision and the reason(s) for the decision. The resident will be notified and provided a copy of the letter of proposed dismissal; and, upon request, will be provided previous evaluations, complaints, counseling, letters and other documents that relate to the decision to dismiss the resident.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed dismissal. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that dismissal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

Appeal - If the resident appeals a decision for suspension, non-renewal or dismissal, this appeal must be made in writing to the DGME within 10 working days from the resident’s receipt of the decision of the person suspending the resident or the Chair. Failure to file such an appeal within 10 working days will render the decision of the person suspending the resident or the Chair the final agency action of the University.

The ADGME will conduct a review of the action and may review documents or any other information relevant to the decision. The resident will be notified of the date of the meeting with the ADGME; it should occur within 15 working days of the ADGME’s receipt of the appeal. The ADGME may conduct an investigation and uphold, modify or reverse the recommendation for suspension, non-renewal or dismissal. The ADGME will notify the resident in writing of the ADGME’s decision. If the decision is to uphold a suspension, the decision of the DGME is the final agency action of the University. If the decision is to uphold the non-renewal or dismissal, the resident may file within 10 working days a written appeal to the Dean of the College of Medicine. Failure to file such an appeal within 10 working days will render the decision of the ADGME the final action of the University.
The Dean will inform the ADGME of the appeal. The ADGME will provide the Dean a copy of the decision and accompanying documents and any other material submitted by the resident or considered in the appeal process. The Dean will use his or her best efforts to render a decision 15 working days, but failure to do so is not grounds for reversal of the decision under appeal. The Dean will notify in writing the Chair, the ADGME, the Program Director and resident of the decision. The decision of the Dean will be the final agency action of the University. The resident will be informed of the steps necessary for the resident to further challenge the action of the University.

**College of Medicine Housestaff Fringe Benefit Overview**

*July 1, 2016 – June 30, 2017*


**College of Medicine Insurance Plans**

Clinical housestaff residents who are appointed at 0.50 FTE and higher, will be provided the following insurance plans – with no monthly premium cost – directly through the College of Medicine. These plans begin on the date of hire and continue until the end of the month in which the housestaff member terminates their program.*

- Health Insurance (employee may select one of two GatorCare plans for up to family coverage)
- $50K Life Insurance
- $10K Accidental Death/Dismemberment Insurance
- Long-Term Disability Insurance (monthly benefit of $2500 tax-free)**
- Additional information can be found by going to the Summary of Benefits link at the following website – [http://adminaffairs.med.ufl.edu/fringe-benefits/housestaff-benefits/](http://adminaffairs.med.ufl.edu/fringe-benefits/housestaff-benefits/)

*Life and Disability Insurance plans end on the last day of employment

**Residents must be appointed at 0.75 FTE (or higher) to be eligible for the Long-Term Disability plan

In addition to the insurance plans listed above which are provided directly through the College of Medicine, the University of Florida and the State of Florida offer optional insurance plans. These plans would require the employee to pay the monthly cost via payroll deduction.

**Health Insurance Plan Information**

The GatorCare health insurance program offers two plan choices for residents – the Premium plan and the Prime Plus plan. Both plans are offered for no monthly cost to the resident, with the ability to enroll a spouse (or domestic partner) and children for no extra cost.

**Premium (recommended)** – offers coverage for the UF Health network (Tier 1), the Blue Cross nationwide network (Tier 2), and out of network benefits (Tier 3). This plan gives the greatest network flexibility and offers lower out of pocket costs for Tier 2 and Tier 3.

**Prime Plus** – offers coverage for the UF Health network (Tier 1) and the Blue Cross nationwide network (Tier 2) only. Very minimal amounts of coverage are provided for out of network claims (usually just for ER coverage). This plan allows for slightly lower out of pocket costs for Tier 1, but higher out of pocket costs for Tier 2 and Tier 3.

**Please see the enclosed sheets with detailed charts for each of the plan guidelines**

More information can be found at the GatorCare website ([http://gatorcare.org/](http://gatorcare.org/)). The contact information for the UF Physicians practices may be found at [https://ufhealth.org/locations](https://ufhealth.org/locations).
**University of Florida Insurance Plans (UF Select)**
The plans offered through the University of Florida are known as UF Select. These plans include additional life and disability insurance (over and above what is automatically provided through the College of Medicine), dental, vision, legal insurance, as well as other supplemental plans. These plans begin on the date of hire and continue until the end of the month in which the housestaff member terminates their program.

The employee is responsible for the monthly cost of any UF Select plan chosen. Additional information about these plans can be found at [http://hr.ufl.edu/benefits/](http://hr.ufl.edu/benefits/).

**State of Florida Insurance Plans (PeopleFirst)**
The State of Florida also offers insurance plans through a company called PeopleFirst. These plans include additional life and disability insurance (over and above what is automatically provided through the College of Medicine), dental insurance, vision insurance, as well as other supplemental plans, including medical and dependent care reimbursement accounts.

**PLEASE NOTE** – The State of Florida offers health insurance plans, but you may not be enrolled in both a GatorCare health insurance plan and one of the State of Florida health insurance plans. Only one health insurance plan may be selected. GatorCare is recommended instead of the State of Florida plan. However, the employee may opt-out of the free GatorCare plan and elect to pay for the State of Florida plan**

The employee is responsible for the monthly cost of any State of Florida insurance plan chosen. Additional information about these plans can be found at [http://www.myflorida.com/MyBenefits/Health/Health.htm](http://www.myflorida.com/MyBenefits/Health/Health.htm).

**Retirement**
All housestaff are placed into the FICA Alternative plan for their retirement program. This deduction is in substitute for Social Security taxes. The FICA Alternative deduction is withdrawn at the rate of 7.5% of the gross salary, on a pre-tax basis.

The FICA Alternative plan is administered by VALIC. More information can be obtained by calling VALIC at (352) 367-2409 or (800) 448-2542, or by going to [https://www.valic.com/plan-details_3750_433090.html](https://www.valic.com/plan-details_3750_433090.html) or [http://hr.ufl.edu/benefits/retirement/fica-alternative-plan/](http://hr.ufl.edu/benefits/retirement/fica-alternative-plan/).

**IMPAIRED PRACTITIONERS**

The sponsoring institution and each program is responsible for monitoring residents for signs of psychological and substance abuse problems and for initiating appropriate interventions.

The University of Florida College of Medicine will fully participate in the provisions of the Florida Medical Practice Act (F.S.458), the rules of the Board of Medicine, and Department of Professional Regulation. The College of Medicine supports the Florida Impaired Practitioners Program.

Faculty, staff, peers, family or other individuals who suspect that a member of the housestaff is suffering from a psychological or substance abuse problem are obligated to report such problems. Individuals suspecting such impairment can either report directly to the Professional’s Resource Network (PRN) or can discuss their concerns with the Program Director, Chairman, or Associate Dean of Graduate Medical Education.

It is the intent of the program that all appropriate rules that govern the practice of medicine be strictly enforced. All referrals to the PRN are confidential and are evaluated by the professionals of the PRN. Decisions about intervention, treatment and after care are determined by the PRN.
As long as the practitioner satisfactorily participates in the PRN program, no regulatory action would normally be anticipated by the Board of Medicine.

Resumption of clinical activity and residency program will be contingent upon the continued successful participation in the PRN and continuation of the resident in the program will be determined in consultation between the program director and the professionals at the PRN.

Information on the Professional’s Resource Network (PRN) and its program can be obtained by calling 1-800-888-8PRN or by writing to the PRN at P.O. Box 16510, Fernandina Beach, Florida 32035-1020.

**SELECTION OF RESIDENTS**

Residents are selected based on their academic achievement, personal qualities and ability to excel in the rigors of surgical education. For the most part, only those most qualified applicants from LCME-accredited schools and ECFMG-certified foreign medical graduates that the faculty consider as providing a superior undergraduate medical education will be interviewed. All first year residents are appointed through the National Residency Matching Program (NRMP). Residents are accepted as categorical residents with the intent that these residents will complete the program, assuming their performance is satisfactory. Preliminary residents are accepted as either designated to go into a subspecialty or as non-designated. The latter group is offered a one-year appointment only and must make arrangements for further education after the year is completed. The program director is happy to assist the resident in finding a suitable position. Upper level residents are rarely accepted and must have superior credentials. Upper level residents will only be accepted if there is a categorical position for them to fill.

**TECHNICAL STANDARDS**

A candidate for the Surgery Residency must have abilities and skills in five categories: observation, communication, motor, intellectual, behavioral and social.

I. **Observation** - A candidate must be able to observe a patient accurately at a distance and close at hand. In detail, observation necessitates the functional use of the sense of vision and other sensory modalities.

II. **Communications** - A candidate must be able to communicate effectively and sensitively with patients. The focus of this communication is to elicit information, describe changes in mood, activity, and posture, and perceive nonverbal communications. Communication includes not only speech but also reading and writing. The candidate must be able to communicate effectively and efficiently in oral and written form with all members of the health care team.

III. **Motor** - Candidates must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate must be able to execute motor movements reasonably required to perform technically complex surgical procedures including difficult dissections, bowel and arterial anastomosis and manipulation of various laparoscopic and endoscopic tools.

IV. **Intellectual-Conceptual, Integrative, and Quantitative Abilities** - These abilities include measurement, calculation, reasoning, analysis, and synthesis of complex information.
V. **Behavioral and Social Attributes** - A candidate must possess the emotional health required for full utilization of his or her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. Candidates must be able to tolerate physically taxing workloads and to function effectively under stress. They must be able to adapt to changing environments, to display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of many patients. Compassion, integrity, interpersonal skills, interest and motivation are all personal qualities that are assessed during the admissions and education processes.

If you think you may not be able to meet these standards, please contact the program director to discuss potential accommodations.

**HEALTH REQUIREMENTS**

The University of Florida’s Occupational Health Services department requires pre-placement screening evaluation and vaccinations for certain infectious diseases. They evaluate the screens and vaccinations and clear ALL residents to begin their training programs. Failure to complete these requirements will delay a resident’s start date, pay, and training.

- All housestaff shall be immune to rubella, mumps, varicella, and measles.
- Housestaff born in or after 1957 who do not have evidence of immunity to these diseases shall be required to have proof of current MMR vaccinations.
- A PPD must be obtained before starting employment and yearly thereafter.
- All health care professionals are urged to receive and provide documentation of the Hepatitis B vaccination.

The complete requirements can be found at: [http://shcc.ufl.edu/files/2011/08/policy.pdf](http://shcc.ufl.edu/files/2011/08/policy.pdf)

**ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION/RESIDENT REVIEW COMMITTEE (ACGME/RRC)**

Graduate medical education is the second phase of professional development and prepares an individual to practice in a medical specialty. Training programs in this country are accredited by the Accreditation Council for Graduate Medical Education and the Residency Review Committees of each specialty. The ACGME is a voluntary organization made up of representatives of the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies. The ACGME establishes institutional requirements for those entities that sponsor training programs. In Gainesville the sponsoring institution is the University of Florida. Each specialty that offers certification also has an RRC made up of representatives of the major specialty societies of that specialty. For Surgery, they are the American Board of Surgery, the American College of Surgeons and the AMA Council on Medical Education. The RRC establishes the program requirements for surgical education and periodically reviews programs. A copy of the full text of the institutional and specialty requirements can be found in the “green book” in the program directors office. Residents and faculty are encouraged to read these documents. Further information can be obtained at: [www.acgme.org](http://www.acgme.org).

**AMBULATORY CARE**

Outpatient activities constitute an essential component of adequate experience in continuity of care. The program is structured so that the residents have ample opportunity to see patients through the whole episode of care. Residents are expected to attend all of the clinic sessions for the services to which they are assigned. It is
the responsibility of the Attending and chief resident to insure that residents have the opportunity to see the patients that they have cared for in hospital. At a minimum all residents must attend clinic and see patients once per week.

**AMERICAN BOARD OF SURGERY**

The following is from the American Board of Surgery information booklet, a copy of which is in the Housestaff Office:

The American Board of Surgery, Inc. is a private, voluntary, non-profit autonomous organization formed for the following purposes:

(a) To conduct examinations of acceptable candidates who seek Certification or Re-certification by the Board.
(b) To issue Certificates of all candidates meeting the Board’s requirements and satisfactorily completing its prescribed examinations.
(c) To improve and broaden the opportunities for the graduate education and training of surgeons.

The Board limits its responsibilities to fulfilling the purposes stated above. It is not concerned with the attainment of special privileges or recognition for its Diplomates in the practice of surgery. It is neither the intent nor the purpose of the Board to define the requirements for membership on the staff of hospitals or institutions involved in the practice or teaching of surgery. Its principle objective is to certify the education, experience and knowledge of broadly qualified and responsible surgeons and not to designate who shall or shall not perform surgical procedures or any category thereof. The Board specifically disclaims interest in or recognition of differential emoluments that may be based upon Certification or Recertification.

**Specialty of Surgery (General Surgery) Defined**

The Board interprets the term “General Surgery” in a comprehensive but specific manner, as a discipline having a central core of knowledge embracing anatomy, physiology, metabolism, immunology, nutrition, pathology, wound healing, shock and resuscitation, intensive care and neoplasia, which are common to all surgical specialties.

A General Surgeon certified by the American Board of Surgery is one who has acquired during training specialized knowledge and experience related to the diagnosis, preoperative, operative, and postoperative management, including the management of complications, in nine primary components of Surgery, all of which are essential to the education of a broadly based surgeon:

- **ALIMENTARY TRACT**
- **ABDOMEN AND ITS CONTENTS**
- **BREAST, SKIN AND SOFT TISSUE**
- **HEAD AND NECK**, including trauma, vascular, endocrine, congenital and oncology disorders—particularly tumors of the skin, salivary glands, thyroid, parathyroid, and the oral cavity.
- **PEDIATRIC SURGERY**
• **VASCULAR SYSTEM**, excluding the intracranial vessels and the heart.

• **ENDOCRINE SYSTEM**, including thyroid, parathyroid, adrenal and endocrine pancreas.

• **SURGICAL ONCOLOGY**, including coordinated multimodality management of the cancer patient by screening, surveillance, surgical adjunctive therapy, rehabilitation, and follow-up.

• **COMPREHENSIVE MANAGEMENT OF TRAUMA**, including musculoskeletal, hand and head injuries. The responsibility for all phases of care of the injured patient is an essential component of general surgery.

• **COMPLETE CARE OF CRITICALLY ILL PATIENTS** with underlying surgical conditions, in the Emergency Room, Intensive Care Unit and Trauma/Burn Units.

Additionally, the General Surgeon is expected to have had significant preoperative, operative, and postoperative experience in pediatric, plastic, general thoracic and transplant surgery during training. Also, the Surgeon must have understanding of the management of the more common problems in cardiac, gynecologic, neurologic, orthopaedic, and urologic surgery, and of the administration of anesthetic agents. In addition, the Surgeon must be familiar with the unique requirements of the geriatric surgical patient.

The General Surgeon must be capable of employing endoscopic techniques, particularly proctosigmoidoscopy, colonoscopy, esophagogastroduodenoscopy, laparoscopy, and operative choledochoscopy, and must have experience in other relevant diagnostic and therapeutic techniques including laryngoscopy, bronchoscopy, colonoscopy, and fine needle aspiration. The General Surgeon should also have experience with sentinel lymph node mapping and biopsy techniques for breast cancer and melanoma, and have the opportunity to become familiar with evolving diagnostic and therapeutic methods, including the following:

• Investigation and manipulation of the distal common bile duct (including sphincterotomy).
• Stereotactic breast biopsy techniques, including advanced breast biopsy instrumentation (ABBI), core needle biopsy, and mammotome techniques.
• Physiologic testing and evaluation of the GI tract.
• Diagnostic ultrasonography of the following areas:
  • Head and neck
  • Breast
  • Abdomen, including intraoperative and laparoscopic ultrasound
  • Endorectal
• Non-invasive diagnostic evaluation of the vascular system and invasive vascular interventional techniques.
• Sentinel lymph node mapping and biopsy techniques for breast cancer and melanoma.

**Training Requirements**

Below is a general overview of the training requirements for general surgery certification. For complete details, please refer to the ABS Booklet of Information - Surgery (pdf).

To be eligible for certification, applicants must fulfill the requirements below.
Program and Time Requirements

- 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. See also Limit on Number of Programs and Credit for Foreign Medical Education.

- 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. See our Leave Policy for details; all time away from training must be accounted for on application form.

- 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.

Specific Requirements

- The programs Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support® (ATLS®) and Fundamentals of Laparoscopic Surgery™ (FLS). Applicants are not required to be currently certified in these programs; they must only provide documentation of past certification.

- At least 2 operative and 2 clinical performance assessments conducted by the program director or other faculty members while in residency. The ABS will not collect these forms, but will ask the program director to attest they have been completed. This will increase to 6 operative and 6 clinical assessments starting with applicants who graduate residency in the 2015-2016 academic year.

Chief Resident Year

- Acting in the capacity of chief resident in general surgery for a 12-month period, with the majority of the 12 months served in the final year.

  The term "chief resident" indicates that a resident has assumed ultimate clinical responsibility for patient care under the supervision of the teaching staff and is the most senior resident involved with the direct care of the patient.

- The entire chief resident experience in either the content areas of general surgery or thoracic surgery, with no more than 4 months devoted to any one area. All rotations at the PGY-4 and -5 levels should involve substantive major operative experience and independent decision making.

Operative Experience

- A minimum of 750 operative procedures in five years as operating surgeon, including at least 150 in the chief resident year. Applicants may count up to 50 cases as teaching assistant toward the 750 total; however these cases may not count toward the 150 chief year cases.
• A minimum of 25 cases in surgical critical care, with at least one in each of the seven categories: ventilatory management; bleeding (non-trauma); hemodynamic instability; organ dysfunction/failure; dysrhythmias; invasive line management and monitoring; and parenteral/enteral nutrition.

• A minimum of 25 cases as teaching assistant by the completion of residency.

Upcoming Requirements

Flexible Endoscopy Curriculum

• Applicants who complete residency in the 2017-2018 academic year or thereafter will be required to have completed the ABS Flexible Endoscopy Curriculum. The curriculum contains several "levels" that must be attained during residency. The final level includes successful completion of the Fundamentals of Endoscopic Surgery™ (FES) program. Applicants will need to provide documentation of FES certification with their application.

250 Cases by End of PGY-2

• Applicants who began residency in July 2014 will be required to have performed 250 operations by the conclusion of the PGY-2 year. These can include cases performed as surgeon or first assistant, endoscopies, or operative exposures (e-codes*). Of the 250, 200 must be either in the defined categories, endoscopies or e-codes.

Cases will be tracked through the ACGME case log. The 250 cases must be completed over 2 consecutive residency years, ending with the PGY-2 year.

*E-Codes: General surgery residents can use e-codes to receive ACGME case log credit for vascular surgical procedures. E-codes allow more than one resident to take credit for an arterial exposure and repair. The resident who accomplishes the exposure should add an "E" to the case ID for the system to allow credit for a second procedure on the same patient. The relevant CPT codes to use are: 35201 (Repair blood vessel, direct; neck); 35206 (upper extremity); 35216 (intra-thoracic without bypass); 35221 (infra-abdominal), and 35226 (lower extremity). Four categories are available under Trauma for residents to enter arterial exposures.

For specific inquiries regarding ABS training requirements, please send an email to the ABS coordinator.

AMERICAN BOARD OF SURGERY, INC.
1617 John F. Kennedy Blvd. Suite 860
Philadelphia, PA 19103-1847

AMERICAN COLLEGE OF SURGEONS

All third year and above general surgery residents are encouraged to become Candidate Members of the American College of Surgeons. As a Candidate Member residents can attend the Annual Clinical Congress meeting and are not charged a registration fee. Contact the Surgery Housestaff Office for more information or go to the web site: http://www.facs.org/

BEEPERS

All residents and fellows in the Department of Surgery are issued a beeper at the beginning of their residency/fellowship. The resident is responsible for insuring that the beeper is functional, has a charged battery and is on during duty hours. If there is a problem with the beeper, contact the Surgery Housestaff Office or the page operator of the hospital to which you are assigned for a loaner. Loss of a pager results in a $35 fee that the program will cover the first time. If you lose or damage a second pager you will be responsible for
covering the cost of its replacement. Be sure that the page operators are notified if you are carrying a different beeper than that on the call schedule.

CALL ROOMS

The Housestaff Affairs Office retains a copy of every area within the hospital that has been designated as a sleep room for housestaff who are required to remain in-house overnight to provide coverage for their specialty. Certain departments have special areas designated to them and these can be determined by contacting the Chief Resident of the program or call the Housestaff Affairs Office.

CASE LISTS

General Surgery residents are required to use the ACGME Op Log to record their surgical cases. It is imperative that all residents keep an ongoing record of the cases in which they have participated. Case lists will be reviewed during your semi-annual review to make sure they are current. Trying to reconstruct a case list at the beginning of the Chief year just will not work. This record is essential for the individual’s ability to take the Boards and for the program to remain accredited by the RRC. There are minimum numbers of cases for the defined categories on the case list forms. It is important that each resident take responsibility for achieving these minimums. Completion of the program is dependant on meeting or surpassing the minimum requirements in each category. These values can be obtained from the program director. Cases must be logged in at the ACGME web site: http://www.acgme.org/

CODE OF CONDUCT

All housestaff are expected to comply with the standards established by the hospital. All housestaff should maintain a professional appearance, conduct, and attitude, as well as exhibit behavior that is exemplary of the medical profession. All housestaff must be identified by their University of Florida identification badge, which should be worn at all times.

CONFIDENTIALITY

The program recognizes that the rights and individual dignity of each patient (including the parents and/or surrogates of minors or incapacitated patients) are to be respected during the delivery of health care services. Reasonable and responsible behavior on the part of the resident with regard to the privacy and feelings of the patient and the patient’s family is expected. Cases are not to be discussed except in the course of the care of the patient. Conversations in the elevator, lunchroom or other public places should not involve patient care matters. No specific information about any particular patient should be released without the written consent of the patient. From time to time colleagues, friends or public personages may be admitted to the hospital. Unless you are directly involved in the care of these individuals it is a breach of confidentiality and medical ethics to read the chart or seek to obtain information on these patients. HIPPA Training is mandatory for all residents.

CONSCIOUS SEDATION

Anyone administering intravenous drugs that may cause loss of protective airway reflexes must be familiar with the hospital’s conscious sedation policy. This includes certain monitoring and competencies, including ACLS, which must be present to use these drugs. Each individual is responsible for being familiar with these requirements.
Current Policy: Sedation and analgesia for diagnostic, therapeutic, and invasive procedures shall be practiced throughout the hospital in accordance with the conscious sedation standards for administering and monitoring sedation and analgesia. Only those physicians who are licensed independent practitioners (current Florida medical license) may perform conscious sedation. In addition, these physicians (including residents) must formally apply through the Department of Surgery, and contact Kellie Howard in the Office of the Medical Staff (244-3134) to be granted privileges to perform these procedures.

**DRESS CODE**

Appropriate standards of dress are required of all medical staff and residents, dentists, health care professionals, and students who provide care for patients. While they are in contact with patients in clinic and on the hospital floors all general surgery residents shall wear a white coat, along with shirt and tie for men and properly coordinated attire for women. A suit coat may be substituted for a white lab coat. Approved attire in patient care areas shall not include shorts, cut-offs, jeans, or similar casual clothing. Name tags shall be worn when on duty within the hospital. Footwear shall be clean and appropriate to the occasion. Midriffs should not be exposed. No tennis shoes (sneakers), flip-flops or heavy boots shall be permitted. Hair shall be trimmed and groomed. A style should be chosen that avoids dangling of hair into the face or onto the body of a patient during physical examination or other patient care activities.

**Hospital-supplied scrub clothing shall be worn in the operating room only. No general surgery residents should wear scrubs while rounding on patient floors, in clinic, outside the hospital, or while entering or exiting hospital property.** The only exceptions to this rule are as follows: 1. Residents in between surgical cases may stay in scrubs (clean) and a clean white lab coat. 2. Residents on the Night Float service or other overnight shifts may stay in scrubs and a white lab coat (that is clean) throughout the shift. Scrubs should not be worn routinely by any other staff. Lab coats when worn, must be clean and free from obvious stains (fresh or old).

**ID Badges:** Each resident should have an identification badge, which includes his or her photograph. The photograph and card generally will be completed at the time of orientation for new residents. ID Badges should be worn at all times.

**FLORIDA LICENSE**

Registration of Unlicensed Physicians - In order to be a member of the College of Medicine Housestaff Program, all interns, residents and clinical fellows must be registered with the Department of Professional Regulations - Board of Medicine, either as a licensed physician or an unlicensed physician.

Unlicensed Physician - Registration Application for Unlicensed Physician form (requires Notary) is required upon acceptance to the program and must be resubmitted every two (2) years if a license is not secured. The $250 initial registration fee for Unlicensed Physicians is required and paid for by Shands Hospital.

Completion of one year of training (internship) is required to become eligible for a Florida medical license. To obtain an application for a Florida license, call the Board of Medicine directly at (850) 488-0595. The program does not reimburse residents who obtain an unrestricted Florida license.

**HOSPITAL COMMITTEES**

Residents are encouraged to participate in hospital committees as time permits. If any member of the housestaff wishes to be involved, they should contact the Housestaff Affairs Office.
LIBRARY

The University of Florida maintains a full service medical library located on the first floor of the Communicore Building. Residents should avail themselves of the resources contained in this library frequently. In addition, the Surgery Education Office and the Dragstedt Library on the sixth floor of the Medical Sciences Building has the major surgical texts and journals available. Electronic access to all library resources is available at http://library.health.ufl.edu/.

There is also a library on the 4th floor at the VA. A key may be obtained after hours in the Emergency Room at the VA. Additional resources are available on the VA intranet.

MEAL TICKETS

Shands Hospital provides free food in the form of GatorBites to all housestaff physicians (enrolled in accredited postgraduate medical education programs). GatorBites are for meals in the Shands at UF cafeteria and/or Mini Mall. Bulk food cannot be purchased from any food service provider including the loading dock, stores, cafeteria, or any other Shands food service provider.

MEDICAL RECORDS

The medical record is a critically important document. It is used for a variety of different purposes. Obviously it is the working document upon which patient care decisions are made and, thus, has a central role in providing quality care to our patients. As such, it is essential that the information in the record be accurate, timely and pertinent to the care of the patient. Direct patient harm can come from incomplete, poorly written or incorrect entries in the record. Since the residents are the primary individuals writing in the chart, your role in this key aspect of patient care is directly related to the outcome the patient experiences. The record is also a legal document and as the saying goes, anything you say will be used in court. Never write anything you don’t want read before a jury. The chart is no place to comment on your opinion of other Practitioners, the hospital or the patient’s social status unless it is pertinent to the care of the patient’s problem. The record is also used for reimbursement. Recently, this has become an issue of considerable financial and legal importance. The Federal government is scrutinizing records for evidence of faculty involvement in all of the training hospitals in this country. Our department has always had a policy of faculty involvement in all cases at all hospitals. We consider this good care and good training. Faculty involvement must now be documented in the chart and it is in the program’s best interest that the residents assist in this by noting faculty presence on rounds, in the OR, and in clinics. Documentation of this presence can take the form of a statement in the resident’s note to the effect that the patient was “seen with Dr. …..” or the case was “discussed with Dr. ….”. Faculty may also write notes and are encouraged to do so. Review of records is also an important part of periodic re-certification that all hospitals must undergo. Specific requirements are set by the Joint Commission for Accreditation of Hospitals and Organizations (JCAHO). These include date and time on all entries, legible signature with degree indicated and certain specific content in the H&P, discharge summary and operative note. The details of these requirements can be obtained from medical records at each hospital. Medical staff bylaws require that discharge summaries be dictated before the patient actually leaves the floor. Operative notes must be dictated immediately after the case is completed. All student entries and verbal orders must be countersigned within 24 hours.

The program director is periodically provided with a list of incomplete medical records and will suspend residents for excessive delinquency.

MEDICAL STUDENTS
It is very important to keep a professional relationship with the medical students. The student is on the service to learn the basic principles of surgery and it is part of the resident’s responsibility to teach the student about the care of the surgical patient. The students should be made to feel that they are a welcome part of the team. Ignoring the students, telling them not to ask questions, or abusing them in any way is not acceptable and will not be tolerated. Since the resident may participate in evaluating the student, social contact with the student outside of the hospital should be limited to group activities as long as the student is on the resident’s service (i.e. no dating). Each resident will be directed to learning objectives for medical students for each of the general surgery services. As teachers you are expected to know the learning objectives and facilitate learning whenever and wherever possible.

COMPUTERS & ACCESS TO ELECTRONIC INFORMATION

Shands Hospital has placed computers in the Housestaff Lounge on the sixth floor of Shands Hospital; additionally there are computers in every call room and at least one in every service workroom. These computers can access Epic and all related patient care applications. The Medical Center Library has an Informatics Lab available for residents and fellows in the College of Medicine.

OPERATIVE PERMITS

Every patient receiving treatment has the right to informed participation in decisions involving their health care. Diagnostic/therapeutic treatment will be undertaken only with the prior informed, voluntary consent of the patient or the patient’s representative. Informed consent implies a careful, thoughtful dialogue between the practitioner and the patient in the presence of witnesses. This conversation should include details about the proposed procedure, indications for the procedure, expected benefits, and the risks, complications and side effects that may be expected. The patient must be informed of any alternatives that may exist to the proposed treatment and the implications of not doing the procedure. The language must be at a level that the patient would reasonably be expected to comprehend and the patient must be given the opportunity to ask questions and indicate understanding of the procedure and risks. The patient has the right to refuse treatment without coercion or jeopardizing future treatment. The person obtaining consent should enter a progress note describing the conversation with the patient and indicating the patient’s understanding of the proposed procedure. Each hospital has specific memoranda describing the consent process and the residents should familiarize themselves with these when rotating to a new hospital.

PROFESSIONAL PRESCRIPTION WRITING PRACTICES

1. Residents may write a prescription only for patients with whom they have a documented patient-physician relationship. Writing prescriptions for co-residents, faculty, or staff is strictly prohibited.

2. Residents must never sign a prescription without personally completing all the information on the prescription pad.

3. Residents must not sign prescriptions written for off-service patients.

Prescription pads for each resident are kept in a locked file in the Surgery Education office and will be distributed to each resident as needed.

RESIDENT MAIL BOXES/EMAIL
Each resident is assigned a mailbox in the South Campus workroom (G-008). Residents should check their mail at least twice weekly as the program communicates with the residents via the mail. In addition the program director periodically sends articles and other items of interest to the residents through the campus mail. The residents will be responsible for information distributed in this manner. There is also a bulletin board in the department that has information of interest to the residents. Each resident will be assigned an email address and this will be the preferred method for communication between the program and resident. It is expected that each resident check email daily. The program director will assume that all email communication is received by the residents. The residents must be sure that the email address used by the housestaff office is accurate.

**RESIDENT MEETINGS**

Periodically the program director will call meetings of all of the housestaff in order to communicate important topics and to receive feedback from the housestaff about items of importance to the residents. The program director meets with Chief Residents before the semi-annual resident evaluation meetings of the faculty to hear their input on the progress of the junior residents. The comments of the Chief Residents are an important part of the evaluation process.

**RESIDENT TEACHING**

At all levels, residents are expected to teach those at more junior levels. One of the tenets of medicine as a profession has always been the transfer of knowledge for the improvement of all involved. Medicine as a profession has as one of its basic tenants, the transfer of knowledge for the improvement of all involved. Teaching is one of the factors used in the evaluation of residents and is of course, one of the factors used by residents to evaluate faculty. Physicians must learn to impart knowledge to be effective practitioners and all will acknowledge that teaching is one of the best ways to learn a subject. Teaching is not abuse but an honest effort to impart information, encourage a spirit of inquiry and foster an atmosphere where discovery is a valued attribute.

**RESOURCE MANAGEMENT**

As the nation changes the system of health care delivery, older styles of practice and attitudes must change. In an environment of limited resources, each practitioner must be aware of the financial implications of their style of practice and be accountable for the resources consumed. While it is easy for the resident to lose sight of the importance of cost effective practice, learning this from the start will enhance your future success in whatever practice arrangements you find yourself. It is essential for the survival of the hospital and department and materially affects the quality of your education. Faculty and housestaff must work together to practice in a manner that is best for the patient and best for the system. Excessive tests, unreasonable delays, inappropriate or poorly done procedures all work to the detriment of those that we serve and cannot be tolerated. You should approach this issue with a positive attitude and a willingness to contribute, as it is good medicine and should be a positive educational experience as well.

**SOCIAL EVENTS**

**End of The Year Party/Chief Dinner** - In honor of the graduating general surgery residents and is usually held mid-June. The Departmental Awards are given to the deserving residents and faculty. All residents, fellows and faculty members are invited as well as special guests.

**Incoming Resident Social** - In honor of all the new residents and fellows in the Department of Surgery. All new residents and fellows are invited as well as faculty members and general surgery residents and subspecialty residents. The Social is usually held the last Sunday of June, but this is flexible.
**Holiday Dinner** - Annual dinner for faculty and residents usually held the week before Christmas.

Other events and dinners are scheduled periodically throughout the year. All residents will be invited and notified via email, text page, or standard mail.

**SHANDS/UF HOUSESTAFF AFFAIRS OFFICE/EXERCISE FACILITY**

**Housestaff Affairs Office** - The Housestaff Affairs Office was developed to provide an ombudsman role for all housestaff physicians who are rotating through Shands Hospital at the University of Florida in Gainesville. Moving into a new city and a new part of the country in a new job can bring on many questions and concerns. This office was established to support the housestaff in a variety of these areas as well as provide support for residents within the hospital environment, overseeing such requirements as sleep room facilities, access to counseling services and facilitating problems that arise within the housestaff. The office is located on the 6th floor of Shands Hospital and the telephone number is 265-0787, email address is harter@ufl.edu.

**Housestaff Lounge** - A lounge was established by Shands Hospital and the University of Florida specifically for housestaff physicians. It is continuously stocked with sodas, juice, water, and light snacks. The location and the current door lock combination can be obtained from your chief resident or through the Housestaff Affairs Office personnel.

**Housestaff Exercise Room** - Shands Hospital and the University of Florida have developed an exercise room specifically for housestaff. The equipment in this area was chosen to support the mental and physical well-being of residents. Aerobic stair steppers, wind and friction resistant bicycles and a universal gym encompass an array of opportunities for housestaff to release energy and stress as well as develop a personal fitness program.

**Loan deferment** – The Surgery Education Office handles all loan deferments and forbearance forms.

**Loans** - The University of Florida Alumni has an interest free loan for unplanned emergency situations available to residents and fellows. The forms for this loan are available in the Housestaff Affairs Office.

**Housing** - The Housestaff Affairs Office provides resources for housing for incoming residents and fellows by making available a listing of homes, condos, etc. which the completing residents and fellows are selling.

**SURGERY EDUCATION OFFICE**

The Surgery Education Office provides support for all general surgery and preliminary surgery residents. Michele Silver is the Assistant Director of Education and is assisted by Joan Wysocki and Marisha De Jesus. These individuals deal with issues such as beepers, call schedules, vacations, pay issues, lab coats, loan deferments, applications for licensure, etc., and are in general the point of first contact in the day to day activities of the Surgery Education Office. The Surgery Education Office handles applications and coordinates interviews for fourth year medical students are applying for general surgery and preliminary surgery positions at the University of Florida. Resident evaluations can be reviewed in the Surgery Education Office located in room 6130 of Shands Hospital; telephone number is 352-265-0916; fax number is 352-265-3292. E-mail address is Michele.silver@surgery.ufl.edu or Joan.Wysocki@surgery.ufl.edu.