



2011 - 2012 MANUAL

**RESIDENT POLICIES &
PROCEDURES**

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Introduction

The Resident Manual/Policies and Procedures provide general information about policies, procedures, and services that Govern, the University of Illinois Metropolitan Group Hospitals Residency in General Surgery (UIC-MGH). However, four integrated and two affiliated Hospitals of this residency have a large number of specialized departments with their own policies and procedures pertaining to patient care and their own GME programs. While all our residents should be well versed with this manual, it does not cover all information and all circumstances. More detailed information on the individual hospitals policies and procedures is available thru the attached Links. GME offices and Human Resources Departments of each institution will also serve as a valuable repository for such comprehensive information.

Advocate Illinois Masonic Medical Center	http://www.advocatehealth.com/body.cfm?id=1106
Advocate Lutheran General Hospital	http://www.advocatehealth.com/body.cfm?id=1106
Mercy Hospital and Medical Center	http://www.mercy-chicago.org/mercyCMS/index.php?option=com_content&task=view&id=87&Itemid=175
Resurrection Saint Francis Hospital of Evanston	http://saintfrancishospital.reshealth.org/sub_sfh/default.cfm
James Stroger Hospital of Cook County	http://www.johnstrogerhospital.org/dom/index.html
University of Illinois Hospital	http://www.uic.edu/com/gme/rpmtoc.htm

PROGRAM ADMINISTRATION

- Executive Director of the UIC/MGH Residency in General Surgery
- The Surgical Joint Conference Committee
- Assistant Program Director
- Site Program Directors at the MGH Participating Hospitals
- Administrative Chief Resident
- Chief Residents
- Central Office of the UIC-MGH Residency Program (Administration)

Metropolitan Group Hospitals Residency in General Surgery was established over thirty years ago to provide Excellence in Surgical training in surgery at Chicago Hospitals, with strong ties to the University academic programs. The University of Illinois (UIC) College of Medicine at Chicago has been a nationally recognized leader for over 100 years in its threefold commitment to provide excellence in teaching, research, and patient care. More details about the program are available on the program's web site at www.uimghsurgery.org and individual hospital web sites.

The following Institutions participate in our program:

Advocate Illinois Masonic Medical Center	836 West Wellington Avenue, Chicago, Illinois 60657	773-296-7093
Advocate Lutheran General Hospital	1775 Dempster Street Park Ridge, Illinois 60068	847-723-5191
Mercy Hospital and Medical Center	2525 South Michigan Avenue Chicago, Illinois 60616	312-567-2074
Resurrection Healthcare – Saint Francis Hospital of Evanston	355 Ridge Avenue Evanston, Illinois 60202	847-316-6163
James Stroger Hospital of Cook County	1835 West Harrison Street Chicago, Illinois 60612	312-633-6000
University of Illinois Hospital	1740 West Taylor Street Chicago, Illinois 60612	312-996-6765

The following is a general guide to sources that can assist you with a variety of issues:

The Executive Director

He ensures that the training is consistent with the requirements developed by the Accreditation Council for Graduate Medical Education (ACGME) and/or other regulatory agencies for the specialty.

1. Chairs the Surgical Joint Conference Committee (SJCC) and implements the Committee's decisions and policies;
2. Defines and implements the goals and objectives of the entire program;
3. Selects, evaluates, and promotes residents;
4. Ensures that institutional and departmental policies for residents are followed;
5. **Administers and maintains an educational environment conducive to educating the residents in each of the six ACGME competency areas**
<http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf>
6. Oversees and ensures the quality of didactic and clinical education in all sites that participate in the program;
7. Approves a local director at each participating site who is accountable for resident education;
8. Approves the selection of program faculty as appropriate;
9. Provides each resident with documented semiannual evaluation of performance with feedback;
10. Ensures attendance of residents at 75% of all core conferences
11. Evaluates program faculty and approves the continued participation of program faculty based on evaluations;
12. Monitors resident supervision at all participating sites.

The resident should directly contact the Executive Director of the MGH Residency Program concerning:

- Overall evaluations
- Opportunities for research and other electives
- Approval and reimbursement of educational activities
- Serving on Institutional Committees
- Filing of disciplinary appeals
- Desired program transfer
- Resignation
- Matters that the resident may not be comfortable discussing with Chief Residents, Faculty or Program Directors at specific training sites

The Surgical Joint Conference Committee (SJCC)

The Surgical Joint Conference Committee is the governing body of this four-hospital integrated program and is chaired by the Executive Program Director. This committee meets eight to ten times a year and makes all important decisions as requested by the Executive Program Director. Its members consist of Site Program Directors, Chairmen of the integrated hospitals, as well as one to three independent teaching attendings from each. Representatives from the University of Illinois including Chair of the Department of Surgery are also standing members. The SJCC has five standing sub-committees whose functions are congruent with their titles.

1. Education, Evaluation and Selection Committee
2. Bylaws, Rules and Regulations Committee
3. Research and Scholarly Activities Committee
4. Ways and Means Committee
5. Resident Committee

From time to time, each committee is asked to accept additional responsibilities.

The SJCC discusses all issues which relate to the residency program and its function. Most issues are resolved by consensus. Occasionally, a vote may be required to reach an equitable conclusion. If so, one vote per hospital will apply to all such deliberations. The Executive Director will have final deciding vote if necessary.

Assistant/Associate Program Director

Is responsible for scheduling all rotations and vacations and has authority to change rotations to complete ACGME requirements. For any issues regarding above, contact Assistant Program Director through the Central Office. She/he operates under full direction and authority of the program director.

Site Program Directors at Integrated Hospitals

- Responsible for the implementation of SJCC policies and its decisions at their hospitals;
- Ensures that the training program is consistent with the requirements, policies and procedures developed by specific hospitals, its Graduate Medical Education Department and other institutional offices;
- Provides an appropriate educational environment that encourages the resident to develop competency in patient care using all 6 ACGME core competencies;
- Responsible for day to day changes in Service assignments, responsibilities, problems, and complaints;
- Monitors absences, vacations, meetings, illness, etc;
- Provides evaluations after each rotation at the specific hospital;
- Provides midterm feedback on request (encouraged) and exit interviews (compulsory) in writing;

- Provides opportunities for research;
- Responsible for timely transmission of all evaluations, exit interviews, attendance, monthly exams and Mock orals results to the central office;
- Ensures that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

The resident should contact the Site Program Director at each hospital concerning:

- Rotation Evaluations
- Opportunities for research
- Any problems arising at the local institution
- Feedback during midterm and at the end of rotations
- Completion of OSATS/OSCA assigned to the rotation for evaluating competence (Site PD may designate another core faculty member to evaluate this competency)

Chief Administrative Resident

The administrative chief resident will serve as a liaison between residents and the SJCC. He/she is a voting member of the SJCC. In general, the administrative chief resident is responsible for addressing the administrative duties of the residency program operation under the supervision of the Executive Director. The job description will include:

- Representing the surgical residents at SJCC meetings;
- Participation in various Ad Hoc subcommittees as requested;
- Designation of one chief resident in each of the four hospitals to serve as local administrative chief for that institution/rotation;
- Monitoring attendance at all mandatory conferences. The local chief resident will maintain attendance sheets for these meetings;
- Create an environment of nurturing and mentoring education in a step ladder fashion, maintaining the highest degree of professionalism;
- Organizing a schedule of Journal Clubs for the entire year with appropriate designated residents and sponsorship;
- To strictly enforce the duty hour guidelines as described in the ACGME Duty Hour requirement;
- To monitor fatigue and sleep deprivation of residents along with help of other chief residents;
- Addressing conflicts between residents;
- Active involvement in the recruitment of new residents at Interview Marathons;
- Chair the Resident Committee with representation from each level to discuss any issues facing the residents as whole or in part and bring input directly to Executive Program Director;
- Additional responsibilities as assigned by Executive Program Director.

The chief administrative resident will be voted in by the resident staff yearly. A simple majority vote is necessary for appointment. The candidate for this position must be in good standing. To be eligible, the candidate must have:

- ABSITE score – 50 percentile or higher
- Excellent Work ethic and overall academic performance
- Role model in the program
- Acceptable to the SJCC

Chief Residents

Senior residents at the level of PGY V or above are usually designated as Chief Residents. The assigned responsibilities of the Chief Resident vary from hospital to hospital, from rotation to rotation, but generally include: scheduling assignments, conducting regular meetings for the residents in the program and serving as Ombudsman between the residents and the Executive Program Director. The Chief Resident(s) should be contacted directly concerning:

- Advice regarding resident life at the MGH Residency Program
- Organization and management of weekly surgical Morbidity and Mortality conferences. This will include case and literature review.
- Scheduling of rotations
- Specific institution policies
- Feedback on any residency problems thru normal chain of command. However direct link to executive Program Director is always open.
- Assignment of residents daily duties including: OR assignments, patient care, and teaching responsibilities

Administrative Central Office of the UIC-MGH Residency Program

It is the primary contact for licensing, visas, payroll, and loan deferrals. The Office also:

- Provides support to the Executive Program Director in recruitment of residency candidates, curriculum development, program evaluation, and resident evaluation.
- Maintains individual resident records related to the Resident Agreement, licensure, and other certification
- Distributes paychecks
- Arranges Long-Term Disability Program
- Originates J-1 visa sponsorship applications
- Completes loan deferment and employment verification letters
- Arranges all social events, graduation proceedings, welcoming luncheon, and the annual reception at the American College of Surgeons meeting.
- Maintains MGH website
- Coordinates resident training among all four affiliated institutions

The Resident should contact the Administrative UIC-MGH Central Office directly concerning:

- Resident Agreements
- Licensure, Federal Drug Enforcement Administration registration, Illinois Controlled Substances registration
- Visa and immigration issues
- Payroll problems
- Residency verifications
- Loan deferments
- Certificates of training
- Tuition waivers
- Graduation and awards
- Identification badges
- Liability insurance verification letters

RESIDENTS CONTRACTS, BENEFITS AND OTHER HOUSEKEEPING DETAILS

Definition of Term: Post Graduate Level (PG)

The PG level designates the training year with a specific residency program in which a resident is enrolled. The UIC-MGH office maintains a record of the total years of graduate medical education for each resident, regardless of the program(s) in which they have been enrolled.

The Resident Agreement

This agreement is the written contract between the UIC-MGH Residency Program and the resident. No resident may work without a valid in-force agreement. The original contract form should be kept in a safe place. The following parties must sign the agreement for it to be valid:

1. The Executive Director of the MGH Residency Program
2. The Resident Candidate
3. Director of Medical Education

Salary	PGY I - \$46,027.00 PGY II - \$48,300.00 PGY III- \$50,572.00 PGY IV- \$52,277.00 PGY V - \$53,981.00 PGY VI - \$56,254.00
Medical Insurance	Per contract
Dental Insurance	Per contract
Life Insurance	Per contract
Disability Insurance	Per contract
Worker's Compensation	Per contract
Uniforms	Three Uniforms per Resident
On-Call Meals	Provided at each MGH Hospital Reimbursement policies vary with each Hospital
Housing	Available at Advocate Illinois Masonic Medical Center
Employee Assistance Counseling	Available at all MGH Hospitals

Non-Discrimination Statement

The policy of the University of Illinois MGH Residency in General Surgery is to fully comply with applicable federal and state nondiscrimination and equal opportunity laws, orders, and regulations. The University of Illinois MGH Residency in General Surgery does not discriminate in programs and activities, against any person because of race, color, religion, sex, national origin, ancestry, age, marital status, handicap, unfavorable discharge from the military, or status as disabled veteran.

The following additional rules apply to resident agreements:

- Resident Agreements are only issued by the Administrative Office of UIC-MGH Residency.
- First-year postgraduate Resident Agreements are issued according to the National Resident Matching Program policy.
- Resident Agreements are written for a specific period of time, which is noted on the Agreements.
- The UIC-MGH may withdraw a Resident Agreement if the applicant does not return a signed Agreement by the designated date.
- Signing a Resident Agreement does not guarantee issuance of a Resident Agreement for the next training period noted on the agreement.
- Requests for Resident Agreements that extend beyond completion of the required time in a particular specialty must be individually approved by the Executive Program Director and are subject to availability of training positions.

Licenses

Every resident must possess a valid medical license in order to participate in any clinical program. While the UIC-MGH Central Office will send reminders of approaching expiration dates and other significant license information, each resident is personally responsible for maintaining a valid license, following the State of Illinois Medical Practice Act, and paying all required fees. The UIC-MGH Office can provide information and applications for temporary and permanent licenses, Illinois Controlled Substance Certificate, DEA Number, and USMLE exams.

Temporary Licenses

A resident who has less than two years of ACGME-approved postgraduate training is eligible only for an Illinois temporary license. This license is the property of the MGH Residency Program and is valid only for the practice of medicine within the scope of the resident's training program.

Temporary licenses are institution and program specific. Residents must apply through the UIC-MGH Central Office for transfer between institutions and programs. If a resident leaves a program for any reason, the State of Illinois Department of Professional Regulation requires the institution to return the resident's license to the State of Illinois.

Temporary licenses are issued for a three-year period, or for the anticipated duration of the Resident's program, whichever is shorter. A resident may request an extension of the expiration date of a temporary license by completing a license extension application and submitting it through the UIC-MGH Central Office. **While the UIC-MGH Central Office will assist residents with maintaining a current license to practice in Illinois, residents are ultimately responsible for maintaining their current license to practice.**

Permanent Licenses

All residents of UIC-MGH program must Pass USMLE Step III examination to be eligible to progress to the 3rd year. A resident who has 24 months or more of ACGME-accredited training and has taken all three parts of the USMLE examination is eligible for an Illinois Permanent License. Residents may apply directly to the State of Illinois for their permanent licenses, or may submit their applications through the UIC-MGH Central Office. In either case, the Residency Coordinator can provide forms and assist with completing the application. Residents who receive their permanent licenses must provide copies to the UIC-MGH Central Office.

Controlled Substance Certificates

Residents with temporary licenses must use the institution's DEA number when prescribing drug. A permanent license is needed to obtain an Illinois Controlled Substance Certification and DEA Certification.

The UIC-MGH Central Office can supply forms for certifications.

Professional Liability Coverage

Each hospital participating in the UIC-MGH Residency Program maintains professional liability insurance coverage for any exposure to liability arising from performance within the scope of the residency program. This coverage does not protect the resident when engaged in professional activities outside the training program. This insurance cannot be converted to individual coverage for a departing resident. In all cases, affiliation agreements between the Executive Program Director and affiliated hospitals specify that the affiliated hospital provide professional liability coverage for the resident for the time he/she is training at the institution.

Any resident who is served a subpoena or requested to make a deposition concerning any legal action pertaining to their training program should immediately contact the UIC-MGH Central Office which will assist the resident in contacting legal counsel.

Records and Employment Verifications

The UIC-MGH Central Office maintains a permanent file for each resident who participates in the program. The file contains application materials, evaluation forms, correspondence, and payroll documents.

The UIC-MGH Central Office will verify residency training to institutions who request information for purposes of confirming credentials. Verification letters will be restricted to dates of attendance, name of program completed, and notation that the resident's performance was "satisfactory." The Central Office will forward all requests for additional information on performance or conduct to the Executive Program Director. The UIC-MGH Central Office will not provide any information on any resident to any outside party without that resident's written release, except where mandated by law.

Terminal Clearance

Each resident must submit a completed UIC-MGH Clearance Form to the Central Office at the time he/she finishes or terminates from the program. The form requires signatures from a number of program offices. In addition, the resident must provide confirmation from the Advocate Illinois Masonic Medical Center, Advocate Lutheran General Hospital, Saint Francis Hospital of Evanston, Mercy Hospital and Medical Center, John Stroger Hospital (Cook County), and the University of Illinois Hospital that he/she has met all obligations, if the resident rotated or took call there. The UIC-MGH Central Office will not release a training certificate or verify a residency until the resident returns the completed Clearance Form. Clearance Forms may be obtained from the UIC-MGH Central Office.

Certificates of Training

The UIC-MGH Central Office issues a certificate of completion to each resident who satisfactorily completes a full year of training in the MGH Residency Program. Any resident who does not complete a full year in the MGH Residency Program may request that a letter be sent from the UIC-MGH Central Office detailing the resident's rotations.

Elective Rotations Outside of the MGH Residency Program

Requests for elective rotations can be considered only as a rare exception, on an individual basis. Requests should be submitted at least one year in advance of the starting date.

Student Loan Deferments

The UIC-MGH Central Office certifies loan deferments within the scope of the loan program. Please bring forms to the Central Office for signatures and/or seals. Allow ten working days for completion of the deferment, especially at the beginning of the fiscal year (July 1).

Proof of Citizenship and Visas

All residents are required to provide proof of U.S. citizenship or of legal alien status at the time of hire. While the UIC-MGH Central Office will assist residents with visa applications and problems, residents are ultimately responsible for maintaining their legal status.

J-1 Visas

The UIC-MGH Central Office assists foreign residents with application and renewal of J-1 visas. Application forms and other materials are available in the Central Office. Residents sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG) must renew their visas yearly. All fees are the responsibility of the resident.

H1-B Visas

At the present time, the UIC- MGH Residency Program does not support H1-B visa applications for foreign medical graduates.

Identification Badges

All residents, regardless of their rotations, must display their identification badge when on duty, which is issued at orientation. The badge enables patients and staff to identify the individual's name, department and job title. Badges are considered hospital property and are returned to your Residency Coordinator at the conclusion of your appointment. You should contact the local site coordinator at each hospital before starting a new rotation.

Lab Coats and Scrubs

Residents are initially issued three lab coats with the UIC-MGH Surgery Residency emblem, with replacement at the PGY III level. Residents are responsible for lost coats. The Chief Residents get a special coat, embroidered with their name during The Coat ceremony at the initiation to the 5th year.

Parking

Residents who wish to park at the hospital parking garage should obtain a parking pass from the Public Safety Department. Payments must be processed for the duration of the rotation. Residents who are rotating to other hospitals should make parking arrangements directly with those institutions.

Moonlighting

No moonlighting is allowed for residents in the clinical years at UIC-MGH Surgery Program

Grievance Policy

The UIC-MGH Residency Program in Surgery adheres to the general house staff Grievance Policy that is delineated in the Graduate Medical Education Policies and Procedures.

Graduation and Awards

Each year at the annual Surgical Residents Graduation Day, awards are presented to the residents and faculty for outstanding service. These include the following:

- Executive Program Director's Award for excellence in administration, leadership and teaching
- Outstanding Resident Award: Presented to the best graduating resident, as elected by all teaching faculty members
- Rudolph Mrazek, M.D. Award for the Highest Junior ABSITE score: Presented to junior resident for the highest ABSITE score.
- William A. Tito, M.D. Award for the Highest Senior ABSITE score: Presented to senior resident for the highest ABSITE score.
- The Society of Laparoendoscopic Surgery Resident Achievement Award: Presented to senior resident for his involvement in developing minimally invasive surgery skills.
- Robert L. Schmitz, M.D. Award for Outstanding Faculty Teacher of the Year
- Best Intern of the Year Award
- Lloyd M. Nyhus "Award Of Academic Excellence" For the Faculty
- Lloyd M. Nyhus "Award Of Academic Excellence" For the graduating Resident

VACATIONS, SICK DAYS, LEAVE OF ABSENCE AND CONFERENCE TIME

Each MGH Hospital must notify the Central Office whenever a surgical resident is off for:

- Vacation
- Sick Leave
- Conference
- Examination Time Off
- Leaving the program earlier than June 27th/28th of the Academic calendar of resident's graduating or completion year in the program*

*Note – Leaving earlier than specified by contract is a breach of that agreement. There may arise a case where an adjustment is necessary. This request will begin with the chief administrative resident and Site Program Director at the affected institution. The Executive Program Director will have the final judgment.

Vacation

UIC-MGH Surgical Residents are allowed four weeks (28 days) vacation time each year. There are no extra days for personal reasons or for working holidays. Vacations cannot be carried over into the next year. It is a mandatory requirement that residents be present during the ABSITE In-service Training Examination which is given on the last Saturday in January each year regardless of scheduled vacation.

To treat residents, patients and hospitals fairly, it is necessary to assign vacation time. Senior residents and Site Program Directors can then plan ahead for coverage and ensure that covering residents have equal burdens. Vacation periods are coupled to certain hospital rotations, and residents rotating through those services are expected to use that time.

At the PGY I level, it is asked that the resident take one month of vacation at one time. At the PGY II, PGY III, IV and V levels, it is asked:

- that it be arranged with their respective hospital Site Program Director and or Chairman
- that it be granted by seniority preference
- that it be taken one week at a time
- that residents take only one vacation per rotation

In general, only one resident should be gone from each hospital at a given time. Requests for changes in vacation are to be approved by the respective hospitals' Site Program Director, Chairman, and Chief Resident (of the service at the time) and the Program Director. The Administrative Chief Resident will adjudicate conflicts.

Residents who choose to interview for jobs or fellowships must do so during their allotted vacation time. It is the residents responsibility to budget their vacation time so that they have an appropriate number of days available for interviews. Like vacation time, leave for interviews must be approved in advance with a leave request form. The Site Director of the affected institution should be provided a schedule of interview days prior to the beginning of that rotation. Leave for interviews will not be granted if vacation time has been used up. Resident will forfeit pay for the duration of the unexcused absence and a disciplinary note will be placed in the file.

Sick Days

When a resident is off ill, the Program Director or the Central Office must be notified with an appropriate contact telephone number. Unexcused absences from clinical duties will result in immediate probation and possible suspension. Additionally, the resident will forfeit pay for the duration of the unexcused absence and a disciplinary note will be placed in the file.

Conference Time Reimbursement

Senior residents (4th and 5th Year) will be allowed one week only paid conference time each year which will be reimbursed to the total of a onetime amount of \$2,000. It is requested that the MGH Central Office be notified one month in advance and all expense receipts be forwarded to that office for reimbursement.

Time Off for Examination

One time off will be allowed for the purpose of taking the USMLE Part III examination. Any others are at the resident's expense and will be charged against vacation time or time off without pay.

Maternity and Paternity Leave

Residents with at least 12 months of UIC-MGH Program employment may take up to 12 consecutive weeks of unpaid family leave per contract year for personal or family illness, or for the birth or adoption of a child. Although time taken is unpaid, this leave may be taken as a combination of vacation and sick time. Eligibility for leave begins with the day of delivery or adoption. A resident who wishes to begin his or her leave prior to delivery or extend the leave beyond six weeks after delivery must receive advanced approval from the Executive Program Director.

The Program may request doctor certification to support the claim of a serious health condition.

Residents who wish to take a maternity/paternity leave must submit a written request for the leave, including tentative dates on which the leave will begin and end, to the Central Office. This confirmation should be signed by the Executive Program Director if additional paid or unpaid days are part of the planned leave. The resident

must contact the Central UIC-MGH Office at least two weeks prior to return to work. Time off for maternity/paternity leave or any other approved reason will need to be made up to complete all requirements of the educational program as required by the American Board of Surgery and other regulatory bodies as applicable at the sole discretion of the program director.

Bereavement leave

Leave is granted for death of a family member or significant other up to three days per contract year.

DUTY HOUR GUIDELINES

- 1) Duty hours must be limited to 80 hours per week averaged over a four week period, inclusive of all in-house call activities.
- 2) Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- 3) Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- 4) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Residents should use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. If needed, please call your Senior resident on call.
- 5) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional 4 hours.
- 6) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- 7) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must appropriately hand over the care of all other patients to the team responsible for their continuing care, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director by e-mail.
- 8) The Program Director will keep record of each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
- 9) Minimum time off between scheduled duty periods for PGY-1 residents should be 10 hours and they must have eight hours free of duty between scheduled duty periods.
- 10) PG2 and PG3 residents should have 10 hours free of duty and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- 11) Residents at PG4 and beyond must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80 hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have 8 hours free of duty between scheduled duty periods,

there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. The Surgical Residency Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. Such circumstances include:

- A) Continuity of care for patients, such as for:
 - i. A patient on whom a resident operated/intervened that day who needs to return to the Operating Room (OR);
 - ii. A patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;
 - iii. A patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;
 - iv. A patient on whom a resident operated/intervened during that hospital admission and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient's family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for a critically-ill patient on whom the resident operated.
 - B) A declared emergency or disaster for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.
- 12) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the Program Director.
 - 13) Night float: Residents must not be scheduled for more than six consecutive nights of night float. Night float rotations must not exceed two months in duration, and there can be no more than three months of night float per year. There must be at least two months between each night float rotation.
 - 14) PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).
 - 15) Home call: Time spent in the hospital by residents on at-home call must count towards the 80 hour maximum weekly hour limit. The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80 hour weekly maximum, will not initiate a new "off-duty period".

Duty Hour Monitoring

UIC/MGH program strictly follows above guidelines and has a 5-way monitoring process:

1. Every quarter all residents meet with the Program Director where, in addition to other agenda items, an anonymous Duty Hour monitor survey is performed along with an open forum for residents to discuss issues regarding Duty Hours. All Duty Hour surveys and comments are collected and analyzed by secretarial staff and reviewed by the SJCC. Information about remedial action, if any is taken, and the results of their surveys are passed back to residents.
2. The Administrative Chief Resident carries on a similar survey of duty hours in between these three quarterly meetings and reports directly to the SJCC for corrective action, if any is needed.
3. Dr. Geri Fox from the UIC GME office comes yearly and meets with all residents in a closed meeting where an open dialogue follows, which is then reported on directly at the UIC GME meeting where the PD is present. Corrective action will be taken, if any is imposed by the UIC GME.
4. GME committees of each institution carry out their own Duty Hour surveys which are reported back to the program director. Since we have residents from other specialties rotating in surgery, we are critiqued by rotating residents as well, if there is a perception of duty hour non-compliance.
5. All residents directly fill out ACGME surveys of which Duty Hours compliance is an important part. Results are conveyed directly to the program and openly discussed by a senior resident at the Day-long Annual Retreat.

Sleep Deprivation, Fatigue and Effects on Performance

The Science and Its Implications for Resident Duty Hours are discussed with all residents at orientation. Dr. David Dinges' work along with treatment strategies are discussed at the Annual Retreat with all residents and Faculty as it pertains to our program. Dr. Geri Fox from UIC discusses this with all residents as well. In addition, at least once a year, all residents and faculty are e-mailed current literature on the topic.

Other articles on the subject:

Caldwell, JA, Caldwell, JL, Schmidt, RM. "Alertness Management Strategies for Operational Contexts." *Sleep Medicine Reviews*, 2008, 12, 257-273.

<http://www.mdconsult.com/das/article/body/239275031-2/jorg=journal&source=&sp=20881652&sid=0/N/653732/s1087079208000063.pdf?issn=1087-0792>

Rosekind, MR, Smith, RM, Miller, DL, Co, EL, Gregory, KB, Webbon, LL, Gander, PH, Lebacqz, JV.

"Alertness Management: Strategic Naps in Operational Settings." *J Sleep Res*, 1995, 4, Suppl. 2, 62-66.
http://humansystems.arc.nasa.gov/zteam/PDF_pubs/strat_naps.pdf

EDUCATION

Goals and Objectives

It is the ultimate Goal of this training program to develop surgeons who are clinically competent in general surgery and meet or exceed all six core competencies as described by ACGME. Physicians completing this program will be eligible for certification by the American Board of Surgery with an ultimate goal of a 100% pass rate on the qualifying and certifying examinations in the first attempt.

To achieve this goal, the program has the following objectives:

1. To provide an educational environment in surgery so that postgraduate trainees receive and utilize adequate knowledge and experience to function as competent surgeons in the field of general surgery, and able to practice independently following the conclusion of five years of progressive education and training.
2. To provide the trainee the opportunity to learn and understand the fundamentals of basic science as applied to clinical surgery.
3. To instill in the trainee a strong sense of honesty, integrity, and compassion in patient care.
4. To instill in the trainee the lifelong discipline to continually learn new developments and changes in patient care so as to better serve patients.
5. To instill in the trainee a sense of responsibility and scholarship in order to disseminate new knowledge and teach other health professionals and colleagues.

This program is composed of educational conferences and clinical training activities which are essential to the goals and objectives of the program. These essential functions of the program provide the broad background required to establish the basic competency to practice general surgery. This residency program is established so that the residents receive a progressive education with increasing responsibilities in the broad field of general surgery over a period of five years.

This program is designed in such a fashion that the trainee receives education for evaluation of the patient, appropriate work-up to establish a diagnosis, management of patients and any complications of the disease or treatment in the broad field of general surgery; included but not limited to, diseases of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and endocrine system, endoscopy, the comprehensive management of trauma and emergency operations, and surgical critical care. The trainee will also receive education and clinical training in the surgical subspecialties to establish and understand basic principles of pre-, intra-, and post-operative management of patients in cardiothoracic surgery, plastic surgery, pediatric surgery, and transplant surgery, common problems in urology, gynecology, neurosurgery, orthopedics, burns, and anesthesiology. Preliminary residents follow the same guidelines and objectives for rotations as the categorical residents with the exception of a burn rotation and anesthesia.

Rotation specific goals and objectives are posted on our internet site, are made available to each resident and Faculty and must be reviewed by each resident at the beginning of a rotation and followed. All Goals and Objectives are reviewed yearly by all residents and faculty at annual retreat and updated as necessary.

CLINICAL TRAINING

The clinical portion of the education is implemented so that the resident gets a progressive exposure and responsibility in the examination, establishment of diagnosis, operative management of patients, and management of expected complications. The educational conferences lay the foundation block on which the resident will build the knowledge of patient management. The clinical training is a progressive, concentrated, experiential training carefully designed so that a resident, at the completion of residency training, becomes a safe, knowledgeable, and compassionate surgeon. All services have teaching rounds which include attending staff, residents, and medical students. These rounds are, in addition to the routine daily patient management

rounds, conducted by residents and staff. The emphasis of these educational rounds is in-depth bedside education in the pathophysiology of the disease and perioperative patient management.

During the PGY I year, clinical competence will be assessed on a monthly basis by supervisory faculty and supervising residents (PGY IV and PGY V) based on direct observation at bedside, in the operating room, and on work and teaching rounds. PGY II, Intermediate (PGY III) and senior (PGY IV and PGY V) residents are assessed in a similar manner but generally on a two-month basis. This information is recorded on evaluation forms and maintained in the resident file.

Six Core Competencies of UI/MGH program

It is expected that, during the training program, residents will become competent in the following six areas at the level expected of an independent surgical practitioner: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Listed below are specific knowledge, skills, and attitudes required, as defined by the Accreditation Council for Graduate Medical Education (ACGME).

1. *Patient Care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Surgical residents must demonstrate manual dexterity appropriate for their training level and be able to develop and execute patient care plans.
2. *Medical Knowledge* of established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Surgical residents are expected to critically evaluate and demonstrate knowledge of pertinent scientific information.

SCORE Initiative

Starting academic year 2010-2011 the UI/MGH program follows curriculum guidelines on Patient Care and Medical Knowledge established by **Surgical Council On Resident Education (SCORE)**. This curriculum was developed to standardize the national curriculum for general surgery. Each resident of our program has direct subscribed access to this site (www.surgicalcore.org). Once on the site, each resident can quickly access, not only the requirements, but also a wealth of educational material including a vast library of teaching CT scans, videos of surgical procedures, as well as surgical textbooks and related up-to-date literature.

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 critique personal practice outcomes and demonstrate 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 communicate effectively with other health care professionals, counsel and educate patients and families, and effectively document practice activities. Effective hand-offs of all pertinent information at the time of duty/shift change is essential to master for the surgical resident.
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 maintain high standards of ethical behavior, demonstrate a commitment to continuity of patient care, and 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 practice high quality, cost-effective patient care; demonstrate knowledge of risk-benefit analysis; and demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

The following specifies the competency, the associated skills required, and the corresponding evaluation methods utilized by the UIC/Metropolitan Group Hospitals Residency in General Surgery program. One or more of these may be used for each competency. (Detailed list under Evaluations)

Patient Care

- Caring and respectful behavior: Checklist, patient surveys and resident evaluations by patients
- Interviewing: Checklist, OSCE, morning round presentation and evaluations
- Informed decision-making: Checklist, OSCE, written/oral examination
- Develop and carry out patient management plans: Record review, checklist, global rating, simulations/models; written/oral examinations
- Perform routine history and physical examination: Checklist, OSCE
- Perform procedures appropriate for level: Checklist, global rating, simulations/models, skills lab, case log
- Preventive health services: Record review, OSCE, case log
- Work within a team: Checklist, global rating

Medical Knowledge

- Investigatory and analytic thinking: Simulation/models, oral examination
- Knowledge and application of basic sciences: Simulation/models, MCQ examination, oral examination, Socratic Questioning on daily morning rounds.
- Scholarship in publications, administration and presentations.
- Absite, Pre-Absite, and monthly basic science exams

Practice-Based Learning and Improvement

- Analyze own practice for needed improvements: OSCE, simulation/models, patient survey
- Use of evidence from scientific studies: OSCE, MCQ examination, oral examination
- Application of research/statistical methods: Checklist, global rating, MCQ examination
- Daily learning portfolio measuring discipline and cognition
- Use of information technology: OSCE, case log, skills lab
- Facilitate learning of others: Checklist, global rating, medical student feedback evaluation

Interpersonal Communication Skills

- Works well with health care team and patients: Checklist, global rating
- Listening, verbal, and writing skills: Checklist, presentations, patient survey, record review
- Counsel and educate patients and families: Checklist, OSCE, patient survey
- Effectively documents practice activities: record review, case log

Professionalism

- Respectful, altruistic: Checklist, OSCE, patient survey
- Ethically sound practice: Simulations/models, patient survey, presentations
- Sensitive to cultural, age, gender, disability issues: Checklist, OSCE, oral examination, patient survey

Systems-Based Practice

- Understand interaction of their practices with the larger system: core modules
- Knowledge of practice and delivery systems: OSCE, Core modules
- Practice cost-effective care: Record review, checklist
- Advocate for patients within the health care system: Checklist, OSCE, patient survey

*Legend: Checklist (performance noted checklist during OSCE); OSCE (Objective Structured Clinical Examination); global rating (post-rotation evaluations); case log (operative record); MCQ (multiple choice question).

First Year Residents

The residents in the first year will do rotations in general surgery and its primary and secondary components. They are expected to be able to take a detailed history, perform complete physical examinations, formulate a preliminary plan for diagnostic evaluation, interpret significance of pertinent history, physical findings, laboratory and diagnostic studies, and know appropriate therapeutic options and priorities of management of the patient. First year residents always work under the supervision of a senior resident or attending staff. At this level, residents do not perform any invasive procedures without direct supervision; exceptions which they should be expected to perform satisfactorily independently include starting peripheral intravenous lines, insertion of nasogastric tubes, insertion of Foley catheters, and management of wound dressing and drains. All other procedures, including placement of central venous lines, are performed under supervision. Residents also learn about the evaluation of critically ill patients in the intensive care unit and emergency room.

First year residents learn basic principles and techniques of surgery and perform biopsies of skin, soft tissue, and other masses under close and direct supervision. They assist senior residents and attending staff in major surgical procedures. The clinical training emphasis is on evaluation of patients, understanding the rationale for different diagnostic tests, interpretation of results of diagnostic tests, and learning basic surgical principles and techniques.

First Year Educational Objectives

1. Demonstrate proficiency in performance of a detailed history and physical examination under both routine and emergent circumstances.
2. Demonstrate proficiency in formulating and implementing plan for diagnostic evaluation.
3. Demonstrate basic proficiency in interpreting significance of history, physical findings, and laboratory and diagnostic studies.
4. Demonstrate a working knowledge of common surgical problems.
5. Demonstrate basic proficiency in knowledge of therapeutic options and priorities of management.
6. Acquire basic operative skills necessary to perform less complex procedures (i.e. biopsy of superficial lesions, insertion of central lines, skin suturing).
7. Acquire basic operative skills necessary to assist more senior surgeons in major surgical procedures.

Second Year Residents

At this level, the residents are expected to evaluate and formulate a plan for management of more complicated patients. Residents at this level achieve more surgical exposure and perform procedures (under direct supervision of attending surgeons or senior residents), such as repair of primary and recurrent hernia, exploratory laparotomy, open and laparoscopic cholecystectomy, and basic vascular surgery. They are also exposed to fulltime intensive care of critically ill patients. Residents learn techniques in diagnostic and interventional surgical endoscopy. The residents at this level are expected to satisfactorily perform placement of arterial lines, central venous lines, and Swan-Ganz catheters, as well as major debridement, skin grafts, and management of less complicated trauma and general surgical patients.

Second Year Resident Educational Objectives

1. Demonstrate proficiency in the interpretation of significance of history, physical findings, and laboratory and diagnostic studies of common and more complex surgical problems.
2. Demonstrate proficiency in knowledge of therapeutic options and priorities of management of patients with common and complex surgical problems.
3. Demonstrate knowledge base and skills necessary to manage critically ill and/or injured surgical patients.
4. Demonstrate increased operative skills necessary to perform more complex surgical procedures (i.e., hernia repair, complex soft-tissue surgery, basic laparotomy/laparoscopy procedures, and vascular access).
5. All residents of UIC-MGH program must Pass USMLE Step III examination to be eligible to progress to 3rd year.

Third Year Residents

At this level, residents receive a more intense clinical training in different components of surgery. The emphasis at this level is to be able to manage patients more independently and to refine surgical skills to the extent that the resident is able to perform technically sophisticated procedures under direct supervision of attending surgeons. Residents at the third year level rotate through vascular surgery, trauma/critical care and general surgery. They are the senior-most residents on all but the general surgery rotations. This schedule allows residents to have excellent exposure to clinical material on those services. The residents are expected to present on patients from their service at Morbidity/Mortality conferences.

Third Year Resident Educational Objectives

1. Continue to develop technical skills necessary for the performance of more complex surgical procedures in general and minimally-invasive surgery (i.e., laparoscopic cholecystectomy, small bowel resection, surgical ultrasound).
2. Establish the knowledge base, judgment, and interpersonal skills necessary to function as a surgical consultant (successfully manages simple consults with minimal help).
3. Develop organizational and teaching skills necessary for basic management of a surgical service (manages service administrative duties assigned by chief resident or faculty).

4. Demonstrate knowledge and skills necessary to function as the trauma team leader for both adult and pediatric patients.
5. Demonstrate proficiency in the rational use of surgical literature and evidence-based medicine (defends discussions and recommendations with scientific evidence).

Fourth Year Residents

During the last two years of the residency, residents are considered senior residents. The residents are the senior-most trainee on their service. They are expected to manage patients more independently and to perform procedures more independently with guidance and advice of attending staff. During on-call at night and on weekends, the senior residents are the highest-level residents and evaluate and manage patients independently with communication and supervision as determined by the attendings. In addition to general, pediatric, vascular and thoracic surgery training, they will learn techniques in diagnostic and interventional surgical endoscopy and transplantation.

Fourth Year Resident Educational Objectives

1. Demonstrate knowledge and skills necessary for the complete management of common problems in general surgery, pediatric surgery, and vascular surgery.
2. Demonstrate proficiency in surgical endoscopy.
3. Demonstrate satisfactory performance as a teacher of junior residents and medical students.
4. Demonstrate basic science and immunology along with basic knowledge of and technical skills in transplantation.

Fifth Year Residents

This is considered the final clinical year, and residents are designated as chief residents. The chief residents work more independently and rotate through four Hospitals (general surgery, trauma and general/colorectal rotations, each of two months duration). The residents at this level are expected to show maturity in patient management, clinical decisions, and surgical procedures, and leadership in clinical skills.

Fifth Year Resident Educational Objectives

1. Demonstrate knowledge and skills necessary to assume complete responsibility for the management of the surgical patient, including mastery of the fundamental components of surgery as defined by the American Board of Surgery.

Specific goals, objectives and competencies of each rotation by PG level are available on our internet site as well as written copies at administrative offices.

Core Curriculum Competency Modules

All residents are required to complete the UIC/GME Online Core Curriculum modules. This is a part of the ACGME accreditation requirement for completion of the residency program. There are 15 modules to be completed before end of residency. Residents should complete their work on these modules as soon as possible if they want to receive their certificates when they turn in their clearance forms to the Executive Director in June of their last year. It is expected that each surgical resident will finish three modules each year. To access the GME Online Core Curriculum, go to www.gme-core.org. Incoming residents will receive their user name and password assignments during the Orientation process. If you have any problems accessing the modules or the website, please contact the Department of Medical Education (DME) at 877-363-6656 or dme-online@uic.edu

Curriculum Modules:

Medical Professionalism
 Evolution, Organization, and Financing of the U.S. Health Care System
 Leadership and the Health Care Team
 Quality, Cost, and Resource Management in Medical Practice
 Health Care Monitoring and Regulatory Systems and Agencies
 Life Long Learning and Evidence Based Medicine
 Teaching Skills for the Physician Educator
 Managing a Successful Medical Practice
 Fundamentals of Medical and Health Care Information Systems
 First Steps in Research Design
 Communication Skills for Health Care Professionals
 Clinical Ethics for Physicians
 Cultural Competency for Health Care Delivery
 Introduction to the General Competencies
 Focus on Patient Safety

EDUCATIONAL CONFERENCES

Residents develop knowledge and judgment skills through a combination of didactic teaching in conferences and active participation in conferences and seminars, ward rounds, self-directed reading, audiovisual instruction, and attendance at local, regional, and national meetings. Attendance at teaching conferences is mandatory and is documented, as stipulated by the Residency Review Committee for Surgery. All conferences begin and end promptly at the appointed time. Seventy-five percent attendance is required of all residents at required conferences.

Each Hospital participating in the UIC-MGH Program has a Daily AM protected-time mandatory conference schedule. It may differ slightly in the day of the week, but generally, all Hospitals follow the same content of teaching conferences every week as established at the beginning of each academic calendar year. Additionally, all conference topics are coordinated for a concentrated learning experience.

Morning Reports

Junior residents provide the report on new consultations, Emergency Room consults, and admissions from the day prior. Diagnostic work-up including review of CT scans and differential diagnosis with treatment options are discussed. Senior residents and attendings discuss pathophysiology and current literature along with evidence-based treatment options. This conference takes place daily in all participating hospitals.

Morbidity and Mortality Conference *(Held for one hour per week)*

All complications and causes of death in patients admitted to the surgical services are discussed to establish the cause of complications or death and methods to avoid this in the future. Also, the etiology of such complications, natural history, prevention strategies, and management of the complications are discussed along with multiple components of six core ACGME competencies. Residents take part in learning quality assurance and improvement, different national data banks and guidelines, and the importance of resident and attending specific report cards.

Basic Science Lecture Series

In this conference, residents receive education on basic science aspects of surgical diseases. This is also a systematic review of information from standard textbooks in surgery to familiarize residents with prevailing principles and methods of diagnosis and management of surgical patients. The faculty member often gives an

overview of the subject. The conference schedule is organized in such a way that the series covers general surgery and all surgical subspecialties. A written exam is given every month over the topics presented during the three preceding weeks. Even though the tests are scored, correct answers are discussed to further increase the learning value.

Trauma and Critical Care Conference

This is systematic review of critical care problems on patients currently under care. Emphasis is placed on curriculum topics from SCORE guidelines. Each hospital achieves the learning objectives through different tools as available. UIC-MGH residency has Surgical Critical Care Board certified attendings at each hospital which provides an excellent learning experience.

Surgical Literature Review

A critical review of selected articles from surgical literature is presented and discussed. *Held twice per month at St. Francis, and once a month at all other Institutions.*

Pathology Conference

Interesting cases are presented by pathology attendings on the current cases, with in-depth discussions. *Held once a month.*

Tumor Board

Attending physicians from Surgery, Surgical Oncology, Medical Oncology, Pathology, Radiation Therapy, Radiology and others, discuss cases and treatment modalities in a multidisciplinary format with concurrent as well as prospective cases. Opportunities for enrollment in clinical trials are also discussed.

Journal Club

In this conference, junior/intermediate and senior residents present subject specific literature to delineate optimal patient care. Presentations are divided into the three parts: 1) relevant translational basic science research, 2) diagnostic modalities, and 3) surgical controversies. Topics for the Journal Clubs are selected by chief residents at the beginning of the academic calendar year based on relevancy, recent controversies and overall curriculum goals and objectives of the year. *Held one time per month for two hours with extensive resident/faculty interaction and built-in social time.*

Multi-institutional Clinical Conference

This is a mandatory 3-hour conference for all residents in the program held on the last Tuesday of every month at one of the four integrated hospitals by rotation. The conference starts at sharp 7:00 a.m. with the first hour dedicated to a Mock Oral examination for the PGY IV and PGY V residents. Typically, four senior residents are examined in the presence of the entire residency and faculty. Each Mock Oral is videotaped and a copy is given back to the resident for self-evaluation. Faculty provides the critique at end of each Mock Oral Examination to add a unique learning experience for all. The last 1.5 hours is dedicated to the Clinical Pathology Conference (Grand Rounds). Best learning cases from each institution are presented by the intermediate resident. Cases are discussed by the faculty. The chief resident of the institution acts as the moderator and is responsible for the entire educational experience of the session.

Grand Rounds

Grand Rounds consist of in-depth presentations of preselected subjects by distinguished visiting professors in their areas of expertise. These are held as part of the **Multi-institutional Clinical Conference**. Visiting professors are requested to take part in one of the four mock orals along with the case presentations for the morning.

Sample Conference Schedule (for AIMMC):

Mondays:

7am – 8 am In-depth discussions of admissions, surgical consults and emergency room consults for the entire weekend.

Tuesdays:

6.45am – 8 am Short Morning Report followed by M&M Conference*
 7am – 10 am Multi-institutional Clinical Conference (Last Tuesday of the month)**:
 1 pm – 2 pm Tumor Board, Multidisciplinary

Wednesdays:

7 am – 8 am Morning Report followed by Basic Science Lecture Series

Thursdays:

7 am – 8 am Critical Care Conference (presented by a critical care attending)
 7 am – 8 am ER/Trauma/Critical Care Combined Conference (every third Thursday)
 7 pm – 9 pm Journal Club (3rd Thursday)**

Fridays:

7 am – 8 am Morning report followed by Literature Review (1st and 3rd Friday)
 7 am – 8 am Surgical Pathology Conference (2nd Friday)
 7 am – 8 am Surgery Tumor Board (4th Friday)

* M&M Conference: All cases on patient care are available for presentation at M&M unless an exception is approved by the Chairman or Program Director. All complications are listed for each service. The senior resident is responsible for ensuring that cases are presented. In general, cases will not be presented unless the responsible attending is present. However, the case will not be postponed excessively due to attending absence. The presenter is expected to be prepared to present the entire case, including operative summary and lab/X-ray/pathology data, and to be prepared to discuss the relevant literature.

** These are mandatory conferences for all UIC-MGH residents, independent of the hospital at which they are rotating. These conferences provide a unique opportunity for all residents to meet and work together on a regular basis.

SCHOLARSHIP

A formal research rotation is not required during residency training in UIC-MGH Residency in Surgery. However, each resident must establish and maintain an environment of inquiry and scholarship with an active research component. All residents must acquire knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. This may be accomplished by clinical research with a faculty mentor. Each graduating resident of this program must have at least a total of two publications in peer-reviewed journals before he/she is considered eligible to take the American Board of Surgery Examination. Presentation of case reports, or a clinical series at local, regional, or national professional and scientific society meetings may be acceptable as a substitute for one peer-reviewed publication. Other academic achievements during residency e.g. PhD, MPH or MBA may be considered as scholarly activity at the sole discretion of the Program. Residents who are contemplating a career in academic surgery or wish to

compete for top fellowships should consider a year of laboratory research, which would be in addition to the five years of clinical training in General Surgery. One categorical resident from the PG II class will be offered a year in research. On approval, the program will fully fund this research year with benefits to the best candidate. From time to time, the Program, at its discretion, may decide to put a PG II resident in the research year.

Clinical Research

General Surgery residents are encouraged to engage in clinical research during their training under the supervision of a faculty member of their choice. Such research may involve a chart review of a particular clinical problem, the report of a new operation or therapy, the impact of the surgical skills lab on operative technique, or surgical education. Whatever subject is chosen, the resident should follow the steps necessary in carrying out

good research, including a careful description of the problem, appropriate review of the literature, definition of the variables to be recorded, gathering of data, data analysis, appropriate statistical analysis, generating a paper for presentation or publication, and solicitation of appropriate consultation and critique at each step of the process.

Research Year/Clinical and/or Laboratory Research:

The one-year of research training will be offered to one resident per year at the third-year level, and the program will pay the salary of the resident with benefits if the research at the parent institution is unfunded. Because another resident may need to step into the position vacated by the resident spending time in the research laboratory, a systematic process must be followed. Residents should choose a laboratory experience under an experienced investigator in a surgical discipline or in a basic science laboratory. The resident must discuss funding for such research experience with the program director and, preferably, should work in a laboratory funded by extramural grant support. A good funded research proposal from a resident will get priority over another applicant for the funded grant from the UIC/MGH program.

During the second year, a complete research application proposal is due by December of the prior year so that a decision can be made and the resident selected. An ABSITE score of 50th percentile along with excellent clinical performance is a minimum requirement for applying for this position. There will be no geographical or institutional limit imposed, but it must be in the U. S. and approved by the Executive Program Director. Such research experience will prolong the period of surgical training by one year.

There must be at least two publications from this endeavor prior to graduation. If research is done in Chicago, there is a requirement to attend the Multi-Institutional Clinical Conferences every third Tuesday of each month and Thursday evening Journal Clubs. Additionally, if in Chicago, one call per week at an UIC-MGH hospital may be required unless there is a call requirement with the research position at that institution.

If no application is received for the research year, the Executive Program Director may designate a candidate for this position. If several applications are received, a simple majority vote of all SJCC members will select the candidate.

UIC/MGH Basic Science Research Laboratory

The program supports an active basic science research laboratory at UIC under the direction of Dr. Ajay V. Maker, Surgical Oncologist. This lab is dedicated to translational research in immunology and cancer. In addition, UIC has a major commitment to research in multiple surgical areas. Since our residents rotate through their Transplant Service, major research opportunities are present in this area.

Simulation Lab

A State-of-the-Art simulation lab is available to all residents and Faculty 24/7 with a key card. A written curriculum of competencies must be accomplished at each PG level for promotion to the next year. The curriculum is designed to master basic skills in the simulation lab prior to graded curriculum of utilizing these skills in the OR. This lab has produced excellent research in teaching and assessing “Gentle handling of tissues” and provides an excellent environment for research in this field.

The year-by-year Curriculum for the Simulation Lab is as follows:

PGYI	Venipuncture	
	IV Line Placement	
	Arterial ABG Sampling	
	Foley Catheter Placement	
	NG Tube Placement	
	Skin Incision	
	Open Suturing	
	Open Knot Tying	
	Laparoscopic Camera Handling	
	MIST VR Clinical Skills 1 (CS1H)	
	ProMIS Locating and Coordinating	
	ProMIS Object Positioning	
PGYII	MIST VR Clinical Skills 2 (CS2H)	
	ProMIS Dissection Competency	
	Laparoscopic Cholecystectomy Simulation	
	Hand Sewn Intestinal Anastomosis	
PGYIII	FLS Junior	
PGYIV	MIST Suturing Skills I (stitching)	
	MIST Suturing Skills II (knot tying)	
	ProMIS Laparoscopic Suturing & Knot Tying	
PGYV	Chief as Assigned Instructor in Skills Lab	
	Pre-FLS	
	FLS Certification	

Library

Excellent libraries are available for UIC-MGH residents at all participating Hospitals. Residents are also encouraged to take advantage of the world class Medical Sciences Library at the UIC Campus. Each resident on request will be assigned a unique pass code for this access. Full access to internet, Medline and other medical web sites are available to all residents at all hospitals 24/7 in the OR as well as in the residents offices.

Membership, Candidate Group of the American College of Surgeons

Residents are encouraged to join appropriate professional societies such as the Candidate Group of the American College of Surgeons. Attendance at Chicago Surgical Society meetings is encouraged; the UIC-MGH Program underwrites the cost of attendance at Chicago Surgical Society meetings.

Resident Research Presentations and Surgery Review Courses

Residents are encouraged to engage in clinical or laboratory research. With prior approval, residents will be reimbursed for attending any meeting at which they present a peer-reviewed paper. In addition, Chief Residents will be reimbursed for travel and expenses for major surgical meetings, preferably the annual Clinical Congress of the American College of Surgeons. Unless specifically approved by the Department, the resident's educational expenses are limited to a total of \$2000 for the entire term per resident.

Teaching Medical Students

Residents are expected to have a major role in teaching medical students assigned to their service. It is the policy of the Department of Surgery that medical students rotate in the department for an educational opportunity and not in a service role. Thus, every effort should be made to provide students with time to learn, read, and develop basic skills in evaluation and management of surgical patients. Residents should make an effort to teach students at every opportunity, including rounds, clinics, and in the operating room. In the latter circumstances, students should participate in the OR. During this time they can learn and or perform simple parts of the procedures, such as suturing skin. **Students are expected to attend all assigned lectures and major conferences, and should not miss a lecture or conference because of a commitment in the operating room or on the wards.**

Teaching Colleagues

Teaching is a very important part of becoming a surgeon and is a vital part of being able to communicate with peers and patients. "How to Teach" courses are available through the University of Illinois and the American College of Surgeons, and it is encouraged for residents to attend them. Teaching skills will be taught and assessed during the residency at multiple steps.

RESIDENT RESPONSIBILITIES

Communication

A key to the successful practice of medicine in general, and surgery in particular, is prompt and effective communication with patients and their families, attending surgeons, and referring physicians. In general, residents are expected to:

- Discuss diagnostic and therapeutic plans and risks with patients and their families.
- Communicate plans and progress of all patients with attending surgeons, including any serious problems or change in status as they occur (including at night and on weekends).
- Notify referring physicians upon admission, operation, and discharge of their patients from the hospital.

Team Work

The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. During the residency education process, surgical teams are made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. The work of the caregiver team is assigned to team members based on each individual's level of education, experience, and competence.

Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.

Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised.

Lines of authority for residents generally flow from junior to intermediate and to the senior resident depending on the rotation and the institution with ultimate goal to maximize quality care and patient safety. PGY-2 and PGY-3 residents are considered to be at the intermediate level.

Residents at the PGY-4 level and beyond are considered to be in the final years of education.

Line of reporting to attendings is summarized under Supervision and Program Administration.

Good surgical outcomes are only possible when entire surgical team works as a cohesive unit in a true Team spirit. The following is a list of qualities that contribute to team work:

- 1) Recognition of and sensitivity to the experience and competency of other team members;
- 2) Good time management skills;
- 3) Prioritization of tasks as the dynamics of a patient's needs change;
- 4) Recognition of when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;
- 5) Communication, so that if all required tasks cannot be accomplished in a timely fashion appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;

- 6) Recognition of signs and symptoms of fatigue not only in oneself, but in other team members;
- 7) Compliance with work hours limits imposed at the various levels of education;
- 8) Continuing team development.

Referrals and Consultations

Residents should respond promptly to all requests for patient referral or surgical consultations. Residents should promptly contact the responsible attending physician and the hospital Admitting Department or the Surgery Clinic when appropriate, to facilitate the referral.

A faculty attending surgeon is assigned to general surgery call each day. The on-call period rotates at 8:00 a.m. For the purposes of assigning a responsible attending, consult or referral is considered to be received at the time that a request is made to a member of the Department of Surgery (resident, attending, or office). Consults directed to a specific attending are presented to that attending, not the attending on call. Procedures for handling attending assignment on specialty call schedules (trauma, vascular, neurosurgery) will be determined by the appropriate division. All In-patient consultations are to be seen by the senior resident on the appropriate division on the day of request. After evaluating the patient and writing an initial note, the senior resident should contact the appropriate attending surgeon who will complete the consultation. Emergency Room consults will be seen promptly by the senior resident and will be discussed with or seen by the responsible surgical attending prior to final disposition. From time to time senior residents may delegate a junior resident to initially evaluate a surgical consult and collect all the data. Each resident must document in writing the findings and recommendations after discussing with the attending surgeon. Consult/referral patients will remain assigned to the responsible attending surgeon unless another attending surgeon accepts responsibility for the patient's care. Arranging of transfers between attendings in the Department of Surgery will not be delegated to residents, but will be done by direct communication between attendings.

Outpatient Offices/Clinics

Residents should attend all outpatient offices/clinics on services to which they are assigned. Every effort should be made for a resident to see patients, both preoperatively and postoperatively, for whom they are the responsible operating surgeon under faculty supervision. A resident from the appropriate service must be present at the start of all outpatient offices/clinics and remain for the duration of the clinic until all patients have been seen, unless otherwise approved by the attending surgeon. On average at least half day a week must be spent in outpatient offices/clinics.

Orders

Residents are responsible for all patient orders, including: admission, preoperative, postoperative, and discharge orders. Telephone orders must be signed as soon as possible, and no later than 24 hours after ordered. All orders must be dated and timed. Discharge orders should be written on the day prior to the anticipated discharge. All four institutions in our program have now switched to CPOE(Computerized Order Entry) systems. Two institutions have gone further to Dragon dictation (verbal dictation to instant type). Residents are required to master these skills as part of Systems-based Practice and to exhibit adaptability to experimentation and innovation.

Rounds

Residents are expected to round at least once daily. These rounds should endeavor to appropriately incorporate the contribution of attending staff, nurses, and medical students in efficient diagnostic assessment and therapeutic planning for patient care. A computer printout of the service patient census, including name, hospital number, diagnosis, date of admission, operative procedure and date, surgeon, and referring physician should be updated daily. The senior resident is expected to ensure that the progress of each patient is discussed daily with an attending surgeon.

Operating Room (OR) Schedule

The senior resident should review the OR schedule daily as well as the evening prior to ensure that appropriate residents are assigned and that they have time to read and review the case. The residents should review the anatomy and technique of elective cases in standard atlases or by videotape. The Residency has subscribed to www.surgicalcore.org which is an invaluable and authoritative source for all general surgery curriculum. This site has access to the videotape library of ACS and SAGES among other critical textbooks and pertinent journal articles. If the resident has not read before an elective case, operative privilege for that case may be suspended at the discretion of the attending surgeon. Pre-op briefing with the attending surgeon should typically occur on the day prior to the operation.

Operating Room (OR) Etiquette

A resident should be present in the OR area 10 minutes before induction of anesthesia (7:50 a.m. for 8:00 a.m. case). All anticipated instruments, supplies, and special equipment should be requested of the scrub and circulating nurses. The entire operative sequence should be briefly reviewed, rehearsed and discussed. Special anesthetic needs and patient positioning should be reviewed with the anesthesiologist. The roles of the operating surgeon and first and second assistants should be determined and clearly understood preoperatively. Professional behavior is expected at all times in the OR.

Required Pre-Operative Preparation

- Preoperative note and informed consent.
- Latest office/clinic note and lab results on chart.
- Relevant patient X-ray reports on chart and reviewed on the PAX system of the hospital.
- Appropriate site and side marked on patient, per policy of the Department of Surgery.
- Timeout policies of the institution.

Medical Records

The medical record is compiled for use in the care and treatment of the patient. It furnishes documentary evidence of the course of the patient's illness and the type of medical care rendered. It must contain sufficient information to justify the diagnosis and warrant the treatment. The Joint Commission on Accreditation of Health Care Organizations (JCAHO), other regulatory agencies, as well as our own internal review groups, find the medical record valuable for use in measuring the quality of medical care rendered by the hospital and its medical staff. Only members of the Medical Staff or Resident Medical Staff are allowed to dictate medical histories and physical discharge summaries.

State law requires that medical records be completed within 14 days of a patient's discharge. An incomplete record is one that requires completion by the physician. A delinquent record is an incomplete record that has been incomplete for more than 14 days after the patient's discharge. It is the responsibility of residents to see that their records are completed at the time of the patient's discharge, including dictation of the discharge summary. Residents are required to complete any remaining incomplete records once a week in Medical Records. Medical Records personnel are available to assist.

Complete patient care documentation is a requirement, and dictations are to be done on a timely basis. The following procedures should be followed:

1. The history and physical examination must be recorded in the patient's chart within 24 hours of the patient's admission.
2. Discharge summaries must be dictated within 24 hours after discharge.
3. All operative procedures must be dictated within 24 hours of surgery, preferably immediately following the procedure.

4. All handwritten entries into the medical record must be legible and in black ink.
5. All verbal orders are to be signed within 24 hours.
6. All medical student notes must be countersigned by the resident.

Daily Chart Do's and Don'ts

ALL ENTRIES in medical records must be LEGIBLE, DATED, TIMED and SIGNED including your professional title and IDENTIFICATION so that any future reader can identify each entry's author.

1. Use only abbreviations and symbols approved by the Medical Staff Executive Committee in the medical record. Do not use abbreviations or symbols when recording final diagnosis(es). Avoid using problem prone abbreviations.
2. Use only hospital approved chart forms with the patient's name, the date, and the time recorded on each sheet and on, if applicable, both sides of every sheet in the record.
3. Use ink; never pencil.
4. Don't skip lines or leave spaces between entries.
5. Don't use vague, non-descriptive terms.
6. Don't get personal. Comments cannot be removed or changed. Refrain from entering into the chart any statement that does not deal directly with the patient's diagnosis, treatment, care, or condition.
7. Don't use the medical record to comment on other health-care professionals or their actions.
8. Don't wait until the end of your shift to chart.
9. Don't back date, add to or tamper with notes on the medical record. Corrections, additions or deletions must be done as neatly as physically possible to the entry being corrected. All such items should be dated and timed with the date of correction and be signed. Errors should have one line drawn through the incorrect information. The original entry must never be obliterated, and must remain legible even after the correction.
10. Don't use terms unless you know what they mean.
11. Always legibly identify yourself below your signature line by either printing or typing your name and residency level.
12. All entries in the medical record must be signed by the author. Federal law mandates that only the author can sign his/her entries in medical records.

Progress Notes

The patient's progress, including details of all operative and special procedures, should be carefully documented, at least daily. Notes should be brief but informative regarding patient condition, planned diagnostic or therapeutic measures, and discharge planning. This documentation is important for patient care continuity, legal protection, and education. The last entry in the patient's progress report should be a discharge note that includes the discharge diagnosis, the procedures performed during hospitalization, any complications from treatment and/or procedures, recommendations for further care, limitation of activity (if applicable), discharge medication, dressings and wound care, dietary instructions, and return-to-clinic appointments, or in all death cases there shall be a death note in the progress notes, including (as minimum) time and cause of death. The discharge orders/instructions/note form, when completed, may substitute for the final or discharge progress notes. Merely noting that the discharge summary was dictated does not meet the requirement for a discharge note and is unacceptable. Medication reconciliations must be reviewed and completed at discharge or transfer.

Pre-Operative Notes

For elective cases, the operating resident will review the chart (including X-rays, lab, and pathology) and discuss the operative plan with the attending surgeon prior to the operation. A preoperative note must be written/entered by the resident surgeon in the progress section of the chart within 24 hours prior to operation, and only after the patient has been examined by the same resident. It should include:

- Preoperative diagnosis and basis for diagnosis
- Planned operation and indications
- Surgeon
- Anesthesia
- Pertinent laboratory data
- Blood/X-ray requests
- Operative risks and indications of risks
- Potential complications discussed
- Signed informed consent

Operative Notes

Unless otherwise designated, the responsible resident should fill out an operative note (dated and timed) in the chart immediately following operation, and should include:

- Surgeon and assistant's names
- Preoperative diagnosis
- Postoperative diagnosis
- Operation
- Anesthesia
- Intra-operative findings
- Complications
- Condition

Of note, a simple diagram of the operation performed is very helpful in complicated cases and with multiple tubes/drains, etc.

Operative Report Dictation

An operative note is dictated immediately upon completion of the operation. Usually this task is delegated to the operating resident, although the attending may wish to dictate the note himself/herself. The operative report should be brief but should cover all salient points of the procedure, including:

- Patient data
- Preoperative and postoperative diagnoses
- Operative procedure
- Operating surgeon and assistants
- Anesthesia
- Estimated Blood Loss
- Samples sent to pathology/lab
- Indications
- Operative findings
- Operative procedure
- Sponge and needle counts
- Condition of patient

Each resident should have at least 5 of their dictated operative reports reviewed by different attendings using the operative dictation OSAT which can be downloaded from the Program's internet site.

Co-signing Orders of Medical Students and Acting Interns

Medical students and Acting Interns may write orders, but they will not be carried out until they have been read, approved and co-signed by a resident or attending surgeon.

Charts On Units

Charts are not to be removed from patient care units or hospital grounds. All disciplines must have access to the charts at all times. Removal can cause delay in a patient's treatment and increase the period of hospitalization. It can also result in permanently lost records and delayed reimbursement.

General Suspension Policy

Failure by residents to complete all records at end of rotation will result in suspension and/or other disciplinary actions. Residents who receive 48-hour notices to complete specified records must complete the records before leaving on vacation or an out-of-town engagement. Suspension may result in the failure to satisfy requirements for training certification, licensure, and privileges at other hospitals. During the periods of suspension, the Program assumes no obligation to provide malpractice insurance coverage. Each UIC-MGH hospital's Program Director will have the flexibility to assure compliance, including withholding operating room privileges for those delinquent periods. A record of delinquency is kept in the resident's files.

Operative Experience Log

All operative experience of residents is maintained in the ACGME Resident Data Collection System. This is an ACGME developed, Internet-based data collection system utilizing CPT codes. Residents can access the system from any PC connected to the Internet by going to the ACGME homepage at www.acgme.org.

The data, when entered into the system, will provide the following:

- Periodic reports of resident operative experience, allowing adjustment of caseload allocation for deficient experience.
- Reports for clinical case reviews.
- Reports of operative experience for program evaluation by the Residency
- Data for Review Committee to decide accreditation.
- Reports for resident submission to the American Board of Surgery for certification.

The Program director and SJCC regularly review this data. Residents who are more than 30 days delinquent will go on automatic warning and probation. At time of the resident's Semi-annual Review with the program Director, the Operative Log should be up-to-date with no exceptions.

Non-operative Experience Record

Residents are required to document at least 60 non-operative Trauma and Critical Care cases and their management. The UIC/MGH residents manage at least twice the amount of this required number.

Sign Outs

Effective, comprehensive and accurate sign-outs are a key component of safe continuity of patient care. Sign outs must happen face to face and in a unhurried manner. All pertinent and key findings from history, physical, lab, radiological and peri-operative course should be discussed. On sick patients, sign outs are better conducted in the patient room as appropriate. Face to face sign out of the patient and family are at times more appropriate.



**DR. VIJAY MAKER'S
TEN NON-NEGOTIABLE COMMANDMENTS**

1. **Registration and completion (pass) USMLE Part III Examination before the end of the PGY 2 year.**
2. **Entering of operative data into the ACGME surgical operative log within 30 days**
3. **100% mandatory and timely attendance at the Core conferences.**
4. **Completion of exit interviews and written faculty feedback after each rotation. This is residents' responsibility.**
5. **Mandatory bi-annual performance evaluations with Dr. Maker. All PG level specific required competencies must be complete and in file prior to this meeting.**
6. **Taking care of your physical ,mental and moral health.**
7. **100% attendance at ABSITE examinations with at least 50 percentile score.**
8. **Daily self study schedule with evidence of cognition and lifelong learning.**
9. **Always work to be a teacher and scholar.**
10. **Outstanding Patient Care and Professionalism must be maintained at all times.**

Any noncompliance will result in automatic probation or dismissal from the program

Quality Assurance/Risk Management

Residents will participate and follow pertinent policies and procedures of hospitals related to quality of care as well as risk management. They will actively participate in Morbidity and Mortality conferences, safety initiatives and RCAs (root cause analyses), while seeking opportunities for improvement in patient care through SCIP, NSQIP and others as made available. Residents will actively participate in new initiatives to improve patient care by learning, critiquing and improving systems, such as the computerized order entry system (CPOE), Dragon dictation, drug Reconciliation, etc. All residents will be up-to-date with all safety modules to provide the best quality of care to our patients. These safety modules deal with fire safety, back health, electrical and surgical equipment, hazardous materials and waste, environmental pathogens, blood-borne injuries, TB, emergency backup systems, security related codes and events, and appropriate business conduct. Copies of successful completion are kept in resident files.

HIPPA

All UIC-MGH Residents will complete the HIPPA Training Program. They will follow all policies and procedures as established by the hospitals participating in the Program.

Dress Code

Objective:

- To maintain a dignified, professional appearance, behooving of a respected surgeon, before patients, families, and other health care professionals.
- To allow for maximum effectiveness in infection control, particularly in the Operating Room.

Inside the Operating Room

- All personnel entering restricted areas of the Operating Room suite shall be required to wear Operating Room dress or scrub suit, hat, and shoe covers if required by OR policy.
- All personnel leaving the Operating Room must remove hat, shoe covers, and masks. Full length lab coats or cover gowns must cover scrub suit and be properly secured.
- Entering or leaving the main hospital building in scrub suits, even covered by a lab coat, is not permitted.
- All possible head and facial hair must be covered with a clean, disposable hat or surgical hood and must be worn in all areas of the Operating Room.
- All personnel should wear a mask at all times within the OR suite.
- Formal eye protection must be used uniformly for every operation.
- Fingernail polish may not be worn, and fingernails must be of reasonable length.
- Universal precautions will be followed in all areas of the hospital environment.

Outside of the Operating Room

For men:

- Informal business attire - men should wear slacks, business shirt and tie.
- Polo- type shirts, jeans, and sneakers are inappropriate.
- A clean lab coat should be worn at all times outside the operating room.
- Gentlemen are expected to wear full-length trousers, dress shirt, tie, and a white laboratory coat. Shorts are unacceptable.

For women:

- Appropriate attire for women consists of blouses, skirts, dresses, or dress slacks.
- Jeans or sneakers are inappropriate
- A clean lab coat should be worn at all times outside the operating room
- Polo- type shirts, jeans, and sneakers are inappropriate
- Shorts are unacceptable

For all:

- Conservative hair style is required both of men and women - unusual hair styles of any kind are inappropriate.
- Inappropriate or excessive use of jewelry is not permitted for men or women.
- A photo ID badge should be worn at all times.

SUPERVISION

1. All physicians (including resident physicians) are authorized and expected to do whatever is considered necessary to preserve life in the event of a life-threatening emergency. In the event of a life-threatening emergency, resident physicians should take whatever action deemed necessary to preserve life while someone else summons help from any available senior resident or faculty member. As three of four institutions are Level I trauma centers, residents have 24/7 access to faculty in house at Illinois Masonic, St. Francis, and within 30 minutes at all other institutions.
2. All patients cared for in hospitals participating in the UIC-MGH Surgery Residency Program are cared for under the direction of a designated faculty attending surgeon. The specific level of faculty supervision will vary depending on the level of training and skill of the resident, the complexity of the care rendered, and the wishes of the responsible attending surgeon. The level of supervision required for an individual procedure will be determined on an individual basis between the resident and the responsible faculty member unless a defined level of supervision is mandated by institutional or service policy.
3. Significant patient care decisions and events are to be discussed with the appropriate attending surgeon. If the responsible attending surgeon or his designated alternative is unavailable, contact the attending surgeon on call for the appropriate service. Although residents are responsible for their individual actions and senior residents are responsible for the performance of their service, overall responsibility for patient care always rests with the attending surgeon.
4. Authority for supervision may be delegated, at the discretion of the attending surgeon, to more senior surgical residents. In general, the senior surgical resident assigned to the service will be in charge of the service and is expected to assume a leadership role. Except in emergencies, the chain-of-command of junior resident - senior resident - attending surgeon should be followed regarding patient care decisions. Under some circumstances, junior residents may work directly with attending surgeons. In these instances, the junior resident must keep the senior resident informed of significant events regarding the service. Individual resident assignments are to be made by the senior resident at the start of each rotation.
5. Attending surgeons are responsible for ensuring that coverage is available for their patients by another attending surgeon during their absence, and that this information is properly posted and available through appropriate channels 24/7 in their absence.

Definitions of Supervision

Direct Supervision:

The supervising physician is physically present with the resident and patient.

Indirect Supervision:

With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight:

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

Indirect supervision is allowed for:

- 1) Patient Management Competencies
 - a) Evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests.
 - b) Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests.
 - c) Evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments.
 - d) Transfer of patients between hospital units or hospitals
 - e) Discharge of patients from the hospital
 - f) Interpretation of laboratory results
- 2) Procedural Competencies
 - a) Performance of basic venous access procedures, including establishing intravenous access
 - b) Placement and removal of nasogastric tubes and Foley catheters
 - c) Arterial puncture for blood gases

Direct supervision is required until Successful progression to PG2

- 1) Patient Management Competencies
 - a) Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations and trauma
 - b) 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
 - c) 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.
 - d) Management of patients in cardiac or respiratory arrest (ACLS required)

- 2) Procedural Competencies
 - a) Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation.
 - b) Repair of surgical incisions of the skin and soft tissues
 - c) Repair of skin and soft tissue lacerations
 - d) Excision of lesions of the skin and subcutaneous tissues
 - e) Tube thoracostomy
 - f) Paracentesis
 - g) Endotracheal intubation
 - h) Bedside debridement

COMPETENCY EVALUATIONS

Purpose of Evaluation System:

1. To provide continuous feedback to residents in order to improve outcomes in their professional development as well as patient care.
2. To help each individual resident to achieve competency in all ACGME defined competencies
3. To provide remediation, change of career or dismissal from the program
4. To help write letters of recommendation.
5. To provide information to various boards and specialty organizations.
6. To provide information to fellowships and Medical staff appointments after finishing education.
7. To improve the program as a whole and in part from data collected.

Process of Evaluation System

The evaluation process at the UIC-MGH is comprehensive and follows the strict guidelines of the ACGME. The Surgical Joint Conference Committee will periodically review the educational progress, behavior, advancement, and actions of residents and provide a vehicle whereby the resident may be consistently aware of his/her status during the training program in General Surgery. This process will be used:

- During review of the periodic written summaries of the resident's educational progress.
- When a resident's evaluations indicate a need for some type of remedial action due to educational deficiencies.
- When other types of institutional policies require that the resident be notified in writing of a problem.

Clinical competence is the main factor in determining performance and progression in the residency program.

Cognitive abilities will be assessed by pre-ABSITE/ABSITE/AM Report/X-ray/Conferences/Presentations/Journal Clubs, etc.

Skills/dexterity will be assessed per rotation in the operating room and at the Surgical Skills Laboratory using the Virtual Reality system of skills acquisition and monitoring, along with multiple OSATS/OSCE.

Professionalism, personality and behavior are considered as important as clinical competence. The ability to get along with colleagues, staff, nursing, paramedical professionals, patients, families and attendings will all be considered. There is an inherent subjectivity in this evaluation process and the Surgical Joint Conference Committee will make a determination when a deficiency exists.

- The resident will be evaluated at the end of each rotation on the goals and objectives of that rotation as handed out at the beginning of each rotation. These global evaluation forms are to be presented by

the resident to the primary teaching faculty. This is done during a meeting with the teaching attending, with direct feedback given to the resident regarding his/her performance during rotation.

- Twice a year each resident is evaluated at the SJCC Committee, representing all hospitals in the program. This is a comprehensive evaluation with emphasis on the previous six months. Extensive discussion with broad input from multiple sources follows to outline strengths and weaknesses of each resident along with appropriate courses of action.
- In addition, we use several 360 degree tools to evaluate the performance of each resident. These evaluations consist of Critical Care nurses at Masonic and Lutheran, and OR nurses at all institutions. This is usually done for senior residents only. To complete the 360 degree evaluation process, each resident is now required to have himself/herself evaluated by his/her patients. Self evaluations as well as student evaluations are part of this process.
- All juniors are evaluated by seniors once a year, while juniors also get a chance to evaluate seniors. A summary of these evaluations are recorded in the resident's files, which are available for review and shared with each resident yearly.
- Senior residents (PGY IV and above) are given monthly Mock Oral Exams. These sessions are used as an important teaching as well as evaluating tool. At the end of each Mock Oral Exam, the examiner discusses the appropriate answers. In addition, citywide Mock Oral Exams are given yearly to all graduating residents by the outside Faculty.
- In addition to all these forms of evaluation, residents are being constantly supervised and quizzed using the Socratic Method during daily morning reports, teaching rounds and in the operating room.
- A summarized report on these evaluations is discussed with each resident at the time of meeting with the Program Director. Twice a year each resident has a compulsory evaluation with the Executive Program Director at which time he/she will have a chance to review his/his entire file, as well as obtain specific comments on strengths and weaknesses in performance. A comprehensive evaluation tool listed on our website is utilized in this process. This is a compulsory evaluation and is the ultimate pathway to progression in the program.

Faculty and Rotation Evaluations

Evaluation is a two-way process with the primary objective being to improve the program as a whole. The same principles, as listed above in the resident's competency evaluations, are employed to evaluate the faculty and each rotation by the residents. Once a year, every resident anonymously evaluates all the rotations and the teaching faculty in the program in a comprehensive manner. These reports are summarized, statistically analyzed and reports are sent to all attending physicians. Deficiencies and progress is closely followed. Actions including dropping from primary teaching faculty may be taken. Rotations may be modified or even eliminated based on resident's feedback.

Overall, the program maintains a constant environment of education, evaluation and feedback. All evaluations by residents are valued and taken seriously and in confidence. To protect resident confidentiality, evaluations are collected in a confidential and totally anonymous manner. Summary of scores and comments are provided to the faculty member, division chief, program director, and chairpersons.

Annual Retreat

This is a daylong retreat held once a year in the month of September outside of the hospital environment. It is compulsory for all the residents and core faculty. The main theme of the retreat is to openly review all educational activities, tools, evaluation data, and outcomes of the program measured internally as well as from external sources (ABS, ACGME, ERAS) and national data banks, as well as the current literature. All opportunities for improvement are discussed and implemented in the oncoming calendar year. Reviews of each hospital and rotation are conducted to maximize resident educational benefit.

Resident Promotion Process

The SJCC will review the clinical and academic performance and progress of each resident twice a year to determine his/her suitability for promotion or graduation. The goal is to keep all categorical residents in the program to completion.

Advancement to the next PG-level is not automatic, but must be recommended by the SJCC to the Executive Program Director. Agreement renewals are customarily issued in December or January for the following July. However, the Executive Director may withdraw an offer based on a resident's performance at any time prior to the new contract date. Residents on probation (see disciplinary action section) must fulfill the requirements specified in the conditions for probation before they will be advanced. The Executive Program Director provides detailed biennial evaluations, covering all aspects of the resident's performance with input from multiple sources including the SJCC, along with personal performance based observations. The Executive Program Director carries the final authority for recommending remediation, probation, warning, and dismissal from the program.

In instances where a resident's agreement is not going to be renewed, the Program Director will provide the resident with a written notice of intent not to renew no later than four months prior to the end of the resident's current agreement. If the primary reason(s) for the non-renewal occur within the four months prior to the end of the agreement, the Program Director will provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow. A resident that has received a written notice of intent not to renew his/her agreement may invoke the "Appeals Process for Residents" policy.

Any resident not recommended for agreement renewal is entitled to a written explanation from the Executive Program Director

The measures that the SJCC uses for resident evaluation are as follows:

1. Patient care and management along with performance in all 6 ACGME competencies on each rotation as documented by the faculty evaluation forms, as well as by verbal inputs and exit interviews. The Administrative Chief Resident is a standing and voting member of the SJCC and provides critical verbal input from a peer perspective. Performance deficits will result in a warning and may be grounds for probation.
2. Attendance at mandatory academic conferences (daily morning conferences, Multi-Institutional Clinical Conferences, Mock Orals, M&M, etc.). Failure to attend more than 75% of any of these conferences in timely manner will result in a warning and may be grounds for probation.
3. Performance on the American Board of Surgery In -Training Examination (ABSITE), which must be taken annually. Failure to score at or above the 50th percentile will result in a warning and two years of remediation and may be grounds for probation.
4. Performance and/or noncompliance on the Mock Orals Examination and the Objective Structured Clinical Examination (OSCE, OSATS). Failure on either of these examinations will result in a warning and may be grounds for probation.

5. Contributions to the academic and scholarly requirements of the Program. Presentations and publications are an integral and required component of scholarship. Performance deficits will result in a warning and may be grounds for probation.
6. Compliance with all hospital, Residency and departmental record-keeping and documentation requirements. This includes timely and accurate completion of operative dictations, medical records, case lists (surgical operative logs), Morbidity and Mortality reports, Simulation Lab and all other requirements for yearly promotion and competence. A pattern of tardiness and noncompliance will result probation and expulsion from the program.
7. Personal integrity, which includes strict avoidance of substance abuse, theft, lying, cheating, unprofessional conduct, inappropriate professional appearance and unexplained absences. Failure to follow one or more of these standards will result in a warning and may be grounds for probation/dismissal.

Competency Evaluation Tools

The Program uses multiple tools which are periodically modified & added to evaluate the 6 core competencies as listed below.

KEY COMPETENCIES –

PC= PATIENT CARE

PBLI= PRACTICE BASED LEARNING & IMPROVEMENT SKILLS

PROF=PROFESSIONALISM

MK = MEDICAL KNOWLEDGE

I & CS = INTERPERSONAL & COMMUNICATION

SBP = SYSTEMS BASED PRACTICE

	TOOLS	COMPETENCIES					
		PC	MK	PBLI	I & CS	PROF	SBP
Written Exams	1. Absite Scores	✓	✓	✓			
	2. Monthly Basic Science Exam	✓	✓	✓			
	3. Pre-Absite Exam	✓	✓	✓			
	4. Step III	✓	✓	✓			
	5. IRB certification (NIH certificate)	✓	✓	✓		✓	✓
360° Degree Evaluation	6. Altruism					✓	
	7. Evaluation by Critical Care Nurse	✓			✓	✓	✓
	8. Evaluation by OR Nurse	✓			✓	✓	✓
	9. Evaluation by Peers	✓	✓	✓	✓	✓	✓
	10. Evaluation by Patient	✓		✓	✓	✓	✓
	11. Evaluation by Student	✓		✓	✓	✓	
	12. Self Evaluation	✓	✓	✓	✓	✓	✓
	13. Monthly Mock orals Evaluation by Juniors				✓	✓	
14. Duty Hour compliance (by Seniors)	✓				✓		
Evaluation by Faculty	15. ACGME Operative Log, content and Timely completion	✓		✓		✓	✓
	16. Annual Mock Orals(Citywide)	✓	✓		✓		
	17. Attendance (Lists)			✓		✓	
	18. Basic Science Presentations		✓	✓	✓		
	19. Clinical Rotations	✓	✓	✓	✓	✓	✓
	20. Core Curriculum modules(UIC)	✓	✓	✓	✓	✓	✓
	21. Critique for Monthly Mock Oral Exam, professional skills	✓		✓	✓	✓	
	22. Daily Quizzes	✓	✓	✓	✓	✓	✓
	23. Evaluations as Moderator (Leadership)				✓	✓	
	24. Journal Club Presentations	✓	✓	✓	✓		
	25. Journal Reviews	✓	✓		✓		
	26. M&M Review	✓	✓	✓	✓	✓	✓
	27. Medical Records	✓		✓	✓		✓
	28. Monthly Grand Rounds & Presentations	✓	✓		✓		
	29. Monthly Mock Orals	✓	✓		✓		
	30. Operative Dictation Monitor	✓		✓		✓	✓
	31. OSATS /OSCA (1-5)	✓	✓				
	32. Meditrek Self portfolio, Yearly update	✓	✓	✓	✓	✓	✓
	33. Daily learning Portfolios (Topic of the Day)	✓	✓	✓	✓		✓
	34. Program Director Evaluation (Biennial)	✓	✓	✓	✓	✓	✓
	35. Publications and Presentations	✓	✓	✓	✓		
	36. SJCC Evaluation	✓	✓	✓	✓	✓	✓
	37. Virtual Reality Scenarios Review	✓	✓				
	38. SCORE logs	✓	✓	✓		✓	
	39. Morning report evaluation	✓	✓	✓	✓	✓	✓
40. Rotation Exit Interviews	✓		✓		✓	✓	
41. Duty hour compliance (by Program)	✓				✓		
42. Simulation Lab Competence (1-5)	✓	✓	✓		✓	✓	
43. ATLS (Adult trauma life support)	✓	✓		✓			
44. PALS (Pediatric trauma life support)	✓	✓		✓			
45. FLS (Fundamentals of Laparoscopic Surgery)	✓	✓					

EXAMINATIONS

American Board Of Surgery In-Training Examination (Absite)

Each year, all General Surgery residents take the American Board of Surgery In-Training Examination (ABSITE) on the last Saturday in January. This multiple-choice test of approximately 225 questions covers a wide variety of clinical and basic science topics in general surgery and the surgical specialties. The examination permits evaluation of performance as a percentile compared to PGY peers throughout the country. All residents should develop a systematic reading program throughout their training (and professional career). Such self-directed learning along with Basic Science conferences, Clinical Science conferences, journal clubs and a host of other teaching opportunities are all designed to assist residents in solidifying their cognitive knowledge.

Residents in the UIC-MGH Program are expected to perform satisfactorily on the American Board of Surgery In-Service Training Examination. Although there is no minimum passing grade on the ABSITE examination, in general, scores below the 50 percentile will be considered unsatisfactory. It is the goal of the SJCC to have residents perform at or above the national average (50th percentile) on the In-Service Training Examinations. Residents who score below the 30th percentile on two successive examinations shall be subject to drastic remedial action, including use of vacation for the study time or an extra year at the discretion of the SJCC. Although poor scores on the In-service Training Examinations in and of themselves are not used as sole criteria for dismissal from the program, persistently low scores for 2 years with or without one or more other factors may result in dismissal from the program.

- **Yearly performance in the six competencies and ABSITE scores are closely followed and various programs of remediation offered should deficiencies exist. However, persistent low scores for 2 years along with other factors may be considered as a reason for non-advancement or non-renewal of your contract.**

USMLE STEP III Licensing Examination

All UIC-MGH residents must apply for the United States Medical Licensing Exam Part III immediately after completing 12 months of clinical training.

The United States Medical Licensing Examination is offered in June and December. American graduates must submit their applications on official forms provided by the United States Medical Licensing Board through the mail. If residents do not hear from the United States Medical Licensing Board, residents should call them at 215-349-6400.

The State of Illinois requires a minimum of 12 months of clinical training before sitting for the United States Medical Licensing Exam Part III. In Illinois, write to the following address:

USMLE Part III Examination Application
State of Illinois Department of
Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

The deadline for registration is usually several months in advance of the examination date itself. The Medical Education Department or the MGH Central Office may have a supply of applications for the USMLE Part III examination. Every categorical resident completing the PGY II year must successfully complete and pass the USMLE Part III to be considered for advancement to the PGY III level status.

OSCA/OSCE/OSATS

The Residency uses multiple OSCA/OSCE/OSATs to assess competency of our residents in cognitive and technical aspects of common surgical procedures. As of 2010, each graduating resident will need five OSCA/OSCE/OSATs completed for each procedure (where applicable) by two different faculty evaluators. This list continues to grow each year as we develop new OSCA/OSCE/OSATs. Each of these technical competency tools is PG level specific and required for advancement. An up-to-date list is available on our internet site at <http://uimghsurgery.org/>.

2011 - 2012 OSATS/OSCE/OSCA

OSATS/OSCE/OSCA	Level	Institution	Rotation
ACLS	1	ALL	ALL
ANESTHESIA OSAT	1	SFH	ANESTHESIA
APPENDECTOMY, LAPAROSCOPIC (UPDATED)	3	ALL	GS
APPENDECTOMY, OPEN (UPDATED)	2,3	ALL	GS
ATLS	2	AIMMC	BOOTCAMP
BREAST OSCA	3	MERCY	BREAST
CHEST TUBE INSERTION (NEW)	2	ALL	ALL
COLONOSCOPY	5	ALGH, SFH	COLORECTAL
DRAGON DICTATION OSAT	1	AIMMC	GS
ENDOTRACHEAL INTUBATION (NEW)	1	SFH	ANESTH
FAST (UPDATED)	3	AIMMC	TRAUMA
FEMOROPOLITEAL BYPASS	5	ALGH	VASCULAR
FLS SENIOR	4,5	ACS	GS
FLS JUNIOR (UPDATED)	3	SFH	GS
INFERIOR VENA CAVA FILTER (NEW)	5	SFH	GS
INGUINAL HERNIA REPAIR, LAPAROSCOPIC	3	ALL	GS
INGUINAL HERNIA REPAIR, OPEN (UPDATED)	2,3	ALL	GS
INTRAOSSEOUS LINE PLACEMENT (NEW)	2	LGH	TRAUMA
IRB (NIH Certificate)	1	AIMMC, LGH	GS
LAP RIGHT HEMI COLECTOMY (NEW)	5	LGH	COLO-RECTAL
LAPAROSCOPIC CHOLECYSTECTOMY	3,5	ALL	GS
OPERATIVE REPORT DICTATION OSAT	1-5	ALL	ALL
PALS	4	LGH	PED SURGERY
PERCUTAENOUS TRACHEOSTOMY	3,4	AIMMC	TRAUMA
PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (NEW)	3	MHMC, AIMMC	GS
SIMULATION LAB 1.	1	AIMMC	24/7
SIMULATION LAB 2	2	AIMMC	24/7
SIMULATION LAB 3	3	AIMMC	24/7
SIMULATION LAB 4	4	AIMMC	24/7
SIMULATION LAB 5	5	AIMMC	24/7
STEROTATIC BREAST BIOPSY	3	SFH	GS
ULTRASOUND GUIDED INTERNAL JUGULAR LINE INSERTION	1	SFH	GS
UPPER ENDOSCOPY	5	SFH, MERCY	GS
VENTILATOR MANAGEMENT	3,4	AIMMC	TRAUMA

Monthly Examination on Basic Science

All residents at each location are given monthly exams on the basic science topics of the month. These topics are discussed in the didactic basic science lecture series presented by junior residents under faculty supervision. Faculty attends these lectures by the residents. Each resident is individually graded and the answers are discussed by the faculty. Residents are allowed to take home answered Question sheets for self study.

DISCIPLINARY PROCEDURES

At request of Executive Program Director, The Surgical Joint Conference Committee as a whole or through its subcommittees will review the performance of any resident referred to it for corrective action, whether with respect to interpretation or application of, or compliance with, any hospital, accrediting or UIC/MGH policy, practice or procedure, or if the resident's educational progress is not satisfactory. Any marginal grade on a rotation may result in automatic probation. Any significant flaw in any of the developmental areas will be a basis for probation. A simple majority vote of the S.J.C.C. membership will be required to place a resident on probation. The final remediation guidelines will be set by the Executive Director as well as a date for re-evaluation and follow-up on progress. This may include adding a full remedial year. In the case of a graduating resident, successful completion of the residency may be denied or deferred depending on the situation.

Causes for Corrective Action

The following list provides examples of resident actions that can be grounds for discipline. It is not intended to be inclusive of all reasons for a disciplinary action. The Executive Program Director's action will depend on the severity of the infraction, prior warnings, and efforts on the part of the resident to correct his or her behavior. In all cases, the basis for the decision will be in the Executive Program Director's best judgment. Reasons for corrective action are as follows:

- Behavior that threatens the well-being of patients, medical staff, employees, or the general public
- Other substantial or repetitive conduct that is considered by the resident's supervisor to be professionally or ethically unacceptable or which is disruptive to the normal and orderly functioning of the institution to which the resident is assigned
- Failure to conform to the letter of the Resident Agreement, or to policies and procedures of UIC-MGH Program, Advocate Healthcare, or other participating hospitals and/or the University of Illinois, The College of Medicine policies
- Failure to comply with federal, state and local laws whether or not related to the medical profession. Convictions for other than minor traffic violations can be cause for dismissal
- Failure to provide patient care of satisfactory quality expected for the resident's training level
- Fraud by commission or omission in application for the residency position, or in completing other official documents
- Suspension, revocation, or any other inactivation, voluntary or not, of a resident's license by the State of Illinois for any reason
- Continued or lengthy absence from duty assignments without reasonable excuse
- Failure to perform the normal and customary services of a resident as defined in the ACGME "General Requirements"
- Sexual harassment or abuse of patients, other residents, or hospital staff

Such corrective action shall be as follows:

Step 1 - Oral Discussion

The resident and the Program Director shall discuss the deficiencies and attempt to reach a satisfactory conclusion.

Step 2 - Written Warning

When the deficiencies involve unsatisfactory progress, the Program director will prepare a written warning noting the identified deficiencies and outlining specific areas which must be improved. When a resident receives a warning, a remedial program will generally be instituted in an attempt to correct the particular deficit(s). A follow-up written evaluation will be made within the time period stated in the evaluation, which will not exceed six months. If the specific deficiencies have been sufficiently improved and/or corrected, it must so be stated in the follow-up written evaluation. Step 2 is decided by the Program Director after consultation with the SJCC membership. The Committee may request the resident to appear before the Committee for additional discussion and clarification. Failure to meet program standards after a resident has received a warning may result in a request by the Executive Program Director to convene a hearing to evaluate the resident for placement on probation.

Step 3 - Probationary Status

Failure to meet UIC-MGH program standards after a resident has been placed on probation will result in his/her expulsion from the program. The program reserves the right to summary expulsion of a resident from the program for severe infractions of established standards. If the resident's performance or competency requires further action, the Program Director in consultation with members of the SJCC may place the resident on probation for a specified period of time not to exceed six months. This action requires a simple majority vote of all SJCC members. Specific deficiencies and required corrective action shall be stated in writing. If the corrections are satisfactory, the resident's probationary status will be removed. Probation status two times while in the program will be automatic grounds for dismissal.

Step 4 - Suspension Without Pay/Repeat of Work/Termination

Suspension/dismissal will result from failure to comply with the Manual on Policy and Procedure and for any egregious act. Should it be determined by the Program Director and SJCC that the resident's performance continues to remain unacceptable, the resident will be suspended without pay, requested to repeat the work, or be terminated. Any such action shall be preceded by a conference with the members of the SJCC. For Step 3 and Step 4 above, in case of a tie vote, the Executive Program Director shall make the final decision.

The Executive Program Director may suspend a resident pending any investigation, evaluation, or appeal process.

Appeal Process

If a resident is placed on probation and/or recommended for expulsion from the program, he/she may appeal in writing to the Program Director within seven (7) days of notification. An attempt to resolve the appeal should be accomplished within fourteen (14) days.

If the resident is not satisfied with the resolution proposed by the Executive Program Director, he/she may submit an appeal to the SJCC. An appeal of the decision of the SJCC must be in writing and directed to the Executive Program Director. The Surgical Joint Conference Committee shall convene within fourteen (14) calendar days from the date on which the notice of grievance was received by the Program Director. The SJCC will make its decision based on majority vote, and the Executive Program Director will be bound by the decision. The resident will receive a written copy of the decision no later than 10 days following the hearing. The resident may appeal the Committee's decision to the Senior Associate Dean, Educational Affairs, University of Illinois, School of Medicine, in accordance with the Due Process policies of the UIC School of Medicine, in writing, no later than 10 days following receipt of the Committee's decision. The Senior Associate Dean will render a decision within 30 days of receipt of the resident's appeal, which will be final.

A preliminary resident will not be allowed appeal of a simple majority decision by the Program Director and SJCC membership against advancement to categorical status in the MGH Residency in General Surgery.

SEXUAL HARASSMENT POLICY

Sexual harassment is defined by law as unwanted sexual advancements, physical contact, gestures, or verbal communication that is offensive or humiliating, or interferes with required tasks or career opportunities in all hospitals participating in the program.

The UIC-MGH Program has promulgated a policy on Sexual Harassment as follows:

- "The UIC-MGH Program in Surgery will not tolerate sexual harassment of students or employees and will take action to provide remedies when such harassment is discovered. Training Program environment must be free of sexual harassment in work and study."
- "In order to assure that the Program is free of sexual harassment, appropriate sanctions will be imposed on offenders in a case-by-case manner."
- "The SJCC will respond to every complaint of sexual harassment reported."

UIC-MGH Program strictly follows policies established by Advocate Health Care (Policy No 90.13.15). The Program is committed to providing an atmosphere of work and study free from the threat of sexual harassment of its patients, students, employees, and residents.

Recognition of:

Sexual harassment can occur between faculty-resident, resident-resident, resident-student, resident-patient, and resident-employee. Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual or gender-related nature constitute sexual harassment when:

- Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's rewards or status in employment or in an academic program. Coercion or bribery could be involved.
- Such conduct is sufficiently severe to create a hostile, humiliating, offensive environment or to interfere substantially with required tasks or career opportunities.
- Repetition of the unwelcome behavior would be viewed as sexual harassment. However, in the case of an unwelcome intimate touch, one occurrence can be sufficient to constitute sexual harassment.

Action

A resident or student who believes that he or she has been the subject of sexual harassment at any institution affiliated with the UIC-MGH Residency Program should report the incident to the Executive Program Director.

When a faculty member or other staff at an institution not governed by UIC-MGH Policies and Procedures is accused of sexually harassing a resident, the appropriate Program Director will consult with that institution's personnel office to ensure that institutional requirements are met.

Residents who themselves are accused of sexual harassment of patients, hospital employees, other residents, or students, will be subject to progressive discipline. The Executive Program Director will investigate and take action as appropriate in concert with the hospital's policies. Residents receiving discipline for sexual harassment may appeal through the prescribed residency grievance procedure.

UIC/MGH Residency in General Surgery Agreement Form

I have read the University of Illinois at Chicago – Metropolitan Group Hospitals Residency in Surgery Program Resident Policies and Procedures Manual, including but not limited to the Goals and Objectives, Clinical Training, Duty Hours Guidelines, Supervision, Team Work, Resident Promotion Process for the General Surgery Residency at UIC-MGH; I agree with and accept these as a prerequisite to my training in this program.

Signature

Date

Type or Print Name