



2017 - 2018 MANUAL

**RESIDENT POLICIES &
PROCEDURES**

CONTENTS

INTRODUCTION	5
PROGRAM ADMINISTRATION	5
THE EXECUTIVE DIRECTOR	6
THE SURGICAL JOINT CONFERENCE COMMITTEE (SJCC)	7
ASSISTANT/ASSOCIATE PROGRAM DIRECTOR	9
SITE PROGRAM DIRECTORS AT INTEGRATED HOSPITALS	9
CHIEF ADMINISTRATIVE RESIDENT	9
CHIEF RESIDENTS	10
ADMINISTRATIVE CENTRAL OFFICE OF THE UIC-MGH RESIDENCY PROGRAM	10
RESIDENTS CONTRACTS, BENEFITS AND OTHER HOUSEKEEPING DETAILS	11
THE RESIDENT AGREEMENT	11
<i>Salary</i>	11
<i>Medical Insurance</i> -	11
<i>Dental Insurance</i>	11
<i>Life Insurance</i>	11
<i>Disability Insurance</i> -	11
<i>Worker's Compensation - P.</i>	11
<i>Uniforms</i>	11
<i>On-Call Meals</i>	11
<i>Housing</i>	12
<i>Employee Assistance - Counseling</i>	12
NON-DISCRIMINATION STATEMENT	12
LICENSES	12
TEMPORARY LICENSES	12
PERMANENT LICENSES	13
CONTROLLED SUBSTANCE CERTIFICATES	13
PROFESSIONAL LIABILITY COVERAGE	13
RECORDS AND EMPLOYMENT VERIFICATIONS	13
TERMINAL CLEARANCE	13
CERTIFICATES OF TRAINING	14
ELECTIVE ROTATIONS OUTSIDE OF THE MGH RESIDENCY PROGRAM	14
STUDENT LOAN DEFERMENTS	14
PROOF OF CITIZENSHIP AND VISAS	14
J-1 VISAS	14
H1-B VISAS	14
IDENTIFICATION BADGES	14
LAB COATS AND SCRUBS	14
PARKING	15
MOONLIGHTING	15
GRIEVANCE POLICY	15
GRADUATION AND AWARDS	15
VACATIONS, SICK DAYS, LEAVE OF ABSENCE AND CONFERENCE TIME	15
VACATION	16
SICK DAYS	16

CONFERENCE TIME REIMBURSEMENT	16
TIME OFF FOR EXAMINATION	17
MATERNITY AND PATERNITY LEAVE.....	17
BEREAVEMENT LEAVE	17
DUTY HOUR GUIDELINES	17
DUTY HOUR MONITORING.....	19
SLEEP DEPRIVATION, FATIGUE AND EFFECTS ON PERFORMANCE	19
EDUCATION	19
GOALS AND OBJECTIVES	20
CLINICAL TRAINING.....	20
SIX CORE COMPETENCIES OF UI/MGH PROGRAM	21
PATIENT CARE.....	22
MEDICAL KNOWLEDGE.....	22
PRACTICE-BASED LEARNING AND IMPROVEMENT.....	22
INTERPERSONAL COMMUNICATION SKILLS	22
PROFESSIONALISM.....	22
SYSTEMS-BASED PRACTICE.....	22
FIRST YEAR RESIDENTS	23
<i>First Year Educational Objectives</i>	23
SECOND YEAR RESIDENTS.....	23
<i>Second Year Resident Educational Objectives</i>	24
THIRD YEAR RESIDENTS.....	24
<i>Third Year Resident Educational Objectives</i>	24
FOURTH YEAR RESIDENTS.....	25
<i>Fourth Year Resident Educational Objectives</i>	25
FIFTH YEAR RESIDENTS.....	25
<i>Fifth Year Resident Educational Objectives</i>	25
EDUCATIONAL CONFERENCES.....	26
MORNING REPORTS	26
MORBIDITY AND MORTALITY CONFERENCE.....	27
BASIC SCIENCE LECTURE SERIES	27
TRAUMA AND CRITICAL CARE CONFERENCE	27
SURGICAL LITERATURE REVIEW	27
PATHOLOGY CONFERENCE	27
TUMOR BOARD	27
JOURNAL CLUB.....	27
MULTI-INSTITUTIONAL CLINICAL CONFERENCE	28
GRAND ROUNDS	28
SCHOLARSHIP	29
CLINICAL RESEARCH	29
RESEARCH YEAR/CLINICAL AND/OR LABORATORY RESEARCH:	30
UIC/MGHBASIC SCIENCE RESEARCH LABORATORY	30
<i>Simulation Lab</i>	31
<i>Library</i>	34

MEMBERSHIP, CANDIDATE GROUP OF THE AMERICAN COLLEGE OF SURGEONS	34
RESIDENT RESEARCH PRESENTATIONS AND SURGERY REVIEW COURSES	34
TEACHING MEDICAL STUDENTS	34
TEACHING COLLEAGUES	34
RESIDENT RESPONSIBILITIES	34
COMMUNICATION	34
TEAM WORK	35
REFERRALS AND CONSULTATIONS	35
OUTPATIENT OFFICES/CLINICS.....	36
ORDERS	36
ROUNDS	36
OPERATING ROOM (OR) SCHEDULE.....	36
OPERATING ROOM (OR) ETIQUETTE	37
REQUIRED PRE-OPERATIVE PREPARATION	37
MEDICAL RECORDS	37
DAILY CHART DO'S AND DON'TS	37
PROGRESS NOTES	38
PRE-OPERATIVE NOTES.....	38
OPERATIVE NOTES.....	39
OPERATIVE REPORT DICTATION.....	39
CHARTS ON UNITS.....	39
GENERAL SUSPENSION POLICY.....	40
OPERATIVE EXPERIENCE LOG	40
NON-OPERATIVE EXPERIENCE RECORD	40
HANDOFF POLICY.....	40
<i>Purpose</i>	40
<i>Background</i>	40
STRUCTURE FOR HANDOFFS.....	40
<i>Application</i>	41
<i>Policy</i>	41
<i>Off-Service Handoffs</i>	41
QUALITY ASSURANCE/RISK MANAGEMENT	44
HIPPA	44
DRESS CODE	44
<i>Objective</i>	44
<i>Inside the Operating Room</i>	44
<i>Outside of the Operating Room</i>	44
ATTENDING RESPONSIBILITIES.....	45
POLICY OF NONCOMPLIANCE IN TIMELY RESIDENT	46
POLICY ON COMPLETION OF SCHOLARLY ACTIVITY FORMS	46
UIC-MGH REPRESENTATIVE TO THE JOINT CONFERENCE COMMITTEE (SJCC)	46
SUPERVISION	46
DEFINITIONS OF SUPERVISION.....	46
<i>Direct Supervision:</i>	46
<i>Indirect Supervision:</i>	46

<i>Oversight</i>	47
COMPETENCY EVALUATIONS	49
PURPOSE OF EVALUATION SYSTEM:.....	49
PROCESS OF EVALUATION SYSTEM.....	50
COMPETENCY EVALUATION TOOLS 2017-2018.....	52
EXAMINATIONS	54
AMERICAN BOARD OF SURGERY IN-TRAINING EXAMINATION (ABSITE)	54
<i>Monthly Examination on Basic Science</i>	56
DISCIPLINARY PROCEDURES	56
CAUSES FOR CORRECTIVE ACTION	57
<i>Such corrective action shall be as follows:</i>	57
APPEAL PROCESS.....	58
SEXUAL HARASSMENT POLICY	58
UIC/MGH RESIDENCY IN GENERAL SURGERY AGREEMENT FORM	60

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 through 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/
Presence Saint Francis Hospital of Evanston	http://www.presencehealth.org/residency-programs-general-surgery-presence-saint-francis-hospital
James Stroger Hospital of Cook County	http://www.cookcountyhhs.org/
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
- Associate 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 forty 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	847-723-7200
Mercy Hospital and Medical Center	2525 South Michigan Avenue Chicago, Illinois 60616	312-567-2074
Presence Saint Francis Hospital	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 six standing sub-committees whose functions are congruent with their titles.

1. Clinical Competency Committee (CCC)
 - C. Andrew Perrott, M. D. Chairman
 - Charles Gruner, M. D.
 - Lew Schwartz, M. D.
 - Nikolaos Dallas, M. D.
2. Bylaws, Rules and Regulations Committee
 - Matthew Hyser, M. D. – Chairman
 - Enrico Benedetti, M. D. – Ex-Officio
3. Research and Scholarly Activities Committee
 - Marek Rudnicki, M. D. – Chairman
 - John Park, M. D.
 - Ajay Maker, M. D.
 - John White, M. D.
 - Rami Lutfi, M. D.
4. Ways and Means Committee
 - Richard Fantus, M. D.—Chairman
 - John White, M. D.

5. Resident Committee

Chief Administrative Resident, PGY 5

PGY 4 Resident Representative

PGY 3 Resident Representative

PGY 2 Resident Representative

PGY 1 Resident Representative

6. Program Evaluation Committee (PEC)

Richard Fantus, M.D. Chairman

Lew Schwartz, M. D.

Matthew Hyser, M. D.

Marek Rudnicki, M. D.

Chief Administrative Resident

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.

The Clinical Competency Committee (CCC) responsibilities include:

1. Review all resident evaluations semi-annually
2. Prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME
3. Advise the program director regarding resident progress, including promotion, remediation, and dismissal.

The Program Evaluation Committee (PEC) responsibilities include:

1. Planning, developing, implementing, and evaluating educational activities of the program
2. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
3. Addressing areas of non-compliance with ACGME standards
4. Reviewing the program annually using evaluations of faculty, residents, and others

The program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). This will be completed at the annual program wide retreat.

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

- Resident performance and faculty development
- Graduate Performance: Qualifying and Certifying Examinations
- Residents and faculty will have the opportunity to evaluate the program confidentially and in writing at least annually
- The program will use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.
- Progress on the previous years action plans

- The PEC will prepare a written plan of action to document initiatives to improve performance in the above categories, as well as delineate how they will be measured and monitored.
- The action plan will be reviewed and approved by the teaching faculty and documented in meeting minutes.

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 duties 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.
- 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;

- Preparing the academic calendar for the year and the rotation schedules by May 30th under the guidance of the Associate program director by May 30th.
- 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. Eligible candidates must meet the following requirements:

- Senior 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

The Chief Resident of a service must conduct a face to face unhurried handoff to the Chief Resident who will be covering their patients in their absence.

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 - Per contract (Sample contract is given to all applicants)

Details available At GME office

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 in Barr Tower

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 residency program only sponsors J-1 visas, no exceptions will be made to this policy. 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 two 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 of excellence for exemplary leadership, dedication and clinical excellence.
- William C. Allen Award of Clinical excellence and Humanitarianism.
- 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
- Outstanding 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.
- Best 4th Year Resident Teaching Award.
- Best 5th Year Resident Teaching Award.

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

*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. Residents are not allowed to take vacation during all MGH trauma rotations. 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. Each Chief Resident is required to participate in City Wide Mock Oral exam the first or second Saturday of May. At Program director's discretion, additional residents might be obligated to participate in City-Wide Mock Oral Exams. Each resident **must** complete at least **48 weeks of full-time clinical activity** in each residency year to graduate from the program.

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 4 weeks (1 month) of vacation at one time.

At the PGY II, PGY III, IV and V levels, it is asked:

- that the vacation request form be submitted to the Residency Administrator four (4) weeks in advance of the requested leave date
- 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 (7 days) at a time
- that residents take only one vacation per rotation

Only one resident can be gone from each hospital at a given time. Requests for changes in vacation must be submitted to the Residency Administrator and 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 four (4) weeks in advance of the requested leave date with a leave request form. All forms must be submitted to the Residency Administrator. 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 and the Residency Administrator 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 all residents 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.
4. 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.
5. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
6. 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.

7. The Program Director will keep record of each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
8. PGY 1, 2 and 3 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.
9. 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
 - iii. Intensive Care Unit (ICU) from a lower level of care;
 - iv. iii. A patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;
 - v. 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.
10. 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.
11. 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.
12. 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).
13. 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 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”.

14. Residents are required log into the Residency Logging system every seven (7) days to document all duty hours & leave time. Residents are highly encouraged to log duty hours daily.

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. Representative 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. Representative 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

The Surgical Council on Resident Education (SCORE) was developed to standardize the national curriculum for general surgery education. The American Board of Surgery, the Surgery Residency Review Committee, the Association of Program Directors in Surgery and the American College of Surgeons have all endorsed “SCORE” as the official guide for all educational requirements in general surgery. We advocate that all residents and faculty use SCORE as the main resource for knowledge and education. SCORE contains PGY level adjusted modules on virtually all topics required for general surgery board examinations in the six core competencies. The website

(www.surgicalcore.org) also contains robust radiologic, video, topic specific journal articles, evidence based reviews used by the Canadian College of Surgeons and representative textbook chapters.

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.
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 professional
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 questions).

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.

A minimum of 250 operations by the end of the PGY-2 year for applicants who began residency in July 2014 or thereafter. The 250 cases can include procedures performed as operating surgeon or first assistant. Of the 250, at least 200 must be either in the defined categories, endoscopies, or e-codes*. A maximum of 50 non-defined category cases may be applied to this requirement. The 250 cases must be completed over 2 consecutive residency years, ending with the PGY-2 year

E-Codes: General surgery residents can use e-codes to receive ACGME case log credit for vascular surgical procedures. E-codes allow more than one resident to take credit for an arterial exposure and repair. The resident who accomplishes the exposure should add an "E" to the case ID for the system to allow credit for a second procedure on the same patient. The relevant CPT codes to use are: 35201 (Repair blood vessel, direct; neck); 35206 (upper extremity); 35216 (intra-thoracic without bypass); 35221 (intra-abdominal), and 35226 (lower extremity). Four categories are available under Trauma for residents to enter arterial exposures.

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 trainees 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.
2. The new defined category minimum numbers have been approved by the RRC-Surgery for implementation effective with residents graduating in the 2017-2018 academic year. The ABS will also change our training requirements as of 2017-2018 to be consistent with the RRC-Surgery: an increase in the minimum number of total operative procedures from 750 to 850; an increase in the minimum number of chief resident year operative procedures from 150 to 200; and an increase in the minimum number of cases in surgical critical care patient management from 25 to 40. New minimums for the residency program are the national 50th percentile in all defined categories.

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 13 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

Out of the 13 modules that must be completed; the following 7 are required: 101 103 106 107 111 114 115

Curriculum Modules are listed below:

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 on average twice a month.

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. Journal clubs are held once a month, 6-8 times a year for two hours with extensive resident/faculty interaction and built-in social time.

Format of the conduct of the Journal club at UIC/MGH program

Goal: Scholarship of up-to-date evidence in surgery

- Topics for the Journal clubs will be selected by the Administrative chief in the month of June prior to the beginning of the Academic year .this must be approved by the PD and the teaching faculty assigned.
- The journal clubs will follow the format of **Evidence Based Reviews in Surgery** offered each month in the SCORE portal. EBRS is provided by courtesy of the Canadian Association of General Surgeons and are presently recognized worldwide for their Academic excellence.
- Each of the topic oriented Journal club will be presented by three residents under direction of a PG5 and a faculty mentor. Senior resident presenting the journal club will seek input from the assigned faculty mentor at least 2 weeks prior.
- Each of the three presenters will have fixed time of 10 minutes to get their key points across and will be evaluated by all present with the UIC-MGH evaluation tool.
- Question and answer session will follow to not exceed 30 minutes.
- Timely attendance by at least 30 residents including all chiefs will be required with rare excused absence for patient emergency with the primary teaching faculty.
- Chiefs will be required to discuss and assess the excused and present residents over the subsequent week for the topic presented.
- Each journal club will continue to rotate among 4 hospitals and local site director/ program coordinator will be in charge of hosting the event.

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 our faculty and or 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 daily 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)**:

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)

1 pm – 2 pm Tumor Board, Multidisciplinary (GI or Breast every other week)

* 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 with the 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 clinical research, or a clinical series at local, regional, or national professional and scientific society meetings may be acceptable. Other academic achievements during residency e.g. PhD, MPH or MBA may be considered as scholarly activity at the sole discretion of the Program.

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. This research may involve a chart review of a particular clinical problem, reporting of a new operation or therapy, the impact of the surgical skills lab on operative technique, or surgical education. Regardless of the chosen subject, the resident should follow the proper steps necessary in carrying out quality 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, authoring a paper for presentation or publication, and solicitation of appropriate consultation and critique at each step of the process.

UIC/MGH Basic Science Research Laboratory

The Program supports an active basic science research laboratory at UIC under direction of Dr Ajay Maker, Surgical Oncologist. The lab is dedicated to translational research in immunology and cancer. UIC has a major commitment to research in multiple surgical areas. Therefore, it is expected that potential candidates for research year should focus upon the labs, skills, and expertise available at the University of Illinois.

Outcomes Research

There is an opportunity to participate in outcome research, using different institutional, state, national and professional society databases. That research has been very productive and allowed multiple presentations and publications at national and international levels. All projects can be completed during normal clinical rotations. Assistance is offered in with research methodology, project design, data collection, statistical analyses, etc. This research is based primarily at the Advocate Illinois Masonic Skills and Simulation Center and interested residents should contact Dr. Marek Rudnicki.

Research Year

One year of laboratory research training will be offered to PGY II Resident to be completed during the third year of his/her Residency.

a/ Purpose

The Research year and its structure has been established by the UIC/MGH Residency Program to allow residents, interested in academic career or research to obtain training in research methodology and participate in meaningful investigational projects that would create a sound background for his/her future career. Residents who are contemplating a career in academic surgery or wish to compete for top fellowships should consider a year of laboratory research. This year would be in addition to the five years of clinical training in General Surgery.

b/ Eligibility

One categorical resident from the PG II class will be offered a year in research. To be considered, the resident must be in good standing, demonstrate exceptional clinical performance and promise towards his/her career goals, and express a keen an interest in academics. The Program may also decide to assign a PGY II resident to the research year at its own discretion.

c/ Application process

The resident needs to identify the potential lab or research center where he/she would like to obtain the academic year of research training. Residents should choose a laboratory directed by an experienced investigator in a surgical discipline or in a basic science. During the second postgraduate year, a complete research proposal must be submitted before the December prior to the intended research year. Applications should be submitted to the UIC/MGH Scholarly Activity Committee. After evaluation of all applications, the Committee selects the most promising projects and a ranking list of is then submitted to the SJCC for a final decision. If no applications are received for the research year, the Executive Program Director may designate a candidate for this position.

d/ Funding

The resident must discuss funding for such research experience with potential research mentor or Principal Investigator and subsequently with the Scholarly Committee Chair and/or the MGH/UIC Residency Program Director. The resident is expected to search for external source of funding for incurred research expenses. SJCC understands, however, that challenges related to securing funding may emerge. In this case, the

UIC/MGH Program will provide funding for the resident working in the basic science laboratory at the University of Illinois at Chicago, under supervision of a researcher from/or collaborating with the UIC/MGH program. UIC/MGH research funding is provided in the form of grant encompassing a full year salary and benefits at the PGYIII level and does not include any additional funds.

Residents applying for Research Year at an institution outside University of Illinois/Metropolitan Group Hospitals will be expected to secure funds (including salary) from an external source. These residents will be given permission to continue with his/her proposed project only after funds have been secured. A well-funded research proposal from a given resident will get priority over another applicant for the funded grant from the UIC/MGH program.

e/ Obligations of Research Year resident

The resident participating in the research year must:

- Follow all standard policies applicable to every UIC/MGH resident in the program.
- Attend the Multi-Institutional Clinical Pathology Conferences every third Tuesday of each month and Thursday evening Journal Clubs (if laboratory is located in Chicago)
- Provide call coverage (as needed, per individual service request, maximum of one to three nights/month at MGH hospitals, but not more, presuming there is no call requirement with the research position at that institution of his/her research)
- Submit monthly progress reports of his/her research to Chairman of Scholarly Committee (co-signed by his Research Mentor or Principal Investigator)
- Consider additional clinical projects
- Take advantage of available spare time from clinical activities, deepen medical knowledge, and improve ABSITE score

f/ expected outcomes of research year

There must be a presentation at national/international level with at least two publications from this endeavor prior to graduation. The resident is also obligated to present results of his research at the UIC/MGH Annual Retreat in September, with his/her Mentor in attendance at his presentation.

It is expected that the successful resident would enter an academic career after completing his/her residency and fellowship.

g/ additional comments

The UIC/MGH Scholarly Committee, SJCC and The Program Director will follow closely entire application process and its policies as well as success of residents awarded with Research Grant. The Program reserves the right to make needed amendments according to ever-changing system of support and research funding.

SURGICAL SKILLS AND SIMULATION CENTER

A State-of-the-Art Surgical skills and Simulation Center is available to all Residents and Faculty at **Advocate Illinois Masonic Medical Center**. Access is 24/7 with a key card. The curriculum is designed to master basic skills in the Skills Lab prior to graded curriculum of utilizing these skills in the OR. The Masonic Surgery Skills Lab offers simulated laparoscopic procedures using the most recently updated SIMBIONIX Mentor II, central line placement modules, laparoscopic cholecystectomy and Nissen fundoplication models, as well as basic tissue incision/suturing models, and hand sewn bowel anastomosis models, etc. The residents can practice FLS (Fundamentals in Laparoscopic Surgery) training modules and take a pre-FLS test under supervision. There is also the opportunity to participate in different simulated clinical scenarios at Advocate Illinois Masonic Simulation Lab. Endoscopic skills can be practiced at **St. Francis Hospital** using a SIMBIONIX GI Endoscopy Simulator. This trainer is utilized to train residents in upper and lower endoscopy skill acquisition, and to

prepare them for human examinations as well as FES certification. Junior Residents will get well acquainted with basic FLS requirements. Details of Surgical Skills and Simulation Curriculum is presented on the following page.

Name:

Level of Training:

PGYI	Sharps Injury Prevention	AIMMC	
	Venipuncture	AIMMC	
	IV Line Placement	AIMMC	
	Arterial ABG Sampling	AIMMC	
	Foley Catheter Placement	AIMMC	
	NG Tube Placement	AIMMC	
	Skin Incision	AIMMC	
	Open Suturing	AIMMC	
	Open Knot Tying	AIMMC	
	Laparoscopic Camera Handling	AIMMC	
	Lap Mentor: Basic Skills	AIMMC	
	Lap Mentor: Appendectomy Tasks 1&2	AIMMC	
	Lap Mentor: Appendectomy Techniques 1-3	AIMMC	
	Lap Mentor: Appendectomy Case 1-3	AIMMC	
	Lap Mentor: LapChole Tasks 1-4	AIMMC	
	Lap Mentor: LapChole Cases 1&2	AIMMC	
	Central Line Simulation Course	AIMMC	
	Femoral Line Simulation Course	AIMMC	
	Laparoscopic Cholecystectomy Box Simulation	AIMMC	
	FES1 Completion	St.Francis	
PGYII	Lap Mentor: Basic Suturing	AIMMC	
	Lap Mentor: LapChole Case 3&4	AIMMC	
	Lap Mentor: LapChole Case 5&6	AIMMC	
	Lap Mentor: Appendectomy Case 4	AIMMC	
	Hand Sewn Intestinal Anastomosis	AIMMC	
	FES2 Completion	St.Francis	
PGYIII	Lap Mentor: Essential Tasks (FLS simulator)	AIMMC	
	Lap Mentor: Incisional Hernia Repair	AIMMC	
	FLS Junior	St.Francis	
	FES3 Completion	St.Francis	
PGYIV	Lap Mentor: Advanced Suturing Skills	AIMMC	
	Lap Mentor: Sigmoidectomy	AIMMC	
	Nissen Fundoplication Simulation	AIMMC	
	FES4 and FES5 Completion	St.Francis	
	Pre-FLS	AIMMC	
	FLS Certification	NMH	
	FES Certification	NMH	
PGYV	Chief Instructor	AIMMC	
	Lap Mentor: Gastric Bypass	AIMMC	

Approved _____

Marek Rudnicki, M.D.

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 resident's 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 attending in the Department of Surgery will not be delegated to residents, but will be done by direct communication between attending.

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 verbal orders are to be signed within 24 hours.
5. 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. Residents should avoid copying and pasting information into a patient's electronic medical record.
3. Don't use vague, non-descriptive terms.
4. 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.
5. Don't use the medical record to comment on other health-care professionals or their actions.
6. Don't wait until the end of your shift to chart.
7. Don't back date, add to or tamper with notes on the medical record. Corrections, additions, or deletions should be clearly identified and labeled as a late entry in the medical record. 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.
8. Don't use terms unless you know what they mean.
9. 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.

Up to date diagnosis list must be maintained in the Computer chart.

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 enter 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

Any Charts or computerized information of the patients are not to be removed from patient care units or hospital grounds 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 suspension of operative privileges. 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.

Handoff Policy

Purpose

The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring responsibility from one physician to another.

Background

In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Handoff refers to the orderly communication of essential information when transitions in the care of the patient are occurring. The information communicated during a handoff must be accurate and sufficiently complete in order to ensure the continuation of safe and effective patient care.

Structure for Handoffs

Face-to face verbal handoffs are the preferred method for all resident levels. The handoff process **MUST** allow the receiving physician to ask questions, so written handoff alone **is not acceptable**. The time chosen should be as convenient as possible for all participants. Handoffs for particularly complicated and sick patients may be done at the bedside and can include the patient and family when appropriate. The Chief Resident of a service must conduct a face to face unhurried

handoff to the Chief Resident who will be covering their patients in their absence.

Handoffs should follow a predictable structure.

- Time for questions must be a part of all handoffs.
- The “sick” patients should be noted.
- The “To Do” list should be explicitly discussed as should the rationale behind the tasks. This should also include specific details on immediately pre and post op patients.
- The “receiving” resident must have the opportunity to summarize and prioritize received information.
- Handoff length will vary based on the complexity and severity of illness for each patient as well as the extent of the resident’s prior knowledge of the patient.
- The Chief Resident of a service must conduct a face to face unhurried handoff to the Chief Resident who will be covering their patients in their absence.

Written information should include the following:

- Identifying information --name, location, medical record number
- Diagnosis and condition (particularly for patients with a poor or rapidly declining condition)
- Reviewed known abnormalities on exam
- Recent important events and clinical course of patient
- Updated problem list
- Medications and other pertinent treatments
- Pertinent laboratory and radiology results
- Pending issues, including laboratory and psychosocial, that the “receiving” resident will need to review.
- Important contact information (e.g., patient’s attending of record, family,)
- Overnight tasks to complete with time course and urgency, rationale and plan with potential results
- Anticipated problems/guidance including “if” and “then” statements with plan and rationale including IV access

Application

This policy applies to all residents in the MGH training program.

Policy

1. Handoffs must follow a standardized approach and include the opportunity to ask and respond to questions.
2. A handoff communicates essential information to facilitate continuity of care. A handoff must occur when any patient will experience a transition of care. Examples of transitions of care include:
 - The patient is assigned to a different physician within the facility, either temporarily (i.e. the physician will be off-duty overnight) or permanently (i.e. the physician is rotating to a new clinical assignment); or if the patient is transferred to another service.
3. The Chief Resident of a service must conduct a face to face unhurried handoff to the Chief Resident who will be covering their patients in their absence.

Off-Service Handoffs

Handoffs will occur at the end of each resident's rotation. Each resident leaving the service will handoff to the corresponding resident replacing them at a mutually agreed upon time and place. The senior residents will guide the overall process. Special emphasis should be placed on making this particular transition a comprehensive summary of each patient's hospitalization up to this point.



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

1. **Registration and completion (pass) USMLE Part III Examination before the January 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, written faculty feedback and required OSATS after each rotation. This is residents' responsibility.**
5. **Mandatory bi-annual performance evaluations with Dr. Maker. All PG level specific required milestones 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, Scholar and Role Model.
10. Outstanding Patient Care, Patient Safety 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 at each institution also participate in multiple hospital quality related committees and 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, list of current working diagnoses etc. All residents will be up-to-date with all safety module 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.

ATTENDING RESPONSIBILITIES

Policy of Noncompliance in timely resident evaluations by faculty

Continued noncompliance of faculty in completing resident evaluations for 12 weeks (delay of more than 2 weeks in two successive rotations) will lead to the notice to the chain of command, specifically site PD, site Chair of Surgery, site GME/DIO, and CEO with subsequent removal from the teaching faculty. If the non-compliant individual is in the chain of command, reporting will be made to the next higher level.

Policy on completion of Scholarly Activity forms

Scholarly activity reporting is an essential component of the yearly reporting requirement to the RRC on the current status of the program. To avoid an automatic site review and possible probation, the residency is required to submit a Scholarly Activity form for each attending on the teaching faculty. It is essential that this is filled out in a timely fashion. There will be a total of 3 reminders sent to each member of the teaching faculty. If these are ignored, there will be an automatic drop of the offending individual from the teaching faculty and resident coverage. Notice will be given to the site PD, site Chair of Surgery, GME/DIO and CEO. If the offender is site PD or Chair, the notification will go to the next higher level.

UIC – Metropolitan Group Hospitals (MGH) Representative to the Surgical Joint Conference Committee (SJCC) Expectations:

- Participation at monthly SJCC Meetings, variable locations
- SJCC meetings are followed by Journal Clubs, eight times a year
- Participation at weekly “Morbidity & Mortality” meetings, locally
- Participation in three “New applicant interview sessions” followed by a ranking session at Illinois Masonic Hospital annually. Interview sessions are on Saturdays and will take at least six hours of your time. Annual ranking session replaces one SJCC meeting
- Participate in assigned Skype interviews for preliminary residents from your location. Typically about two hours per year
- Compulsory attendance at the annual September retreat and graduation ceremony

- Attendance at the annual welcome luncheon for new residents, tie/scarf awarding for new PG3 residents, coat ceremony for chief residents in July. Annual year end party for all residents and faculty
- Provision of didactic lectures locally
- Participation in Monthly Mock oral – Grand rounds

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.

Who may supervise residents and fellows in the clinical environment?

Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed American Board of Medical Specialties (ABMS)-certified surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g. anesthesia critical care, critical care medicine, critical care pediatric, and surgical critical care physicians).

Who may provide direct supervision to PGY-1 residents?

Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or manage a particular clinical scenario and include more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined relationship outlined in the supervision policy may directly supervise PGY-1 residents

What does "indirectly with direct supervision immediately available mean?"

For certain tasks, supervision may be provided "indirectly" (supervising physician not physically present) by phone/text/e-mail discussion. When needed (as outlined by the programs supervision policy) or requested by the resident, the supervising physician must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes.

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)

What are examples of defined tasks for which PGY-1 residents may be supervised indirectly and examples of defined tasks for which PGY-1 residents should have direct supervision until competency is demonstrated?

Indirect supervision is allowed for:

Patient Management Competencies

1. 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
2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
3. evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
4. transfer of patients between hospital units or hospitals
5. discharge of patients from the hospital
6. interpretation of laboratory results

Procedural Competencies

1. performance of basic venous access procedures, including establishing intravenous access
2. placement and removal of nasogastric tubes and Foley catheters
3. arterial puncture for blood gases

Direct supervision is required until competency is demonstrated for:

Patient Management Competencies

1. initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
2. evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
3. evaluation and management of critically-ill patients, either immediately postoperatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
4. management of patients in cardiac or respiratory arrest (ACLS required)

Procedural Competencies

1. carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
2. repair of surgical incisions of the skin and soft tissues
3. repair of skin and soft tissue lacerations
4. excision of lesions of the skin and subcutaneous tissues
5. tube thoracostomy
6. paracentesis
7. endotracheal intubation
8. bedside debridement

What skills should members of the caregiver team have and how should these be ensured across the team?

All members of the caregiver team should be instructed in:

1. recognition of and sensitivity to the experience and competency of other team members
2. time management
3. prioritization of tasks as the dynamics of a patient's needs change
4. recognizing 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. 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. team development

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 attending 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.

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/promotion 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 Examinations and the Objective Structured Clinical Examination (OSCE, OSATS) as well as list of current Milestones for surgical procedures maintained on the UIC/MGH website . Failure on either of these 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 2017-2018

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	2. Monthly Basic Science Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	3. Pre-ABSITE Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	4. Step III	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	5. IRB certification (NIH certificate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
360° Degree Evaluation	6. Evaluation by Program coordinators					<input type="checkbox"/>	
	7. Evaluation by Critical Care Nurse	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	8. Evaluation by OR Nurse	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	9. Evaluation by Peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	10. Evaluation by Patient	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11. Evaluation by Student	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	12. Self-Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	13. Monthly Mock orals Evaluation by Juniors				<input type="checkbox"/>	<input type="checkbox"/>	
	14. Duty Hour compliance (by Seniors)	<input type="checkbox"/>				<input type="checkbox"/>	
	Evaluation by Faculty	15. ACGME Operative Log, content and Timely completion	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
16. Annual Mock Orals(Citywide)		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
17. Attendance (Lists)				<input type="checkbox"/>		<input type="checkbox"/>	
18. Basic Science Presentations			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19. Clinical Rotations		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Core Curriculum modules(UIC)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Critique for Monthly Mock Oral Exam, professional skills		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Daily Quizzes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Evaluations as Moderator (Leadership)					<input type="checkbox"/>	<input type="checkbox"/>	
24. Journal Club Presentations		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
25. Journal Reviews		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
26. M&M Review		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Medical Records		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
28. Monthly Grand Rounds & Presentations		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
29. Monthly Mock Orals		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
30. Operative Dictation Monitor		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
31. OSATS /OSCA (Level specific)		<input type="checkbox"/>	<input type="checkbox"/>				
32. Meditrek Self portfolio, Yearly update		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Daily learning Portfolios (Topic of the Day)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
34. Program Director Evaluation (Biennial)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Publications and Presentations		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
36. Curriculum Competency Committee		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. SCORE logs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
39. Structured Case Discussion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Rotation Exit Interviews		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
41. Duty hour compliance (by Program)		<input type="checkbox"/>				<input type="checkbox"/>	
42. Simulation Lab Competence (1-5)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
43. Out Patient Experience (CAMEO)							
44. ATLS (Adult trauma life support)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
45. PALS (Pediatric trauma life support)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
46. FLS (Fundamentals of Laparoscopic Surgery)	<input type="checkbox"/>	<input type="checkbox"/>					
47. FES (Fundamentals of endoscopic surgery)	<input type="checkbox"/>	<input type="checkbox"/>					

Competency Evaluation Tools to advance to 3rd year, 2017-2018

Promotion for PG2 to PG3 is an important Milestone in the residency and require achievement of following competencies.

KEY COMPETENCIES

PC = PATIENT CARE

PBLI= PRACTICE BASED LEARNING & IMPROVEMENT

PROF=PROFESSIONALISM

MK= MEDICAL KNOWLEDGE

I & CS= INTERPERSONAL & COMMUNICATION SKILLS

SBP = SYSTEMS BASED PRACTICE

			COMPETENCIES					
TOOLS			PC	MK	PBLI	I & CS	PROF	SBP
Written Exams	1.	ABSITE Scores Over 49 percentile at PG2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	2.	Monthly Basic Science Exam Over 80%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	3.	Pre-ABSITE Exam at least 50%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	4.	Step III and license Pass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	5.	IRB certification (NIH certificate) Completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
360° Evaluation	6.	Program Coordinators Level 2 or above					<input type="checkbox"/>	
	7.	Evaluation by Peers Level 2 or above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	8.	Evaluation by Patient 5 with Cameo	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	9.	Evaluation by Student 2 or above	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	10.	Self-Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11.	Monthly Mock orals Evaluation by Juniors				<input type="checkbox"/>	<input type="checkbox"/>	
	12.	Duty Hour compliance (by Seniors) Following guidelines	<input type="checkbox"/>				<input type="checkbox"/>	
Evaluation by Faculty	13.	ACGME Operative Log and timely completion Over 250 cases	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	14.	Attendance 100% in all mandatory conf. unless excused			<input type="checkbox"/>		<input type="checkbox"/>	
	15.	Basic Science Presentations Satisfactory performance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	16.	Clinical Rotations Level 2 in all milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	17.	Core Curriculum modules(UIC) 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	18.	Daily Quizzes Satisfactory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	19.	Journal Club Presentations Scholarly with clear PEARLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	20.	Journal Reviews Scholarly with clear PEARLS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
	21.	M&M Review QI Lessons learnt in Meditrek Portfolio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	22.	Medical Records Up-to-date	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	23.	Monthly Grand Rounds & Presentations Level 2	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
	24.	Operative Dictation Monitor At least 2 reviews in file	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	25.	OSATS/OSCA At least 2 of all PG2 level OSATS	<input type="checkbox"/>	<input type="checkbox"/>				
	26.	Meditrek Self Portfolio Updated yearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	27.	Daily learning Portfolios Timely and up to date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	28.	Program Director Evaluation (Biennial) Up-to-date with Milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	29.	Publications /Presentation At least one in press or presented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	30.	SJCC Evaluation at least Level 2 in all milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	31.	SCORE logs at least weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
	32.	Structured Case Discussion Satisfactory and improving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
	33.	Structured Case Presentations Satisfactory and improving	<input type="checkbox"/>					
	34.	Rotation Exit interviews Satisfactory and improving	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	35.	Duty hour compliance (by Program) 100%	<input type="checkbox"/>				<input type="checkbox"/>	
	36.	Simulation Lab competence (1-5) Up-to-date for PG2 level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
37.	Out Patient Experience (At least 5 CAMEO)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
38.	ATLS (Adult trauma life support) pass in file	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
39.	FLS (Fundamentals of Laparoscopic Surgery) Passed	<input type="checkbox"/>	<input type="checkbox"/>					
40.	FES (Fundamentals of endoscopic surgery) Passed	<input type="checkbox"/>	<input type="checkbox"/>					

EXAMINATIONS

American Board Of Surgery In-Training Examination (ABSITE)

Each year, all General Surgery residents take the American Board of Surgery In-Training Examination typically 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. Each of these must be signed off with in 24hours after the procedure to be valid. This is resident's responsibility.

2017 - 2018 OSATS/OSCE/OSCA MILESTONES

OSATS/OSCE/OSCA	#Required	Level	Institution	Rotation
ACLS	1	1	ALL	ALL
ANESTHESIA OSAT	1	1	SFH	ANESTHESIA
APPENDECTOMY, LAPAROSCOPIC	20	1-5	ALL	GS
APPENDECTOMY, OPEN	5	1-5	ALL	GS
ARTERIOVENOUS-FISTULA	10	3-5	ALL	VASCULAR
ATLS	1	1-2	AIMMC	BOOTCAMP
BREAST OSCA	1	3	MERCY	BREAST
CHEST TUBE INSERTION	10	1-5	ALL	ALL
COLONOSCOPY	5	1-5	ALGH, SFH	COLORECTAL
UPPER ENDOSCOPY	5	1-5	SFH/IMMC	
ENDOTRACHEAL INTUBATION	5	1-2	SFH	ANESTH
FAST	5	3	AIMMC/LGH	TRAUMA
ULTRASOUND GUIDED INTERNAL JUGULAR LINE INSERTION	10	1-2	SFH/IMMC	GS/TRAUMA
FLS SENIOR	1	4,5	ACS	GS
FLS JUNIOR	1	1-3	SFH	GS
FES (SIM)	1	1-3	SFH	GS
PERCUTAENOUS TRACHEOSTOMY	2	2-5	AIMMC/LGH	TRAUMA
PERCUTANEOUS ENDOSCOPIC GASTROSTOMY	2	3-5	SFH/IMMC	GS
INGUINAL HERNIA REPAIR, OPEN	20	1-5	ALL	GS
LAPAROSCOPIC CHOLECYSTECTOMY	20	3-5	ALL	GS
IRB (NIH Certificate)	1	1	AIMMC, LGH	GS
LAP COLECTOMY	10	3-5	LGH/IMMC	COLO-
SMALL BOWEL RESECTION_OPEN COLECTOMY	10	3-5	ALL	GS
LAPAROSCOPIC VENTRAL HERNIA	10	3-5	ALL	GS
OPEN VENTRAL HERNIA	5	2-5	ALL	
OPERATIVE REPORT DICTATION OSAT	20	1-5	ALL	ALL
PALS	1	4	LGH	PED
OUTPATIENT CLINICAL EXAMINATION(CAMEO)	20	1-5	ALL	GS/TRAUMA
SIMULATION LAB	1-5	1-5	AIMMC	24/7
PARATHYROIDECTOMY	2	5	AIMMC	
THYROIDECTOMY	2	5	AIMMC	GS
VENTILATOR MANAGEMENT	1	3,4	AIMMC	TRAUMA

Most of the OSATS and Outpatient clinical examinations (CAMEO) are structured at 3 different levels of difficulty. It is expected that senior residents will have at least 50% of their OSATS and CAMEO passed at the advanced level. (Maker 2013)

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.

MGH RESIDENT CERTIFICATIONS

BLS/ACLS – 2 year certification

- Required on or before PGY-1
- Required re-certification for PGY-3 to PGY-5

ATLS – 4 year certification

- All PGY-2 continuing in our program, should be completed by the end of PGY-2
- ATLS Orientation at LGH
- ATLS principles covered in Trauma orientation at LGH by Dr. Nikolich

PALS – 2 year certification

- Need to be certified by the end of PGY-3 (required for PGY-4 at LGH)

Effective as of academic year 2018-2019:

FLS certification examination to be taken during PGY-3 year

FES certification examination to be taken during PGY-4 year

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 and progression in this program.

Signature

Date

Type or Print Name