

GENERAL SURGERY RESIDENCY

PROGRAM MANUAL

2022-2023

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

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

Program Mission & Education Statement

AdventHealth Mission:

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

Program Mission:

Aspire for excellence, service with compassion, live with purpose

Education:

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

We commit to:

- Provide residents the opportunity to learn the fundamentals of basic science as applied to clinical surgery.
- Provide an experience in preoperative, operative, and postoperative care for patients in all areas of general surgery, including abdominal, alimentary, breast, vascular, endocrine, head & neck, pediatric surgery, skin & soft tissue, trauma and surgical critical care. We will also provide experience in cardiac and thoracic surgery, endoscopy, and transplant surgery among others.
- Provide general surgery training requirements following the American Board of surgery standards [Training Requirements | American Board of Surgery \(absurgery.org\)](https://www.absurgery.org)
 - A minimum of five years of progressive residency education satisfactorily completion ;
 - 16 months of training at no more than three residency programs;
 - At least 48 weeks of full time clinical activity in each residence a year ;
 - The 40 weeks maybe averaged over the first three years of residency for a total of 144 weeks required, and over the last two years, for a total of 96 weeks required.
 - At least 54 months of clinical surgical experience with increased levels over the five years, with no fewer than 42 months devoted to the content areas of general surgery.

The content areas are: Abdomen, Alimentary Tract, Head and neck, Skin Soft tissue and breast, Endocrine surgery, Surgical oncology, Trauma/burns, Surgical critical care, Vascular surgery, Pediatric surgery, and Transplantation.

- No more than six months assigned to nonclinical disciplines;
- No more than 12 months allocated to anyone surgical specialty ;
- The final two residency years (PGY 1–3) in the same program.
- Require residents to participate in research and provide teaching and mentoring of medical students.
- Provide residents with the opportunity to maintain continuity of care for their patients through time spent in the General Surgery office setting and on night call.
- Provide residents and faculty with educational goals and objectives at the beginning of each rotation, and the opportunity to complete peer evaluations on rotation.
- Provide each resident with a summative evaluation of performance on a semi-annual basis to show progression of expertise.
- Provide each resident with supervisory lines of responsibility, fair grievance policies, and resources for mental/emotional support.
- Provide a sufficient number of surgical cases, as determined by RRC standards of achievement, to advance operative skill and surgical judgment.
- Provide educational conferences on a weekly basis with a protected block of time designated on Friday mornings. These conferences will follow a set format with a developed curriculum. Attendance is mandatory and conference time is protected.
- Provide a working environment that is optimal for resident education and patient care. This environment will be safe and will provide adequate space for sleep, food, and lounge/study facilities.

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

Program Personnel:

Program Director

Scott W. Bloom, MD

Office: (407) 303-7399

Email: Scott.Bloom.MD@adventhealth.com

Residency Coordinator

Maria C. Cepero

Phone: (407) 303-7203

Email: Maria.Cepero@adventhealth.com

Program Faculty:

General Surgery Core Faculty: (407) 303-7399

Fahd Ali, MD

Christopher Anderson, MD

Scott W. Bloom, MD
Melissa Bagloo, MD
Jeffrey Chiu, MD
Alexandros Coutsoumpos, MD
Marcus Darrabie, MD
Sebastian De la Fuente, MD
Steve Eubanks, MD
Michael Gregg, MD
Joshua Goldberg, MD
Christopher Olukoga, MD
Bernadette Profeta, MD
Alric V. Simmonds, Jr., MD
Enrique Vega, MD
Jonah White, MD
Georg Wiese, MD
Alan Wladis, MD

Site Directors:

William Havron, MD – Orlando Health
Scott Magnuson, MD – AdventHealth Celebration
Michael McPhee, MD – AdventHealth Altamonte Springs
Enrique Vega, MD – AdventHealth Winter Park
Jeffrey Chiu, MD – AdventHealth East

Surgical Specialties

Breast Surgery

AHMG Breast Surgery at Altamonte Springs 407-303-5214

Thoracic Surgery:

AHMG Transplant Institute at Orlando 407-228-7373

Cardiac Surgery:

Critical Care Specialists 407-303-7283

Colorectal Surgery:

AHMG Colorectal Surgery at Orlando 407-303-2615

Endocrine:

AHMG Otolaryngology & Head and Neck 407-303-4120

Gastroenterology and Endoscopy:

AHMG Gastroenterology and Hematology at Orlando 407-303-1812

General Surgery (Private):

Surgical Associates of Central Florida 407-647-1331

General Surgery (East):

AHMG General Surgery at East 407-303-6691

General Surgery (Winter Park):

AHMG General Surgery at Winter Park 407-646-7931

Pediatric Surgery:

AHMG Pediatric Surgery at Orlando 407-303-7280

Plastic Surgery:

AHMG Plastic Surgery Hospitalists at Orlando **407-303-1373**

Surgical Critical Care:

AHMG General Surgery at Orlando **407-303-7399**

Surgical Oncology

AHMG General Surgery at Orlando **407-303-7399**

Transplant Surgery:

AHMG Transplant at Orlando **407-303-2474**

Trauma Surgery:

Orlando Health **321-841-8739**

Vascular Surgery:

AHMG Vascular Institute of Central Florida - Orlando **407-303-7250**

Accreditation Council of Graduate Medical Education (ACGME):

The ACGME is the accrediting body for the General Surgery residency program. They may be contacted with questions via their website at: www.acgme.org or by mail and phone at: 401 North Michigan Ave. Chicago, IL 60611, Phone (312) 755-5000, and fax (312) 755-7498.

Recruitment, Eligibility & Selection:

In conjunction with the [ACGME Resident Appointments; Eligibility Requirements](#), the AdventHealth Orlando GME offers clinical clerkships to medical students from affiliated medical schools and other accredited medical schools on a case by case basis.

Applicant Eligibility:**I. Medical School Diploma**

1. LCME (Liason Committee of Medical Education) and AOA graduates:
 - i. Eligible for Doctor of Medicine or Doctor of Osteopathy diploma without reservations
 - ii. Dean's Letter
 - iii. Letter from residency Program Director (if applicable)
 - iv. Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination) at first attempt.
 1. Transcript directly from the FSMB (Federation of State Medical Boards)
 - v. Acceptable explanation of any break in education (if applicable)
 - vi. Demonstrated written and spoken fluency in English language
 - vii. Proof of Citizenship or resident alien status as required by AdventHealth Orlando Human Resources

- viii. Internship requirement in Osteopathic Program [American Osteopathic Association | AOA](#) (required by Florida Board of Osteopathic Medicine and the American Osteopathic Association) or AOA-approved waiver

Please see the GME Manual for the Eligibility Resident/Fellow & Selection process (ACGME) Policy [GRADUATE MEDICAL EDUCATION MANUAL \(adventhealth.com\)](#)

II. ERAS Application

1. Completed application through ERAS (Electronic Residency Application Service), through the AAMC (American Association of Medical Colleges), and participation in the NRMP (National Resident Match Program) match.
 - i. Online application
 - ii. Personal statement
 - iii. CV
 - iv. Transcript
 - v. Dean's letter
 - vi. Three letters of recommendation by surgeons
 - vii. USMLE/COMLEX scores
 - viii. Photograph

III. Candidates that are selected to the next level for consideration for interviews, will be asked to submit a 2-minute “handshake” video highlighting themselves, their application or their interest in general surgery and our program. This is to assist the program in our holistic evaluation of each applicant. That video will be reviewed by 3 committee members and evaluated independently by each member using the following criteria:

1. Quality of Video
2. Communication
3. Content

Final scores of reviewers will be considered by the Applicant Review Committee. Committee will decide in extending an interview or not.

*per NRMP request, the program trains the reviewers, committee members, and core faculty on Bias to assure unbiased views when evaluating candidates.

IV. Reasons for Ineligibility:

- A. Applicant does not demonstrate sufficient commitment to the specialty of General Surgery, included but not limited to:
 - 1. No advanced-level electives during medical school
 - 2. No letters of support from surgeons
- B. Applicant did not present favorable impression to faculty, resident physicians and/or residency coordinator during elective time or interview process at AdventHealth Orlando.
- C. Quality of interaction during preliminary contact with staff suggests incompatibility with the mission and values of AdventHealth Orlando
- D. Quality of personal statement (content, typographical and grammatical errors), including no obvious commitment to General Surgery
- E. Limited verbal and written English skills, including the inability to write clearly and legibly

V. Non-eligible candidates may not be offered an interview or accepted into AdventHealth Orlando Graduate Medical Education residencies (see exception in #IX).

VI. Applicants must have successfully participated in formal clinical training, medical school, residency training, or full-time clinical practice within the last 24 months (from date of application to the residency program).

VII. The Candidate files are reviewed and screened by the selection committee, Program Director, chairman and residency coordinator. The following criteria are utilized:

- 1. Personal statement
- 2. Transcript
- 3. Dean's Letter
- 4. USMLE scores
- 5. Letters of recommendation
- 6. Input from resident interaction with applicant
- 7. Hobbies
- 8. 2-minute video "handshake video: and committee member evaluation results

- VIII. For this academic year, we are going to maintain the Virtual format for our interview season, a series of virtual interviews with the AdventHealth Orlando General Surgery program is required for applicants who wish to be considered for a residency position. The interview process is conducted as follows:
1. The applicant reports to the first virtual meeting at 7:00 AM.
 2. The applicant is interviewed by: The Program Director, Chairman, select General Surgery faculty, subspecialty preceptors and select current residents.
 3. The applicant attends a meet & greet with a group of our residents.
- IX. Each interviewer completes an evaluation form accessing the following areas:
1. Grit
 2. Leadership & Team player
 3. Integrity
 4. Professionalism
- X. The Program Director may permit the waiver of one or more of these requirements under special circumstances.
- XI. All applicants who have been interviewed will be reviewed for ranking by the selection committee, made up of faculty and resident leaders in early February.
- XII. The Program Director may contact applicants to answer any questions. The rank order list will be compiled and submitted to the NRMP. The Match list is at the discretion of the Program Director and is confidential.

Examinations, Licensure & Certification:

USMLE:

All interns must complete USMLE Step 3 prior to the end of the PGY-1 year. We urge you to take USMLE Step 3 as soon as possible. The cost of application is paid by the program for your first attempt.

To apply for USMLE Step 3, information and the application can be obtained at the following website.

[FSMB | USMLE Step 3](#)

Or: (817) 868-4041

Once you have submitted your application and have scheduled your exam date, please let the Residency Coordinator, chief residents, and rotation preceptor(s) know so that necessary departments can adjust coverage for your approved absence. Taking the exam means two days away from your rotation.

Licensure:

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

PGY-2:

Within three (3) months of completion of USMLE Step 3, the resident will be expected to complete the application for full medical licensure in the State of Florida. The fee for this will be paid by the Program. Information for licensure can be obtained from the Residency Coordinator or via the Department of Health website. Make sure to read directions carefully to expedite your application (EBAHR, National Practitioner Data Bank Self Query, AMA Profile, fingerprint), from the Florida board of Medicine website.

License Applicants: [Florida Board of Medicine- Healthcare Practitioner Licensing and Regulation \(flboardofmedicine.gov\)](http://flboardofmedicine.gov)

Certifications:

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

FLS: [Fundamentals of Laparoscopic Surgery \(flsprogram.org\)](http://flsprogram.org)

FES: [SAGES - Fundamentals of Endoscopic Surgery - Fundamentals of Endoscopic Surgery \(fesprogram.org\)](http://fesprogram.org)

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

American Board of Surgery Requirements:

- The American Board of Surgery has defined guidelines for certification eligibility.

Those guidelines can be found at [Training Requirements | American Board of Surgery \(absurgery.org\)](https://www.absurgery.org). The AdventHealth Orlando General Surgery Residency Program adhere to those specifications for residency training.

The Board of Surgery also requires the residents complete **at least 250 operations by the beginning of PGY3 year**. This requirement can also be found in the American Board of Surgery Training Requirements.

- **Procedure logs:** The ACGME mandated log of **operations will prove** to be invaluable in preparing your American Board of Surgery (ABS) application and is essential for our residency accreditation. The Case Log System utilizes Common Procedural Terminology (CPT) codes. The five-character codes and descriptions included in the system are obtained from CPT, copyright 2021, by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Each resident is responsible for keeping an accurate log of all procedures performed during their residency.

ACGME Website: [ACGME - Login](https://www.acgme.org)

The program will provide each resident with an ID and password. Procedures and cases should be logged as soon as completed and are required to be entered prior to Wednesday of every week so that the Program Director can assure adequate and equivalent experience in the index cases. This will allow prompt and accurate submission to the American Board of Surgery as a preface to the qualifying examination. The RRC requires a minimum number of cases [Case Log Information \(acgme.org\)](https://www.acgme.org) which can be found below.

RRC Minimum Cases: (Defined Categories)

Category	Minimum
Skin, Soft Tissue	25
Breast	40
Mastectomy	5
Axilla	5
Head and Neck	25
Alimentary Tract	180
Esophagus	5
Stomach	15
Small Intestine	25
Large Intestine	40
Appendix	40
Anorectal	20
Abdominal	250
Biliary	85
Hernia	85
Liver	5
Pancreas	5
Vascular	50
Access	10
Anastomosis, Repair, or Endarterectomy	10
Endocrine	15
Thyroid or Parathyroid	10
Operative Trauma	10
Non-operative Trauma	40
Resuscitations as Team Leader	10
Thoracic Surgery	20
Thoracotomy	5
Pediatric Surgery	20
Plastic Surgery	10
Surgical Critical Care	40
Laparoscopic Basic	100
Endoscopy	85
Upper Endoscopy	35
Colonoscopy	50
Laparoscopic Complex	75
Total Major Cases	850
Chief Year Major Cases	200
Teaching Assistant Cases	25

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

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

ABSITE: All residents will take the annual American Board of Surgery In-Training Examination (ABSITE) each academic year. The examination is customarily given within the last weeks of January (date to be announced annually). This examination is most helpful in the resident's and the faculty's assessment of clinical and basic science knowledge and allows the resident to be able to compare his own academic progress with his peers on a nationwide basis. Although performance on this exam alone is not the sole determinant in promotion and advancement in the Residency, it is a helpful tool in assessing that the resident will be able to pass the ABS Qualifying Exam. Residents are expected to score above the 50th percentile for the appropriate year in training. In the event a resident score at or below the 50th percentile, the Academic Performance Improvement Policy and a Corrective Action Plan, in conjunction with the residents attending mentor, will be put in place.

Academic Performance Improvement Policy

- Out of compliance = Below 50thtile

- Resident is to consider an ABSITE prep course
 - Mandated monthly meetings with the Program Director

- Academic remediation = Under 35thtile

- PGY 2/3 residents that score <35th %ile will be mandated to utilize the following year's CME monies to attend an ABSITE review course
 - Residents that score less than 35thile on the annual In-Training exam (ABSITE) will be placed on academic remediation
 - Development of a Personal Learning Plan
 - Between 10-35 %ile will mandate biweekly meetings with their attending mentor to review PLP
 - < 10th %ile will mandate weekly meetings with their attending mentor to review PLP
 - Mandated monthly meetings with the Program Director
 - Noncompliance with remediation plan will result in academic probation

- Probation = Under 10thtile

- PGY 2/3 residents that score <35th %ile will be mandated to utilize the following year's CME monies to attend an ABSITE review course
 - Residents that score less than 35thile on the annual In-Training exam (ABSITE) will be placed on academic remediation
 - Development of a Personal Learning Plan
 - Between 10-35 %ile will mandate biweekly meetings with their attending mentor to review PLP
 - < 10th %ile will mandate weekly meetings with their attending mentor to review PLP
 - Mandated monthly meetings with the Program Director
 - Noncompliance with probation plan may result in non-renewal or non-promotion.

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

Program Curriculum:

The curriculum of the Program is consistent with AdventHealth's mission, the needs of the Central Florida community that we serve, the desired capabilities of its graduates, and will provide experience in all areas mandated by the Residency Review Committee. For any requirements not available at AdventHealth Orlando, the Program will make such arrangements as necessary in order to provide the resident with the requisite experience. If such arrangements mandate rotations in remote sites, the Program will provide living facilities at its expense. This does not apply to rotations in the greater Orlando area.

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

Program Goals and Objectives:

These competency-based goals and objectives are for each educational experience designed to promote progress on a trajectory to autonomous practice.

ACGME Clinical Competencies

1. Professionalism:

Residents must demonstrate a commitment to professionalism and adherence to ethical principles.

Residents must demonstrate competence in:

- compassion, integrity, and respect for others
- responsiveness to patient needs that supersedes self interest
- respect for patient privacy and autonomy accountability to patients, society, and the profession
- respect and responsiveness to diverse patient populations, including but not limited to diversity and gender, age, culture, race, religion, disabilities, national origin, socio economic status, and sexual orientation
- ability to recognize and develop a plan to for one's own personal and professional well-being
- appropriately disclosing and addressing conflict or duality of interest

2. Patient Care and Procedural Skills:

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

Residents must develop competence in and execute comprehensive patient care plans appropriate for their residence level .

Resident must demonstrate a commitment to continuity of comprehensive patient care.

Resident must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

Residents must demonstrate competence and manual dexterity appropriate for their level.

Residents must demonstrate competence and technical and non technical skills sufficient to safely perform essential slash core procedures with an appropriate level of independence based um the individual residence required level of supervision.

3. **Medical Knowledge:**

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

Residents must demonstrate competence in D critical evaluation and demonstration of knowledge of pertinent scientific information

Residents must demonstrate knowledge of the fundamentals of basic science as applied to clinical surgery and

Residents must participate in an educational program that includes: applied surgical autonomy and surgical pathology; the elements of wound healing; Hemostasis, shock and circulatory Physiology; Surgical infection; Hematologic disorders, immunobiology and transplantation; oncology; surgical endo chronology; surgical nutrition, fluid and electrolyte balance ; and the metabolic response to injury, including burns

Residents must demonstrate knowledge of the principles of immunology, immunosuppression, and diminishment of general surgical conditions arising and transplant patients

4. **Practice-based Learning and Improvement**

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

Residents must demonstrate competence in :

Identifying strengths, deficiencies, and limits and one's knowledge and expertise

Setting learning and improvement goals

identifying and performing appropriate learning activities

systematic analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement

incorporating feedback and formative evaluation into daily practice

locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems

using information technology to optimize learning

Residents must participate in mortality and morbidity conference to evaluate and analyze patient care outcomes

Residents materialize in evidence-based approach to patient care

5. Interpersonal and Communication Skills:

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

Residents must demonstrate competence in:

Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socio economic and cultural backgrounds

communicating effectively with physicians, other health professionals, and health related agencies

working effectively as a member or leader of a health care team or other professional group

educating patients, families, students, residents, and other health professionals

acting in a consultative role to other physicians and health professionals

maintaining comprehensive, timely, and legible medical records, if applicable.

Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

6. **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

Residents must demonstrate competence in:

Working effectively in various healthcare delivery settings and systems relevant to their clinical specialty

coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty

advocating for quality patient care and optimal patient care systems

working in interprofessional teams to enhance patient safety and improve patient care quality

participating in identifying system errors and implementing potential systems solutions

incorporating considerations of value, cost awareness, delivery and payment, and risk benefit analysis in patient end or population based care as appropriate

understanding healthcare finances and his impact on individual patients health decisions

practicing high quality, cost effective patient care

demonstrating knowledge of risk benefit analysis

demonstrating an understanding of the role of different specialties and other health care professionals in overall patient management, and actively participating in interprofessional and multi specialty teams

Residents must learn to advocate for patients within the health care system to achieve their patients and families care goals, including, when appropriate, end of life goals.

Research and Scholarly Activity Requirements:

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

The residents will be required to complete research projects as outlined below as requirements by the Program. Research projects are reviewed semi annually with the Program Director

PROCESS:

This requirement will be accomplished through one-on-one mentoring by faculty of choice and/or teamwork with peers. The resident will also be responsible for the completion of certain tasks with the guidance from faculty and the GME Research Department.

GOAL:

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

REQUIREMENTS:

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

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

EVALUATION:

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

RECOMMENDED READING/RESOURCES:

- AdventHealth Orlando Institutional Review Board Handbook.
- AdventHealth Orlando Office of Research Administration Handbook.
- IRB NET user's manual.
- International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals: Writing and editing for biomedical publication www.icmje.org.
- Outlines and articles on how to write case reports, scientific papers, and preparation for presentations are available through the Research Coordinator.

GME RESEARCH TRAINING GUIDELINES

Before engaging in human subject's research at AdventHealth, all members of a research team must comply with the following requirements:

1. Register on IRBnet.org and affiliate with AdventHealth

2. Complete the required training of the Collaborative Institutional Training Initiative Program (CITI training). Complete the following courses:

- **REQUIRED:** "Basic Biomedical" or "Basic Social/Behavioral" depending on the type of research that you will be conducting.
 - **Biomedical:** Research that involves any drugs/devices, medical record data, physical activity, venipuncture, radiation, or the collection of biological samples, or physiological statistics.
 - **Social/Behavioral:** Research involving surveys, interviews, observation, focus groups, etc.
 - If the project is both social/behavioral and biomedical in nature, the biomedical course must be completed.
- **REQUIRED:** Health Information Privacy and Security (HIPS).
- Good Clinical Practice (GCP) – **REQUIRED** for research personnel conducting research subject to FDA oversight or otherwise subject to ICH-GCP

* Refresher courses must be completed every 3 years to maintain your education credentials with the AdventHealth IRB.

*Link the CITI and IRBNet accounts

3. Complete Conflict of Interest (COI) Disclosure and Training:

- Fill the COI Disclosure forms (must be completed yearly)
 - Conflict of Interest Disclosure
 - Significant Financial Disclosure (if applicable)
- Complete the CFD Research Conflict of Interest Training in ALN (must be completed at least every 4 years)

4. Complete Florence Training and Attestation Form. Florence is an electronic binder system used to store and manage study documents. This requirement includes:

- Completing a training module
- Signing an attestation form to confirm training

For detailed instructions to complete these requirements, use the following link:

<https://ahsonline.sharepoint.com/sites/SYS-ResearchServices/SitePages/Research-Credentialing.aspx>

Please note that depending on the specific study, additional training and steps may be required

*** Please contact the GME research support team at CFD-S.GME.Research@AdventHealth.com for further assistance and support***

IMPORTANT REMINDERS FOR RESEARCH AND OTHER SCHOLARLY ACTIVITIES

- Research studies, QI/QA projects and case reports are subjected to different processes and regulations. In order to avoid non-compliance incidents, please contact the GME research support team **early** in the project development process to receive the appropriate guidance.
- Please contact the GME research support team for guidance **before** any project-related data is accessed or collected. This includes accessing existing data to assess project feasibility. Not following the appropriate steps make cause a non-compliance incident.

- Any changes to an approved study, including addition or removal of research study team members, **must** be reviewed and approved by the IRB. Please contact the GME research support team **before** any changes are implemented.
- Submission of required documents to the IRB will be done **only** by the GME research support team. Please do not make any submissions yourself.

Conferences and Teaching Rounds:

Weekly conferences will be held on Friday mornings from 7:00 am to 10:30am and residents will be given dedicated time to attend. Attendance will be monitored via New Innovations QR code and duty hour logging and is mandatory unless by exception made from the Program Director. The conferences are comprised of Basic Science, Grand Rounds, Mortality and Morbidity (M & M), Cleveland Clinic monthly series, and practice questions. M&M conferences will be presented by residents at all levels. Invited guest speakers will also be utilized. A variety of simulation labs are scheduled for residents during this weekly conference which include: Robotic Training, Quarterly FLS Simulation Lab, Hemostasis Lab, Wet Labs and Dry Labs. The simulation labs are held at AdventHealth Orlando Celebration Health and AdventHealth Orlando Nicholson Center.

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

Evaluations and Process:

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

ACGME Milestones:

The Milestones are used in a semi-annual review of resident performance, and then report to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME Competencies organized in a developmental framework. The narrative descriptions are targets for resident performance throughout their educational program.

Milestones are arranged into levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert resident in the specialty or subspecialty. For each reporting period, the Clinical Competency Committee will review the completed evaluations to select the milestone levels that best describe

each learner's current performance, abilities, and attributes for each subcompetency.

These levels *do not* correspond with post-graduate year of education. Depending on previous experience, a junior resident may achieve higher levels early in his/her educational program just as a senior resident may be at a lower level later in his/her educational program. There is no predetermined timing for a resident to attain any particular level. Residents may also regress in achievement of their milestones. This may happen for many reasons, such as over scoring in a previous review, a disjointed experience in a particular procedure, or a significant act by the resident.

ACGME Milestones can be found at [Surgery \(acgme.org\)](https://www.acgme.org)

Resident Performance:

ACGME requires a Clinical Competency Committee (CCC) comprised of faculty members, peers, self, and other professional staff members to determine each resident's progress on achievement of surgery milestones and advise the Program Director regarding each resident's progress.

A few of the tools that the CCC uses to review and determine the resident's progression during training are as follows:

- Evaluation results (i.e. End of Rotation, peer evaluations, 360 patient evaluations, etc.)
- Truelearn activity report
- Mock examination results
- Case log dashboard compliance
- Work Hour compliance
- Simulation
- Direct observation
- Complexity Assessment and Monitoring to Ensure Optimal Outcome (CAMEO) and Operative Performance Rating Systems (OPRS)
- In-Training Examination
- Morbidity and mortality conference
- Medical Record (chart) audit
- Reflection
- Research
- Multisource feedback
- Compliance with deadlines or timelines

The CCC Milestone results are then reviewed, discussed and finalized by the CCC head and Program Director. Results are then submitted to ACGME and New Innovations.

Residents will be evaluated by the faculty/preceptor at the end of each rotation. Evaluations will be reviewed periodically, by the faculty and Program Director. Faculty rotation evaluations, Truelearn activity, and results from written examinations will be utilized in determining the progress of the resident. In addition, evaluations shall also include the American Board of Surgery operative and clinical assessment tools and, the Flexible Endoscopy Curriculum Evaluations – GAGES.

In the event a resident's performance is suffering, the CCC and Program Director can initiate the Academic Performance Improvement Policy. In initiating the policy, the assigned faculty mentor would work with the resident in completing the necessary steps. Any additional remedial determinations would be decided by the Program Director and when indicated, individuals may be placed on remediation, probation or suspended in conjunction with review of the Program Evaluation Committee (PEC). Evaluations will be kept in the resident's personnel file and will be accessible to the resident through the Surgical Residency office under supervision. Please see "Resident File Access". Seniors on academic remediation will attend a board review course earlier in the year with the opportunity to repeat the course if the resident does not improve their performance.

Resident Evaluation of Faculty Teaching:

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

Other Evaluations of Residents:

Residents will be evaluated by means of a 360-degree approach which will include evaluations by peers (senior residents), nurses, and patients. The results of these evaluations will be made available to the resident to review through New Innovations.

Confidentiality Process:

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

Faculty Mentor:

Each resident will be assigned a faculty mentor at the beginning of residency training. The faculty member will be considered a mentor of the resident and will be expected to meet with the resident at a minimum of quarterly. These meetings will be arranged by the residents throughout the year. However, all our faculty members are eager to be of assistance to residents, and residents should feel free to discuss problems, situations, ideas, etc. with the faculty at any time.

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

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

The mentor/advisor shall:

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

In the event the designated resident falls into the academic program improvement qualifications, the mentor and mentee would be required to follow the academic program improvement policy and report the correction plan and non-confidential updates to the Program Director accordingly.

Supervision Policy:

A resident's privilege of conditional independence, progressive authority and responsibility, and supervisory roles in patient care is delegated by the Program Director and faculty members following the ACGME guidelines on Supervision . The Program Director evaluates the resident's abilities based on specific criteria that are guided by the Milestones.

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

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

Direct Supervision:

The supervising physician is physically present with the resident and patient during key portions of the patient interaction

Direct Supervision – Can be achieved:

- 1) The supervising physician is physically present with the resident during the key portions of the patient interaction
- 2) The supervising physician is not physically present within the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

Indirect Supervision – Can be achieved:

- 1) The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

Oversight:

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

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

The attending surgeon is expected to:

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

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

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

Establishing Competency

A. Patient Management Competencies:

1. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
 - a. Interns will obtain ATLS certification fall of the intern year.
 - b. Supervision by in-house senior resident until competency achieved
 - c. Competency
 - i. Observed examination with appropriate management plan and sign off through new innovations by observer
 - ii. 20 patients with 5 by an attending observer
2. Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
 - a. Interns will be ACLS certified by July 1 of the intern year.
 - b. Completion of ACS Fundamentals of Surgery Curriculum by July 1 of the intern year.
 - c. Competency
 - i. Observed examination with appropriate management plan formulated and discussed prior to implementation with subsequent sign off through new innovations by observer
 - ii. 10 patients with 3 by an attending observer

3. Evaluation and management of critically-ill patients, either immediately post-operatively or in the ICU, including the conduct of monitoring, and orders for medications, testing, and other treatments
 - a. Interns will be ACLS certified by July 1 of the intern year.
 - b. Completion of ACS Fundamentals of Surgery Curriculum by July 1 of the intern year.
 - c. Competency
 - i. Observed examination with appropriate management plan formulated and discussed prior to implementation with subsequent sign off through new innovations by observer
 - ii. 10 patients with 3 by an attending observer
 - iii. ICU orders must be cosigned by a senior resident or attending until completion of 2nd year ICU rotation

4. Management of patients in cardiac or respiratory arrest (ACLS required)
 - a. Interns will be ACLS certified by July 1 of the intern year.
 - b. Competency
 - i. Observed management of cardiac or respiratory arrest
 - ii. 5 patients with an attending observer
 - iii. Management cannot occur until completion of 2nd year ICU rotation
 - iv. They must also complete the Simulation arrest curriculum and experience

B. Procedural Competencies:

1. Carry-out of advanced vascular access procedures, including central venous catheterizations, temporary dialysis access, and arterial cannulation
 - a. 5 observed central venous access completions on simulation model prior to July 1 of the intern year.
 - b. Competency
 - i. 10 observed and completed vascular access procedures with minimum of 2 each IJ, subclavian and femoral in overall total.
 1. These must be recorded and signed off through new innovations by observer (senior or mid-level resident or attending)
 2. An attending must sign off on 1 each of IJ, subclavian and femoral prior to competency achieved.
 3. An intern should not place a central line on their own.

2. Repair of surgical incisions of the skin and soft tissues

- a. Completion of suture and knot tying skills lab prior to July 1 of the intern year.
 - b. Competency
 - i. Observed skin closure and sign off through new innovations by observer (senior or mid-level resident or attending)
 - ii. 10 patients with a minimum of 3 by an attending observer
3. Repair of skin and soft tissue lacerations
- a. Completion of suture and knot tying skills lab prior to July 1 of the intern year.
 - b. Competency
 - i. Competency achieved in Part B Number 2
 - ii. Observed laceration repair and sign off through new innovations by observer (senior or mid-level resident or attending)
 - iii. 5 patients with a minimum of 1 by an attending observer
4. Excision of lesions of the skin and subcutaneous tissues
- a. Completion of suture and knot tying skills lab prior to July 1 of the intern year.
 - b. Competency
 - i. Observed excision and sign off through new innovations by observer (senior or mid-level resident or attending)
 - ii. 10 patients with a minimum of 3 by an attending observer
5. Tube thoracostomy
- a. 2 observed thoracostomy completions on simulation model prior to July 1 of the intern year.
 - b. Competency
 - i. Observed tube thoracostomy placement and sign off through new innovations by observer (senior or mid-level resident or attending)
 - ii. 5 patients with a minimum of 2 by an attending observer
6. Paracentesis
- a. Competency
 - i. Observed paracentesis and sign off through new innovations by attending observer
 - ii. 3 patients by an attending observer
7. Endotracheal intubation
- a. 3 observed intubations on simulation model prior to July 1 of the intern year.

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

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

Level of Training Privileges

PGY- 1:

Under the direction of a mid-level resident or higher, the PGY-1 resident can bring patients into the operating room for induction of anesthesia; can insert IV lines and Foley catheters; can write admission orders; pre- and post-op orders and notes; can dictate discharge summaries, H&P's and operative notes; can write orders for restraints. Under supervision, the PGY-1 resident may provide in-hospital care, assist in surgery, and perform certain operations at the discretion of the attending surgeon. She/he may place arterial lines, central lines, chest tubes, Swan-Ganz catheters under the direct supervision of a senior or mid-level (\geq PGY- 3) resident. Eventually these procedures may be done under indirect supervision after having been directly supervised and certified by an attending. (see above)

PGY- 2:

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

PGY- 3:

The PGY- 3 resident can function as a senior resident on selected services under the direction of the chief resident and attending surgeon. The PGY- 3 resident can initiate

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

PGY- 4, 5 (Chief Resident):

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

Evaluation of Patients in the Emergency Department:

PGY-1 residents must be directly supervised by a more senior (\geq PGY-3) resident or faculty, until deemed competent per the supervision policy. PGY-2 residents may evaluate patients in the ER under the indirect supervision of a more senior (\geq PGY-3) resident. PGY-4 & 5 residents may evaluate patients in the ER under the indirect supervision of the attending surgeon. If requested by the attending in the ER, the senior resident must consult with the attending surgeon on call prior discharging a patient from the emergency department. The attending physician must also be informed about all patients admitted to their service from the ER.

Change in Patient Status:

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

Chief Resident Duties:

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

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

Patient Charting Responsibilities:

Inpatient Charting:

See the “Health Information Management” section of the AdventHealth Orlando Graduate Medical Education policy manual.

Outpatient Charting:

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

Delinquent Charts:

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

Medical Records:

See also the GME Manual section on “Health Information Management.” [AdventHealth Graduate Medical Education | AdventHealth](#)

- Health care providers must maintain adequate medical records to:
 - Afford continuity of patient care
 - Document that quality care has been rendered
 - Justify payment for services rendered
 - Serve as defense against malpractice claims
 - Function as a basis for submitting required reports to appropriate governmental agencies
- All operative reports should be dictated immediately, but **absolutely** within 24 hours of the time of operation. They should contain sufficient information concerning the pathology found as well as techniques used.
- Discharge summaries are to be completed the day of discharge. Discharges are to be approved by the responsible senior resident. Correct terminology is essential, both for diagnosis and operation. Complete diagnoses, including complications and operations are necessary.
- Keep in mind that the patient’s record could become a legal document, which you may be asked to interpret and defend in a court of law many years from now. It, therefore, should not be treated as anything less. It is not a forum for unproven opinions, personality comments, assumptions, or derogatory statements to consultants, patients, peers, etc.: record the facts, omit opinions, judgments, and assumptions. Never alter a medical record after a query regarding the care of a patient.
- Death Certificates must be completed within 72 hours of the patient’s death.
- Medico-legal issues, such as adverse events, angry patients, or family members, etc. should be relayed to the Chief Resident and/or attending immediately. A lack of timely intervention frequently exacerbates problems.
- Delinquency in record completion may result in loss of vacation time or loss of OR privileges in order to correct deficiencies.

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

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

- Do not discuss patients with others while walking in the halls, in the elevator, in the cafeteria, or while in any public areas.
- During Grand Rounds and conferences, patients are never to be presented by their names.

- Copies of discharge summaries, operative reports, and other medical data are confidential and must be disposed of by acceptable legal means when no longer needed.
- Confidential, locked shred bins are provided in the out-patient office as well as on the units. Do not place any confidential information in waste baskets or other receptacle that eventually ends up in a commercial or city dump.
- In all instances, patients are to be treated with the same respect and confidentiality that you would afford your own family members.
- Cases presented at morbidity and mortality conference are confidential and summaries sent to AdventHealth Orlando patient safety organization are protected as part of the patient safety work product.
- Failure to comply could result in immediate dismissal from the program and termination from AdventHealth Orlando.

Promotion and Dismissal:

See also the GME Manual section on Promotion and Dismissal [GRADUATE MEDICAL EDUCATION MANUAL \(adventhealth.com\)](http://adventhealth.com)

AH as the Institutional Sponsor for GME programs requires training programs to provide residents with standards for promotion to each successive level of the training. As such: I. There shall be evaluations for each trainee, which shall be augmented by other evaluation methods, including a 360 evaluation, and other relevant observations. II. Trainees must meet standards for promotion as defined by the ACGME, Review Committee and program. III. If there are significant deficiencies in their performance, a remedial plan will be given to the trainee in both verbal and written notification in accordance with the program's remediation policy. IV. Trainees failing to demonstrate satisfactory progress of performance or achieve specified performance goals may be dismissed from the training program within four (4) months' notice (if possible). V. If a resident/fellow will not be promoted, the program director will notify the resident in both verbal and written notification.

71 Resident dismissal procedures: I. AH GME training programs subscribe to a policy that residents/fellows may be dismissed for cause including but not limited to: 1. Failure to fulfill probationary corrective actions; 2. Unsatisfactory academic and/or clinical performance; 3. Failure to appear for duty when scheduled without notification to the program; 4. Failure to comply with the rules and regulations of the residency program; 5. Revocation, suspension or restriction of license to practice medicine; 6. Theft; 7. Unprofessional behavior; 8. Insubordination; 9. Use of professional authority to exploit others; 10. Conduct that is detrimental to patient care; and, 11. Falsification of information in patient charts or other documents of the residency program. II. The program director who is considering dismissing a resident shall consult with the resident's Advisor/Mentor, the Director and DIO who will compose the Dismissal Panel. The process for dismissal shall be: 1. The resident will be notified in writing that the program is considering dismissal. The reasons dismissal is being considered must be included; 2. Upon notification, the resident will have an opportunity to meet with the Dismissal Committee to present oral and written support for his/her position in response to the reasons for the

action set forth by the program director; and, 3. If after the meeting (or, if the resident declines to meet, after the opportunity to meet is provided), the program director determines that dismissal is still recommended, the resident will be informed of the dismissal in writing and offered a hearing regarding the dismissal. 4. The trainee has a right to a hearing regarding a non-promotion or a dismissal. 72The resident may request for a hearing in writing. Such a written request must be made to the program director within fifteen calendar days from the date of receipt of the document informing the resident of the non-promotion or dismissal. The hearing process will follow the process outlined in the Appeal Policy section of this manual.

Disciplinary Policy

See also the GME Manual section on Promotion and Dismissal [GRADUATE MEDICAL EDUCATION MANUAL \(adventhealth.com\)](http://adventhealth.com)

AH is committed to provide the highest quality of educational programs. The program director may take remedial and/or disciplinary actions including reprimand, suspension or termination against the resident when there has been failure to attain a proper level of scholarship or professionalism including but not limited to: I. AH's Citizenship Policy; II. AH's Code of Ethics; III. Competencies as specified by the appropriate accrediting body; IV. Breach of the Resident Contract; V. Behaviors due to alcohol and/or substance abuse; VI. Violation of AH and GME policy. To ensure the quality of care for patients and resident adherence to a standard of excellence in performance and conduct are never compromised, the hospital follows a procedure for corrective disciplinary action when necessary. In the event of a perceived need for formal discipline based on documented deficiencies, the resident will be notified verbally and in writing regarding the deficiencies and the steps outlined to correct these deficiencies: A. If this corrective action fails to remediate the deficiencies, the program director shall B. take the problem to the program's faculty group. The faculty will vote to recommend placement of the resident on a "probationary" status for a period of one to six months. Along with the probationary status, there will be a verbal discussion and a notification letter to the resident stating the corrective actions required. If the deficiencies are serious enough, immediate dismissal may be enacted. C. If the resident fails to fulfill the corrective actions outlined in the notification letter or continues activities contrary to those expected and defined by any of the documents referenced in this disciplinary action section, then the Program director will bring the issues again to the faculty. Disciplinary action of formal dismissal from the program, suspension (up to three months) or probationary status with remediation will be determined. All such recommendations shall be provided verbally and in writing to the resident when approved and shall be implemented by the program director. D. Should the resident be placed under suspension, the resident will not work or be in AH property other than for official activities approved or requested by the Program director. E. In the case of an act or threat endangering the health, welfare or safety of any patient, visitor, colleague or employee, the program director may suspend or terminate the resident immediately

Professional Relationships:

Patient Care:

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

Nursing Staff:

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

Pharmacy Staff:

- The pharmacist is another vital member of the health-care team. They are responsible for all medications dispensed in the hospital.
- They are also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicities, administration forms, and combinations.

- It is the pharmacist's legal and professional responsibility to ensure that the intent of your order is fulfilled. When the pharmacist questions an order, they are doing so to ensure that the patient receives the appropriate medication in the appropriate dosage.
- If you are paged by the pharmacist, it is your duty to respond quickly and courteously.

Resident Interaction with Rotating Students:

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

- Teaching requisite patient care procedures
- Instructing in the development of logical approaches to clinical problems
- Encouraging reading in General Surgery texts and journals, providing the student with select review articles on topics concerning their patients
- Instructing and assisting in the development of good patient care and treatment
- Ensuring attendance at all necessary conferences
- Reviewing each student's "work-ups" and providing constructive criticism
- Treating the medical student in a professional and courteous manner
- Maintain a professional interpersonal relationship with the rotating students. Any concerns should be brought to the attending on service or Program Director.
- Assigning cases and patients
- Enforcing reading and preparation for specific cases that they will observe in the operating room

Continuity of Care/Night Call Activities:

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

Clinic Requirements:

A portion (minimum of ½ day per week) of all General Surgery rotations will be spent seeing patients in the office. This time will provide continuity of care training for the resident as they see pre- and post-operative patients as well as minor surgeries in the suite. This is in addition to any time spent in postop/ resident clinic.

Night Call/Night Float:

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

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

Call:

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

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

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

Transitions of Care:

- Residents are responsible for providing safe and effective transitions of care during hand-off situations. Sign out sessions occur twice daily to ensure adequate communication and appropriate transfer of patient information
- Morning sign out begins at 6:00am daily, at the end of the night shift with transfer of patient information from the prior night's residents and the oncoming team (residents and nurse practitioner).

- At 6:00pm during the week, transition of night between the general surgery service residents and the oncoming resident. During this time all the day's surgeries are discussed in preparation for post-operative checks that evening. Additionally, the status of each patient on the general surgery service are communicated to the oncoming resident to ensure safe and effective patient care.
- Residents are instructed during the annual communication and patient safety lectures on proper, complete and successful transitions of care.

On-Call Guidelines:

- The GMEC adheres to ACGME guidelines regarding the frequency of call. The clinical and educational work hours policy may be found in the GME manual [AdventHealth Graduate Medical Education | AdventHealth](#)
- The call schedule will be made on a monthly basis.
- In-House Call duties extend on weekdays from 6:00 pm to 6:00 am and on weekend days from 6:00 am to 6:00 am. The appropriate phone is to be on during call hours and in your possession at all times. The correct phone number must become available to the surgery scheduling office during weekdays or to the next resident on call during weekends.
Notification of the correct phone number must be given to the answering service and nursing staff units. Individual phone devices must be kept on at all times during work hours. While covering the Emergency Department or Operating Room, devices should not be unattended or turned off. Other staff should be able to respond to the call if the resident is not able to do so.
- Responsibilities while on call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate. Additionally, any significant changes in patient coordination will be communicated to a senior resident and the responsible attending surgeon.
- Support systems: The resident on call will have access to support from both the Chief Resident and the faculty member/surgeon on call during all call assignments, when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. The chain of command is as follows: Resident → Next more senior resident → Chief Resident → Attending. As mentioned previously, there are clinical situations where this hierarchy should and must be circumvented with direct contact with attending.

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

Clinical and educational work:

As per ACGME guidelines, residents will be limited to a maximum of 80 hours per week (averaged over a 4-week period) inclusive of all in-house clinical and educational activities, clinical work done from home and all moonlighting. Required educational activities, such as teaching conferences, M&M conferences, etc., constitute as work hours.

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

The GMEC shall oversee that all specialty and subspecialty programs comply with ACGME policies on residents' clinical and educational work which include on-call activities, at home call, moonlighting, and oversight compliance. See the GME Manual for the Resident Clinical & Educational Work Hours Policy [AdventHealth Graduate Medical Education | AdventHealth](#)

Maximum Hours of Clinical and Educational Work per Week

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

Mandatory Time Free of Clinical Work and Education

The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Residents should have eight hours off between scheduled clinical work and education periods.

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

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

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

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

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

Maximum Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.

Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions

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

to continue to provide care to a single severely ill or unstable patient;

humanistic attention to the needs of a patient or family; or,

to attend unique educational events.

These additional hours of care or education will be counted toward the 80-hour weekly limit.

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

The Review Committee for Surgery will not consider requests for exceptions to the 80-hour limit to the residents' work week.

In-House Night Float

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

Night float rotations must not exceed two months in duration, four months of night float per PGY level, and 12 months for the entire program

Maximum In-House On-Call Frequency

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

At-Home Call

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

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

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

Resident Clinical & Educational Work Hours:

Following the GME Resident Clinical & Educational Work Hour Policy, Clinical and educational work should be recorded daily after completion of duties but must be current by Mondays morning allow for review by the Program Director and the Graduate Medical Education department. If by the following day, Tuesday morning the clinical and educational work have not been completed, the resident will be relieved from duty to report to the Graduate Medical Education office at which time the Designated Institution Official will complete a written notice of non-compliance to be placed in the Resident's permanent file.

Residents who remain past the duty hour period or have a work hour violation are responsible for submitting justification through New Innovations to the Program Director. The Program Director will review the violation and justification and determine if a true violation occurred and whether there is reasonable justification. If the justification is

deemed unacceptable, a discussion ensues between the Program Director and the resident with appropriate counseling. If there are continued unjustifiable violations, this is determined to be unprofessional behavior and the resident will subsequently be disciplined and reported to CCC for milestone reporting.

Other Policies:

Dress and Grooming:

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

The resident is expected to follow the dress code as printed in the GME manual [AdventHealth Graduate Medical Education | AdventHealth](#). A white coat with name tag attached is to be worn at all times while on work hours. Scrubs may not be worn in the outpatient office except when post-call. At any time that the resident is scheduled to be in the operating room, clean scrubs will be worn, including changing to fresh scrubs after a dirty/bloody case. The resident must ensure that no body fluids are on their clothes/shoes when out of the operating room. Please refer directly to the GME Manual for specific dress requirements.

Work Environment:

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

Leave:

The ABS requirements [Leave Policy - General Surgery | American Board of Surgery \(absurgery.org\)](#) for residency training in order to qualify for certification are specific regarding the amount of time that may be taken away from training in each year. This includes ABS Family Leave Policy, extending chief year, completing 5 years in 6, and other case-by-case arrangements. The requirement is that 48 of the 52 weeks per year must be full-time clinical activity. In the case of family leave, Residents may take an

additional four (4) weeks off during the first three (3) years of residency, for a total of **140 weeks** required, and an additional four (4) weeks off during the last two (2) years of residency, for a total of **92 weeks** required, all while maintaining admissibility to the ABS initial certification examination process.

No time-off requests are permitted during the last two weeks of a resident's contract period. General guidelines for time away can be found in the GME manual [AdventHealth Graduate Medical Education | AdventHealth](#). Program-specific guidelines follow:

- **Paid Day Off (PDO):** Residents are allowed 20 days to be used for vacation/leave/sick per academic year. This paid time off is inclusive of granted days for Board Examinations.
- There will be no vacation time taken in July, January, or June – unless specifically approved by the Program Director.
- All scheduled vacation during the year must be approved by chief residents, the coordinator, and the Program Director.
- The week of leave will also include the weekend following the vacation week(s). The weekend *prior* to leave is not part of the vacation and may or may not be granted depending on the call schedule – subject to approval by the Program Director.
- Sick leave or Emergency leave will first be deducted from credited PDO and then from the last week of leave if necessary.
- **Education:** AdventHealth Orlando provides the resident with an annual continuing education allowance and paid leave to attend educational activities that will contribute to the quality of their training.
- With the exception of the education leave allowance, leave may not be carried over from one appointment year to the next, and there is no payment for unused time.
- **FMLA:** Please refer to the GME Manual [AdventHealth Graduate Medical Education | AdventHealth](#) for specific policy on family and medical leave, extended sick leave, maternity leave, paternity leave, and adoption leave. The ABS leave options are also to be reviewed and considered.
- Written request for time off is mandatory and must be submitted and approved by the Chiefs, Coordinator and the Program Director. Initial requests will be solicited prior to the start of the academic year while the annual schedule is being written. Requested vacation periods are not guaranteed. Requests for changes must be accompanied by prearrangement of who will cover the resident's absence on a service with mandatory coverage.
- **Holidays:** Coverage of these holidays will be rotated among the residents while maintaining work hour compliance. Coverage hours will be the same as on weekends.
- **Unexcused Absences:** If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident and the Program Director, the absence will be considered unexcused. Unexcused time will be taken from the resident's leave bank. If the unexcused absence is repeated, disciplinary action will be taken by the Program Director depending on the severity and frequency of

the infraction. Arrangements for “payback” to the other residents who may be assigned to cover in the resident’s absence will be made at the discretion of the Program Director.

Please see the GME Leave of Absence; Effects of Leave, Policy [AdventHealth Graduate Medical Education | AdventHealth](#). The program will accommodate resident needs of chest feeding breaks and private space during work hours.

Elective Guideline:

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

- The surgical resident must be in good standing in the program with a minimum of 400 cases at the time of request.
- The elective is with an ACGME accredited surgery residency or fellowship program. The chosen institution and program must be in good standing with the ACGME and respective RRC.
- The elective must demonstrate educational merit and be an operative rotation, not an observership.
- The elective month cannot occur in (July or January)
- The resident is to discuss their elective rotation interest with the Program Director and submit to the Program Coordinator the elective request by April 1st of the preceding (PGY-3) year with:
 - i. GME Elective request form (found in the New Innovations home page)
 - ii. Goals and Objectives (in accordance with the six core competencies)
 - iii. Month
 - iv. Preceptor CV
 - v. Practice administrator or program Coordinators contact information.
- Preceptor and Off-Site agreements must be in place at the time of the rotation.
- During the away elective, the following is expected of the resident:
 - Adherence to the work hour restrictions as outlined by the ACGME.
 - The resident will continue to check designated AdventHealth Orlando email address on a daily basis for communication/updates.
 - Attendance and participation in M&M, Case Presentations, and didactic conferences on a weekly basis at elective site as outlined by the ACGME program requirements.
 - On-going and current recording and documentation of participation in cases through the ACGME case log system.

- The resident is responsible for acquiring and paying for living arrangements during the elective month.

Moonlighting:

Because residency is a full-time endeavor and following the ABS requirements, it is the policy of the General Surgery Residency Program that moonlighting is generally not allowed. Extenuating circumstances may lead to individual consideration, but it is based on the needs of the sponsoring institutions rather than the need of the residents to acquire additional earnings. Please see the GME Manual [AdventHealth Graduate Medical Education | AdventHealth](#) for the Moonlighting Policy.

PGY-1 residents are not permitted to moonlight.

Disability:

Please see the GME Manual [AdventHealth Graduate Medical Education | AdventHealth](#) for the Accommodations for Disabilities Policy.

AdventHealth Orlando General Surgery Simulation and Technical Skills Training Center

The AdventHealth Orlando General Surgery Simulation and Technical Skills Training Center, located on the 4th floor of the Medical Office building which is attached to the clinical practice as well as Administrative offices. Guests are asked to please maintain conversation at a professional volume.

The unit has well over a million dollars in capital assets and for this reason, we maintain high security standards. Please be aware that the lab is under **24/7** video surveillance. Our security protocol requires card access to the Center for authorized users as well as a paper log to record every visitor's time in and time out of the lab as an additional measure. While eating and drinking is permitted in the building, please limit it to areas away from the equipment.

Guests are asked to restrict use of items in the lab to those pieces of equipment they are approved to use. For example, if you are here for laparoscopic simulation with haptic feedback enabled simulators (LAP SIM), you are not authorized to access the DaVinci simulator. Please

make sure that you return the equipment in the state that you found it. Failure to comply will result in immediate dismissal from the lab and potential permanent ban from future use.

We anticipate that this will be of great educational value to you and your colleagues. Please do not hesitate to contact the General Surgery Coordinator or General Surgery Residency Program Director with any questions, concerns or comments.

Individual simulation use:

Guests are to contact the general surgery coordinator to request for badge access to the simulation center and indicate specific simulation equipment that guests plan to use during their visit.

Upon entry to the simulation center, the paper log would need to be filled out. Guests are to restrict use to the pieces of equipment they are approved to use. If guests come across any issues with the equipment, please report accordingly (see Problems with Equipment instruction below).

For a learner to use the simulator, an appointment is not needed. However, we anticipate the paper log book to be filled out and broken equipment reported as stated above. We also ask that the lab space be kept neat and uncluttered to be considerate of other trainers and office staff.

Group Bookings:

For program use simulation and SimNow program, you will need to have a Faculty Lead assigned to your group and follow the below steps.

- 1) Please contact the general surgery residency coordinator to register for a group booking.
- 2) The designated Faculty lead is to set up the curriculum and register which can be coordinated through the Program Director who would then allow the assigned Faculty lead privileges to set up your own curriculum for the learners to complete.
- 3) Once the Faculty learner has created the curriculum, learners are to go to <https://learning.intuitive.com/> to register and view the curriculum assigned to them. Please keep in mind that it is with the direction of your program (i.e. Faculty lead, program coordinator, etc.) that the learners register at Intuitive for proper curriculum credit.

Badge Access:

Please contact the general surgery residency coordinator to complete the badge access form. The badge access request form must be submitted at least 36 hours prior to the date of lab use.

Problems with Simulation Equipment:

In the event the simulation equipment is not working correctly, guests are asked to please contact the Residency Coordinator to report issues. When reporting issues, please include details such as: Simulator machine, detailed issue at hand and the date of when one noticed the problem. Guests are asked to please restrict usage of items in the lab to those pieces of equipment approved to use.

Stress, Fatigue, and Impairment:

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

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

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

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

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

Resources:

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

Employee Assistance Program (EAP):

This program assists faculty, staff, and their families with the resources they need to resolve personal, family, or job-related problems. EAP offers a free of charge and comprehensive worksite-based program to assist in the prevention, early intervention, and resolution of problems that may impact job performance. The EAP is staffed with well-trained, caring professionals who listen and offer support and guidance. EAP is confidential and voluntary. You can contact EAP at: 1-888-802-5821 TTY:711 or visit resourcesforliving.com and use username/password: AdventHealth

Employee Health Clinic:

The employee health clinic handles pre-employment physicals, performs annual physical assessments and PPD tests, and administers vaccinations. It also provides triage and evaluation for work-related injuries during normal business hours and does educational promotions, blood-borne pathogen counseling and treatment, and follows up on TB and other infectious disease exposures. The employee clinic can be reached at: [Home \(sharepoint.com\)](#) (407) 303-7135.

GME Wellbeing Service:

This service offers counseling for individuals, couples, family, and groups along with psychotherapy sessions, coaching, residency small groups discussions, and workshops. Special events are also offered to residents and faculty members. To schedule an appointment, please email Alexandra.Lajeunesse@AdventHealth.com .

General Information:

Electronic Medical Records (EMR):

AdventHealth Orlando has a couple (EMR) systems. Residents will receive training on EMR during PGY1 resident orientation. In the event that a resident is in need of additional training, the residency coordinator can arrange for further training. Physician Informatics “Red Shirts” technicians are also readily available to assist physicians.

Electronic communication device:

Residents are to use a cellphone for communication regarding educational work. A stipend is issued to residents on a yearly basis to help remedy the yearly expense. Contact numbers are to be kept updated in New Innovations and with the program. That device will be used as the primary method of communication while on duty. The device should be turned on during all clinical and educational work and the battery should be checked frequently to assess signal strength. Damaged or lost devices shall be the responsibility of the resident and alternative means of communication is to be obtained and shared with all needed parties as soon as possible.

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

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

Resident Spectralink:

The program has a spectral link to be utilized specifically for doctor-to-doctor calls. We ask that you keep this number private to maintain efficiency in patient communications from residents to attendings or vice versa. Please do not distribute this number.

Residents are instructed those calls from nurses or staff anyone other than attendings will be respectfully asked to refrain from calling.

- to call the spectral link went in the hospital 831-112-2044
- call from outside 303 -5600 x112-2044
- to call from the spectral link outside of the hospital dial 9 (area code) number

Keep in mind that spectral links do not work outside of the hospital. The phone has two batteries (one on the phone and the other charging on the charger), cord for charger, belt clip, and rubber case. If you have any issues with the phone please let the residency coordinator known immediately.

Resident File Access:

The General Surgery Residency program follows the GME Trainee Files policy which can be found in the GME Manual [AdventHealth Graduate Medical Education | AdventHealth](#).

Resident Loan Deferment:

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

Resident Workspace, Email, Lockers & Mailboxes:

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

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

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

Resident mailboxes for regular mail and schedules are located in the General Surgery Administrative office suite. These mailboxes must not become a repository for outdated information, etc. Mail and notices should be dealt with **on a weekly basis** and cleaned out.

Travel:

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

is encouraged. Residents are to present any podium presentations to the program at a Friday conference prior to presenting it at a conference. They are to schedule this with the designated education chief.

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

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