Resident's Manual
2023-2024
(Last updated: 12/2023)

General Surgery Residency
Department of Surgery
SUNY Upstate Medical University

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I. CONTACT INFORMATION

TITLE	DEPARTMENT OF SURGERY	CONTACT INFORMATION	
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	Suite 8147 - University Hospital	**Email:**	Myersba@upstate.edu
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Program Director	**Dr. Andreas Meier**	**Phone:**	**315-464-7261**
	Room #8601A - University Hospital	**Pager:**	**315-411-1094**
		Email:	meierAn@upstate.edu
Associate Program Director	**Dr. Jeffrey Albright**	**Phone:**	**205-529-8762**
	4900 Broad Rd., POBN, ST. 2E, Rm 2214 - UCH	**Pager:**	**315-213-0281**
		Email:	AlbrighJ@upstate.edu
Administrative Assistant	**Nicole Merrill**	**Phone:**	**315-492-3338**
	4900 Broad Rd., POBN, ST. 2E, Rm 2212 - UCH	**Email:**	MerrillN@upstate.edu
Associate Program Director	**Dr. Michael Archer**	**Phone:**	**732-740-9258**
	Room 8801 A - University Hospital	**Pager:**	**732-740-9258**
		Email:	ArcherMi@upstate.edu
Administrative Assistant	**Amanda Doerle**	**Phone:**	**315-464-1857**
	UH 8801 - University Hospital	**Email:**	DoerleA@upstate.edu
TITLE	**ACADEMIC OFFICE**	**CONTACT INFORMATION**	
Residency Administrator	**Kelly Liberati**	**Phone:**	**315-464-7261**
	Room #8602 - University Hospital	**Email:**	LiberatK@upstate.edu
		Fax	315-464-6233
UME Administrative Director	**Rebecca Bellini**	**Phone:**	**315-464-6248**
	Room #8602A - University Hospital	**Email:**	bellinir@upstate.edu
Administrative Assistant	**Pamela Derck**	**Phone:**	**315-464-6276**
	Room # 8601 - University Hospital	**Email:**	DerckP@upstate.edu
TITLE	**GME OFFICE**	**CONTACT INFORMATION**	
Associate Dean for GME	**Danielle Katz, MD**	**Phone:**	**315-464-8948**
	RM 8016 - University Hospital	**Email:**	katzd@upstate.edu
GME Director	**Sue Henderson-Kendrick**	**Phone:**	**315-464-5136**
	RM 8016 - University Hospital	**Email:**	henderss@upstate.edu
TITLE	**UPSTATE COMMUNITY HOSPITAL**	**CONTACT INFORMATION**	
Medical Admin. Services	**Beth Sellers**	**Phone:**	**315-492-5551**
	4900 Broad Rd.,1st Floor, Room 1501 - UCH	**Email:**	SellersB@upstate.edu
TITLE	**CROUSE HOSPITAL**	**CONTACT INFORMATION**	
Residency Contact	**Dr. Benjamin Sadowitz**	**Phone:**	**315-727-6714**
		Email:	Sadowitzbd@gmail.com
TITLE	**VAH HOSPITAL**	**CONTACT INFORMATION**	
Residency Director	**Dr. Amit Goyal**	**Email:**	GoyalA@Upstate.edu
TITLE	**OPERATORS & MEDICAL RECORDS**	**CONTACT INFORMATION**	
UMU Paging System **Medical Records**	**Medical Center Operator** **University Hospital**	**Phone:**	**315-464-5540** **315-464-4310**
Medical Records	**Crouse Hospital**		**315-470-7194**
Medical Records	**VA Medical Center**		**315-425-4400 ext. 2004**

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II. SYRACUSE VA MEDICAL CENTER CHECK LIST

800 Irving Avenue, Syracuse, NY 13210
Surgery & Diagnostics

VA access Checklist

Contacts:

HR Specialist & Admin	Email	Phone #	Room #
1. Chari Mayer	Chari.Mayer@va.gov	315-750-8798	B911
2. Mildred Barringer	Mildred.Barringer@va.gov		

Step 1:

A. Complete and Return HR packet

B. Fingerprinting - *(PIV Office -1st floor, Room A168)*

Please note: Fingerprints are only valid for 90 days.
(After 90 days you must be re- fingerprinted at the PIV office)

Step 2: Complete TMS Training:

- Log into TMS www.tms.va.gov
- TMS account will be disabled in 60 days if password is not re-set.
- If account becomes disabled, call/email one of the TMS contacts
  - TMS Help Desk at vatmshelp@va.gov
  - Phone every day, 24x7, at 1 (855) 673-4357

Step 3: PIV Card/Pictures taken – *(PIV Office -1st floor, Room A168)*

- Bring two forms of ID (driver's license, SS card, passport, or Upstate ID)
- ID will expire on date printed on the card
- If you have any issues obtaining your PIV contact Chari

Step 4: Access Codes/Computer Training

- Contact Chari to schedule CPRS Training and get your codes
- You must have a PIV CARD and codes before you may be assigned to a CPRS training class
- CPRS courses are also available in TMS -VA 35795 CPRS Tab by Tab: A Basic Orientation (6 hours)
- Computer Access Codes will deactivate in 90 days if password is not re-set

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III. PGY-1 – PGY-5 PAGER LIST 2022-2023

RESIDENT	PGY - YEAR	PAGER NUMBER
Abi-Aad, Karl	**PGY-1**	315-213-1386
Ahmed, Moez	**PGY-1**	315-441-0251
Ahsan, Mehrab	**PGY-1**	315-441-0258
Cammisa, Allison	**PGY-1**	315-213-0479
Cannizzaro, Sean	**PGY-1**	315-249-0400
Capriotti, Dante	**PGY-1**	315-249-0319
Cloutier, Matthew	**PGY-1**	315-441-0299
Collins, Alexander	**PGY-1**	315-213-1182
Daugherty, Mitchel	**PGY-1**	315-441-0302
Eccleston, Catherine	**PGY-1**	315-213-0487
Fatima, Munazza	**PGY-1**	315-441-0317
Golosky, Mitchell	**PGY-1**	315-441-0326
Gopalakrishnan, Maithili	**PGY-1**	315-213-1183
Hughes, Evan	**PGY-1**	315-441-2156
Khalil, Yousuf	**PGY-1**	315-441-0350
Lacourrege, Kelsey	**PGY-1**	315-441-2155
Lal, Divakar	**PGY-1**	315-249-0349
Lee, Jamie	**PGY-1**	315-213-0489
Melnyk, Brooks	**PGY-1**	315-213-0469
Miller, Karl	**PGY-1**	315-441-0351
Moon, David	**PGY-1**	315-441-0353
Peet, Gideon	**PGY-1**	315-213-0471
Quatela, Olivia	**PGY-1**	315-213-0498
Schumacher, Katherine	**PGY-1**	315-213-0511
Shlimun, Zeia	**PGY-1**	315-441-0361
Steinmetz, Emma	**PGY-1**	315-213-0690
Tan, Youri	**PGY-1**	315-441-0376
Terhaar, Samantha	**PGY-1**	315-441-2154
Useva, Anastasija	**PGY-1**	315-213-1184
Weintraub, Collin	**PGY-1**	315-213-0463
Willenbring, Collin	**PGY-1**	315-249-0394
Wilson, Danielle	**PGY-1**	315-213-0528
Zickefoose, Scott	**PGY-1**	315-426-6070

RESIDENT	PGY - YEAR	PAGER NUMBER
Ellis, Jarrod	**PGY-2**	315-213-0335
Francois, Jean Luc	**PGY-2**	315-213-0667
Laskar, Sahib	**PGY-2**	315-213-0681
Pinkes, Katherine	**PGY-2**	315-213-0682
Read, Sydney	**PGY-2**	315-213-0687
Sykes, Alexis	**PGY-2**	315-213-0700
Farhat-Sabet, Ashley	**PGY-3**	315-213-1293
Iyer, Advait	**PGY-3**	315-213-1313
Mahendran, Karthika	**PGY-3**	315-213-1338
Marmor, Hannah	**PGY-3**	315-213-1051
Okoye, Amarachukwu	**PGY-3**	315-213-1380
Pruekprasert, Napat	**PGY-3**	315-213-1384
Ramcharran, Harry	**PGY-3**	315-213-0907
Samuel, Ankhita	**PGY-3**	315-213-1055
Arul, Manu	**PGY-4**	315-213-1010
Beaulieu, Daphnee	**PGY-4**	315-213-1011
Bieterman, Andrew	**PGY-4**	315-213-0419
Chen, Alexander	**PGY-4**	315-213-1335
Khan, Asama	**PGY-4**	315-213-1030
Mana, Gary	**PGY-4**	315-213-1339
Rahman, Naveed	**PGY-4**	315-213-1340
Senay, Ayla	**PGY-4**	315-213-1389
Hargis-Villanueva, Angela	**PGY-5**	315-213-0079
Magowan, Elizabeth	**PGY-5**	315-213-0883
McElfresh, Megan	**PGY-5**	315-213-1387
Quinzi, Allison	**PGY-5**	315-213-1026
GROUP PAGER	**PGY-1**	**315-467-1359**
GROUP PAGER	**PGY-2**	**315-467-1710**
GROUP PAGER	**PGY-3**	**315-467-3554**
GROUP PAGER	**PGY-4**	**315-467-1727**
GROUP PAGER	**PGY-5**	**315-467-3341**
ALL RESIDENT GROUP	**PGY-1 thru PGY-5**	**315-467-4131**

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IV. PRINCIPAL TEACHING FACULTY

Robert N. Cooney, M.D., FACS, FCCM
Professor and Chair of Surgery

Tamer A. Ahmed, M.D., FACS
Assistant Professor of Surgery (Pediatrics)

Jeffrey Albright, M.D., MBA
Assistant Professor of Surgery (Colorectal)
Associate Program Director
Chief of Service at Upstate Community Hospital

Michael Archer, D.O.
Assistant Professor of Surgery (Thoracic)

Ankur Chawla, M.D.
Assistant Professor of Surgery (Vascular)

Michael J. Costanza, M.D., FACS
Professor of Surgery (Vascular)
Division Chief of Vascular Surgery

Mark Crye, M.D.
Assistant Professor of Surgery (Thoracic)

Mashaal Dhir, M.B.B.S.
Assistant Professor of Surgery (Hepatobiliary, Endocrine)

Joan Dolinak, M.D., FACS
Assistant Professor of Surgery (Burns)

Rahul Dudhani, M.B.B.S
Assistant Professor of Surgery (Trauma-Nights & Weekends)

Anthony Feghali, M.D.
Assistant Professor of Surgery (Vascular)

Kristina Go, M.D.
Assistant Professor of Surgery (UCC, UH, Crouse: GS & Colorectal)10/1

Amit Goyal, M.D.
Assistant Professor of Surgery (Colorectal)

Roseanna Guzman-Curtis, M.D., MPH, FACS
Assistant Professor of Surgery (ACS, Trauma)
Director, Surgery Clerkship
Trauma Medical Director

Matthew Hanlon, M.D.
Assistant Professor of Surgery (Transplant)9/1/20

Moustafa Hassan, M.D., FACS
Associate Professor of Surgery/Associate Professor of Anesthesiology
Division Chief of Acute Care Surgery Services

Samir Iskhagi, M.D.
Assistant Professor of Surgery (Transplant) 11/1/21

Kristin Kelly, M.D.
Assistant Professor of Surgery (Hepatobiliary)9/1/20

Leslie J. Kohman, M.D., FACS
Distinguished Service Professor of Surgery

Michaela Kollisch-Singule, M.D.
Assistant Professor of Surgery (Pediatrics, Research)10/1

Lisa Lai, M.D.
Assistant Professor of Surgery (Breast)

Michael Luca, D.O.
Assistant Professor of Surgery (Trauma)8/10
Associate Clerkship Director

Amie Lucia, D.O.
Assistant Professor of Surgery (ACS, Trauma)

Brian Maclaughlin, M.D.
Assistant Professor of Surgery (Colorectal, Auburn – Upstate)

Mehdi Marvasti, M.D.
Assistant Professor of Surgery (Cardiac)6/9/21

Andreas Meier, M.D., MEd, FACS, FAAP
Professor of Surgery & Pediatrics
Program Director, General Surgery Residency
Vice Chair of Education, Dept. of Surgery
Division Chief of Pediatric Surgery

Lauren Rabach, M.D.
Assistant Professor of Surgery *(Bariatric, General Surgery) 11/16/20*

Reza Saidi, M.D.
Associate Professor of Surgery (Transplant)
Division Chief of Transplant Surgery

Rauf Shahbazov, M.D.
Assistant Professor of Surgery (Transplant)

Palma Shaw, M.D.
Professor of Surgery (Vascular)
Associate Professor of Emergency Medicine

Timothy Shope, M.D.
Assistant Professor of Surgery (Bariatrics)11/1/21
Division Chief of Bariatrics

Jennifer Stanger, M.D.
Assistant Professor of Surgery (Pediatrics)

Scott Surowiec, M.D.
Associate Professor of Surgery (Vascular)

Daniel Thomas, M.D.
Assistant Professor of Surgery (Endocrine) 9/1/22

Mackenzie Trovato, M.D.
Assistant Professor of Surgery (UCH- General Surg) 9/5/22

Joseph Valentino, M.D.
Assistant Professor of Surgery (Colorectal)9/1/20

Thomas VanderMeer, M.D.
Professor of Surgery
Chief of Surgical Oncology

Jason Wallen, M.D.
Associate Professor of Surgery (Thoracic)
Division Chief of Thoracic Surgery

Kim G. Wallenstein, M.D., PhD
Assistant Professor of Surgery (Pediatric)

Crystal Whitney, M.D.
Assistant Professor of Surgery (Trauma & Critical Care)

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V. STRUCTURE OF THE RESIDENCY PROGRAM

PRINCIPLES:

The Residency Program is conducted under the Requirements established by the Accreditation Council for Graduate Medical Education (ACGME), of which the Residency Review Committee (RRC) for Surgery has direct responsibility for formulating policies for the organization and conduct of the General Surgery Residency Program. (In Appendix B of this Manual is a copy of the Special Requirements for Residency Training in General Surgery. Please read this document and become familiar with its contents.)

The RRC is charged with the responsibility of accrediting residency programs; general surgery residents graduating from accredited programs are, however, certified by a separate organization, the American Board of Surgery. Upon successful application[1], to the Board at the completion of training, the applicant may sit for Part I (the Qualifying Examination), a written test encompassing the basic and clinical sciences of surgical practice. After passing Part I, the applicant is allowed to take Part II, the Certifying Examination, an oral test of the surgeon's ability to exercise sound judgment in various clinical situations.

A fundamental education principle of any general surgery program is to adequately prepare the resident for Board Certification. Simply "Passing the Boards" is not sufficient. The goal of the SUNY-Upstate program is to provide the best possible education and training for a career in General Surgery or one of its disciplines. To derive the maximal benefit from your residency requires that you actively participate in every aspect of the program, from the operating room to the classroom. You have been selected to this residency program primarily because the faculty believes that you can successfully fulfill the educational goals of the program.

REGULATORY AGENCIES:

- **ACGME Common Program Requirements (Residency)**
- **www.ACGME.org**

GOVERNANCE OF THE RESIDENCY PROGRAM:

The following job descriptions describe the overall governance of the residency program. The goal of this organization is to ensure adequate bi-directional communication between the individual resident and the Program Director, the Associate Program Director (if applicable) and the Program Administrator.

The Program Director *(Dr. Andreas Meier)* has ultimate authority and responsibility for all aspects of the residency program. However, the Program Director cannot be expected to perform these activities without considerable help from all of the faculty and residents. In general, the Program Director is responsible for the overall supervision of the academic responsibilities of the teaching faculty, maintenance of the academic milieu of the residency program, overall performance evaluation of each individual resident and each individual rotation, and the preparation of documents necessary to comply with accreditation. The Program Director periodically meets with the senior level residents in an open forum format for discussion and assistance in managing day to day issues which may arise in the operation of the residency program.

The Associate Program Director *(Dr. Jeffrey Albright & Dr. Michael Archer)* have been appointed by the Chair of the Department of Surgery and the Program Director to assist in the management of the educational aspects of the program. They'll share responsibility for the overall evaluation of resident rotations and scheduling. Together with the Program Director the Associate Program Director will confirm that each rotation provides adequate resources for the residents for academic and personal needs. They will evaluate each rotation to maintain a balance of education and service. The Associate Program Director will track the residents' participation in all required activities ensuring that at least minimal standards are met. The Associate Program Director will act as Program Director in the Program Director's absence.

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The Program Evaluation Committee (PEC) is made up of the Program Director, at least two appointed faculty and at least one resident. The PEC participates actively in planning, developing, implementing and evaluating the educational activities of the program. Members review and make recommendations for revision of competency-based curriculum goals and objectives. The committee addresses areas of non-compliance with ACGME standards and reviews the program annually using evaluations of faculty, residents and others. The residency program, through the PEC must document formal, systematic evaluation of the curriculum at least annually and is responsible for rendering a written, annual program evaluation.

On each general surgery rotation, a Chief Resident has been assigned. This PG-V or PG-IV resident will be the administrative leader for the rotation and should be the "go to" person to manage the administrative activities of the rotation and assign tasks and responsibilities to the other members of the team. Scheduling issues and conflicts should be directed to this Administrative Chief Resident, *as well as the Program Administrator*. The chief resident on each rotation will be responsible for case coverage, clinic assignments, mandatory meeting attendance for the members of the team, and maintaining a communication about the service with the attendings and the program director.

The Administrative Chief Resident(s) will be PGY-5 residents elected by their peers, supported by the PGY-4/5 on the ACS (D) service at University Hospital. They will be the day-to-day administrative liaison between the residents, the Program Director and the attending staff; a resource to deal with resident issues on a daily basis. The Administrative Chief residents will maintain a vigilant contact with the residents concerning administrative issues in the program. They will attend the Education Committee meeting on the second Thurs. of each month and the PEC meeting on the 4th Monday of each month. They will help prepare the monthly call- schedule and will assist in scheduling the M and M conference.

VI. General Surgery Residency Job Descriptions

PROGRAM DIRECTOR JOB DESCRIPTION:

The Program Director of the General Surgery Residency will be a full-time faculty member of the SUNY Upstate Medical University. The Program Director will be certified by the American Board of Surgery and will be on the medical staff of both integrated institutions participating in the program.
The term of appointment will be six years.

The responsibilities of the Program Director include (adapted from RRC program requirements):
The program director must administer and maintain an educational environment conductive to educating the residents in each of the ACGME competency areas.

The program director must:

1. Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program.
2. Approve a local director at each participating site who is accountable for resident education.
3. Approve the selection of program faculty as appropriate.
4. Evaluate program faculty and approve the continued participate of program faculty based on evaluation.
5. Monitor resident supervision at all participating sites.
6. Prepare and submit all information required and requested by the ACGME, including but not limited to the program application forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete.
7. Provide each resident with documented semiannual evaluation of performance with feedback.

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8. Ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution.

9. Provide verification of residency education for all residents, including those who leave the program prior to completion

10. Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end must:
    - Distribute these policies and procedures to the residents and faculty.
    - Monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements.
    - Adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
    - If applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

11. Monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.

12. Comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents.

13. Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures.

14. Obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
    - All applications for ACGME accreditation of new programs
    - Changes in resident complement
    - Major changes in program structure or length of training
    - Progress reports requested by the Review Committee
    - Responses to all proposed adverse actions
    - Requests for increases or any changes to resident duty hours
    - Voluntary withdrawals of ACGME-accredited programs
    - Requests for appeal of an adverse action
    - Appeal presentations to a Board of Appeal or the ACGME, and,
    - Proposals to ACGME for approval of innovative educational approaches

15. Obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
    - Program citations, and/or
    - Request for changes in the program that would have significant impact.

16. Devote his or her principal effort to the program.

17. Designate other well-qualified surgeons to assist in the supervision and education of the residents.

18. Responsible for all clinical assignments and input into the teaching staff appointments at all sites.

19. Responsible for the preparation and implementation of a comprehensive, effective, organized curriculum.

20. Ensure conferences are scheduled to permit resident attendance. Resident time must be protected.

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21. Ensure that the following types of conferences must exist within a program:
    - A course or a structured series of lectures that ensures education in the basic and clinical sciences fundamental to surgery, including technological advances that relate to surgery and the care of patients with surgical diseases, as well as education in critical thinking, design of experiments and evaluation of data.
    - Regular organized clinical teaching, such as grand rounds, ward rounds, and clinical conferences.
    - A weekly morbidity and mortality or quality improvement conference.
        - sole reliance on textbook review is inadequate
22. Along with the physician faculty, assess the technical competence of each resident. The Review Committee required that each resident perform a minimum number of certain cases for accreditation. Performance of this minimum number of cases by a resident must not be interpreted as an equivalent to competence achievement.

23. Ensure that each resident has at least 750 major cases across the five years of training.

    This must include a minimum of 150 major cases in the PGY 5 year.

24. Ensure that residents have required experience with a variety of endoscopic procedures including Upper GI endoscopy, colonoscopy, and bronchoscopy, as well as experience in advanced laparoscopy.

25. Ensure that residents have required experience with evolving diagnostic and therapeutic methods.

26. Appoint an associate program director for programs with more than 20 categorical residents.

PROGRAM ADMINISTRATOR JOB DESCRIPTION:

The residency administrator reports directly to the General Surgery Program Director and is an ex officio member of the Education Committee and Governance Committee. In general, the residency administrator is responsible for the day-to-day operations of the residency program and handles many of the administrative needs of the residents. The Program Administrator will:

1. Manage the daily administrative operations of the residency.

2. Maintain the residency office as the “communications center” of the Program.

3. Supervise, with the help of the chief resident, the development and distribution of the monthly call schedules both at University Hospital and all outside institutions, also oversees quarterly meeting schedules.

4. Maintain personnel files on each resident and coordinate the availability of the contents to the residents.

5. Provide reports of the surgical logs to the residents and to the Program Director as needed and the annual report for the RRC/ACGME.

6. Coordinate the vacation/education schedule for all residents. Maintains compliance with the policies established by the ABS, Program Director and Governance Committee.

7. Schedule and attends all Education Committee meetings.

8. Coordinate appropriate evaluative sessions and exams such as the Mock Oral Exams and ABSITE.

9. Prepare appropriate reports for the Residency Review Committee and facilitates any RRC accreditation visits.

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10. Ensure resident compliance with hospital rules and regulations, including monitoring the certification process.

11. Maintain program specific information on numerous websites (e.g., ACGME, ABS, NRMP, GME Track, ERAS. FRIEDA, etc.)

12. Provide verification letters for residents currently enrolled in the Program. Assists international medical graduates with any visa problems and maintains documentation of current ECFMG certification. Tracks attendance at mandatory conferences for residents.

13. Coordinate the entire application/recruitment process for new residents. Maintains ERAS database. Schedules all interview dates along with accompanying events and coordinates evaluative meetings of all candidates. Prepares the final rank list
14. for submission.

15. Maintain MedHub online database, submits monthly resident time sheets to Payroll, monitors resident work hours for "405" compliance, coordinates requests for leave of absence with Human Resources.

16. Oversee administration of AMION and MedHub.

DOCUMENTATION OF WORK HOURS FOR RESIDENCY ADMINISTRATION:

As one of the duties of the Residency Administrator is to submit Payroll, it's imperative that each resident record their hours weekly, in Medhub, under Resident tab, (Common Task, Work Hours). This is especially important to provide documentation to the ABS for licensing requirements

If you fail to enter your duty hours, you will receive a weekly reminder from Pam Derck

VII. GLOBAL RESIDENT PHYSICIAN RESPONSIBILITIES

1. Develop a program of self-study and professional growth with guidance from the teaching staff.
2. Participate in effective, safe and compassionate patient care, under supervision, commensurate with his/her level of ability and responsibility.
3. Participate fully in the education and scholarly activities of their program including the teaching and supervising of medical students and residents of a more junior level.
4. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
5. Participate in institutional committees/councils, especially those that relate to patient care review.
6. Participate in evaluation of the quality of education provided by the program.
7. Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and of how to apply cost containment measures in the provision of patient care.

VIII. THE CLINICAL EDUCATION PROGRAM OF THE RESIDENCY

The SUNY-Upstate General Surgery Residency Program includes a categorical track (five or more years of clinical training) leading to Board certification in general surgery and a preliminary track of 6 PGY-1s for residents seeking a broad experience in general surgery. The program encompasses training in general surgery: its principal and additional components and related surgical specialties.
Since surgery is a "hands-on" specialty and requires exposure to a variety of patient problems and pathologies, residency training in surgery is primarily an exercise in direct patient contact. Historically, clinical education has been provided in the format of a combination of mentorship and work experience. It had been thought that an immersion into the clinical setting as a "house officer" was the best form of clinical education.

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REQUIRED RESIDENCY EXPERIENCE FOR INITIAL CERTIFICATION IN GENERAL SURGERY:

American Board of Surgery (ABS) Booklet of Information: www.absurgery.org/xfer/BookletofInfo-Surgery.pdf

SPECIFIC RESIDENCY OBJECTIVES BASED ON LEVEL OF TRAINING:

Residency and surgery training is a progressive educational experience that entails a complex interaction of learning through patient care. Residency training requires maintenance of a balance between the educational and patient care responsibilities. In order to maintain the educational purpose of the training program, surgery residents are expected to attend all teaching conferences.

Residents are assigned progressive responsibility for patient care by the supervising attending physician and the Surgery Program Director/Chair based on faculty evaluations of clinical competence including patient care, medical knowledge, evidence of practice-based learning and improvement, interpersonal and communications skills, professionalism, and the surgical resident's demonstrated awareness of the systems-based practice of medicine. Promotion and assignment to progressive patient care responsibilities requires satisfactory completion of the training objectives specific for each PGY year as assessed by the faculty.

The following outline is a detailed summary of the PGY specific role and responsibilities in patient care which are expected from residents assigned to the surgery services.

CHIEF RESIDENT(S) (PGY-5) RESPONSIBILITES:

- **BE A ROLE MODEL FOR ALL OTHER RESIDENTS.**
- ALWAYS BE AWARE OF THE CORE-COMPETENCIES FOR RESIDENT EDUCATION. PROMOTE THE EDUCATION AND DEMONSTRATION OF THE CORE-COMPETENCIES AMONG THE OTHER RESIDENTS.
- BE A TEAM LEADER!
- Participate in the operating room, as either primary or teaching surgeon based on the level of the educational value and/or complexity of the procedure.
- The resident is expected to be released from the OR/ICU (junior resident can assist) to respond to trauma codes unless their continued presence is CRITICAL to managing a life-or-death situation; the PGY4/5 should assure the back-up trauma surgeon is called.
- Conduct daily rounds on ICU, floor, consults.
- Assist in the care of critically ill patients.
- Attend outpatient clinic at least two half-days a week and monitor team outpatient participation.
- Attend all conferences. Be leaders at all conferences.
- Keep attending staff informed of service/patient issues.
- Liaison between house staff, nursing, office staff, and attending staff. All issues with junior medical/interns/medical students should be directed through the administrative chief resident prior to involving attending staff.
- Dictates responsibilities and define published policies to service members. Orient team members to function and activities of the team.
- Assist in designating teaching procedures to more junior members of team.
- Assist the Administrative Chief resident with any additional responsibilities to maintain optimal communication within the residency.

ADMINISTRATIVE CHIEF RESIDENT RESPONSIBILITIES (PGY-5):

The Administrative Chief Resident is the day-to-day administrative liaison between the residents, the Program Director, and the attending staff. The Administrative Chief resident will maintain a vigilant contact with the residents concerning administrative issues in the program.

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The Administrative Chief will work collaboratively with Kelly Liberati to make sure that there is continuity in the

call schedules to ensure efficient, optimal coverage of each patient service. They will be actively involved in assisting services with cross coverage issues, along with coverage on holidays, weekends, residents' days off, during vacations, emergency leave, and illness. The Administrative Chief has the ultimate responsibility for assigning residents to operative cases and/or consults. The Administrative Chief resident will work closely with faculty to identify areas of resident strengths and weaknesses. In collaboration with the Program Director, they will be available to receive comments/complaints/suggestions from faculty and implement changes to improve patient services. They will work with residents who may be struggling to improve their performance. It is hoped this will allow residents to receive constructive criticism and "real time" feedback in a timely fashion.

In addition to the PGY-5 Chief Resident responsibilities listed above, the Admin. Chief responsibilities include:

- Be a meaningful liaison between house staff, nursing, office staff, and attending staff. All issues with junior medical/interns/medical students should be directed through the Administrative Chief Resident prior to involving attending staff.
- Dictate responsibilities and defines published policies to service members.
- Assist in designating teaching procedures to more junior members of team.
- Assist the residency office with the creation of call and vacation scheduling as well as coverage.
- Assist the residency office in monitoring and maintaining ACGME and NYSDOH Code "405" duty hour requirements.
- Act as a liaison between the residents, the Program Director, and the support staff.
- Act as the residents' advocate with respect to rotation-specific problems as they arise.
- Ensure timely communication of all relevant academic and administrative events to the residents.
- Represent the residents at the Departmental Education Committee.
- Participate in the remedial/disciplinary discussions regarding more junior residents.
- Bring forward concerns of the residents to the Program Director and/or the faculty.
- Represent the resident staff at all visiting professor functions.

SENIOR RESIDENT RESPONSIBILITIES (PGY-4):

Generally, the senior resident will have the day-to-day responsibility of organizing and running the service which they are assigned. They are responsible for all aspects of care (preoperative evaluation, participation in the OR as surgeon or first assistant, providing postoperative care and a post discharge follow-up visit) for all patients admitted to the assigned service.

Sr. Resident responsibilities:

- Oversees patient care in ICU and floor
- Rounds with team daily
- Attends clinics for one half-day session per week, monitors and assists junior residents' compliance with this requirement.
- Teaches minor surgical procedures. Teaches and monitors junior residents' participation in invasive bedside procedures.
- Participate in the operating room as the operating surgeon on cases assigned by the chief resident.
- The resident is expected to be released from the OR/ICU (junior resident can assist) to respond to trauma codes unless their continued presence is CRITICAL to managing a life-or-death situation; the PGY4/5 should assure the back-up trauma surgeon is called.
- Shares call responsibility with the chief resident and the junior residents when necessary
- Prepares/presents assigned conferences
- Contributes to daily notes/orders, but does not primarily write the notes
- Evaluates consults with junior residents/staff as needed, including ER consults.
- Maintains operative log and duty hour log

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Junior Resident (PGY-2, 3):

The junior resident is the resident liaison between the upper-level residents and the interns and medical students.

The following list includes some of the responsibilities:

- Responsible for overseeing daily care of floor patients on floor/ICU.
- Seeing consults on floor and ICU when contacted or designated as the consult resident, and discussing the clinical details with chief resident or staff member.
- Round with team daily.
- Attend clinic for at least one half-day session per week. Makes sure that clinic attendance cards are signed.
- Write daily progress notes/orders in ICU.
- Evaluate ER consults primarily.
- Create admission history and physical examination and orders.
- Remain available for patient care and ancillary staff questions.
- Participate in the OR as the operating surgeon on cases assigned by the Chief Resident.
- Assist the senior or chief as required.
- Share call responsibilities.
- Dictate discharge summaries in conjunction with PGY-1 and extender.
- Maintain operative log and duty hour log.

MASTERY OF BEING A CONSULT RESIDENT – SSCL (PGY-2):

When you get a consult always ask for: Name, MR#, location, attending requesting the consultation, and a reason for the consultation. You'll need to have all these when you are trying to find the patient, write notes, etc. Next, examine the patient. Every patient (with a few exceptions) needs a full H&P and your chief/attending will expect that you have taken a thorough history. All patients, aside from those with APRs, or occasionally when not indicated, need a rectal exam. Present to your senior/attending in a full H&P format, especially in the beginning. You will quickly discover your own presentation style and the format that each consultant prefers. For each patient, keep in mind that there are always four things that need to be done called SSCL.

S – Start a (Brief) Note:

Start a brief note with the pertinent information. You only need to write out a full H&P immediately if the patient is going to the OR. The goal of this note should be to communicate thought by: (i) demonstrating you examined the patient (and the time), (ii) answering the reason for the consult, (iii) providing a brief history, and (iv) establishing the recommended plan. This allows the consulting service to know you were there and know your plan. Ideally you should try and communicate all plans to the primary service after you have staffed the patient (professional courtesy). This is not always easy. However, doing so ensures good patient care and develops rapport. If you see a patient in the ED, you must communicate a plan. If for whatever reason, you are having trouble staffing a patient or deciding on a plan, let them know you have seen the patient and will get back to them. They appreciate it. Be sure to "pend" the note instead of signing it so that you can amend it later.

S – Staff:

During the day, after you have seen a patient/consult case, you are expected to staff it with the senior resident from the appropriate service. Many times, they may be unavailable, but try your best to staff it with them. If the senior is in the OR, pop your head in, you may be able to consult with them and the attending. They will usually listen to the history. If all else fails, find another senior resident to staff the case. If you do this, make sure that you let the senior resident responsible for the admitting service know about the patient.

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Also, give a "heads up" to the junior resident if you are admitting, so they are familiar with the patient, can help

follow-up on results on the patient if needed, and know what to sign out at night. At night, you must run all consults by the in-house chief. This makes it easier because you are not running around finding the chiefs of various services. It can be difficult sometimes when, during a busy night, when the chief is not available. If you have an acute patient that you are worried about and your chief is not available, let them know and call the appropriate attending. At night if you need any supplies, plan to get them yourself from the supply rooms on the floor or from Central Distribution (basement, past Engineering) for rarer items.

C – Consult Note (Full):

All consults need a full Consult note written. If you were able to write and "pend" a brief note, then you may simply edit this note to make it a full note and then save it. Please re-read your note before saving, make edits, and sign the note at the end of each shift (when possible). Be sure to write the appropriate co-signing attending, which is the attending with whom the consult was staffed. Deficient/Incomplete notes hurt you and the on-call attending. It is also helpful for the assigned team to be able to review the history. If you make a mistake, you can always addend the note to alter it. In the end, this is your responsibility, and the work keeps piling up, it is easy to get behind and overwhelmed.

L – List Update:

All consults that are seen (whether primary or consulting service) needs to go on a surgery service list. Even if the consult resident tells the day team about new patients, it is generally their responsibility to sign-out their new consults to the incoming team.

ADDITIONAL CONSULTS SERVICE TIPS:

Use the medical students to help. They are required to see a certain number of new patients. If a medical student examines a patient for you, you must verify the H&P yourself. If they write a note, then you also need to write a short blurb and cosign their entry into the medical record (remember, they do not have NPI numbers, and are not legally authorized to provide care).

- You must triage your consults and see the most acute consults first. If you feel yourself getting behind, call other junior residents to help (or a senior resident to help delegate consults). Always try to get consults cleaned up by 6 pm since the night staff is much lighter than the day staff. Consults that come in after 5:45 am/pm can legitimately be signed out to the following shift.
    - URGENT consults or any patient that you're worried about, must be staffed immediately:
    - hemodynamic instability
    - bowel and/or limb ischemia
    - free air
    - peritoneal signs
    - bleeding (GI, arterial, aortic injury/rupture, etc.)
    - wet gangrene
    - necrotizing fasciitis
    - compartment syndrome
    - ascending cholangitis
    - incarcerated hernia
    - any level trauma

- Do not blow off consults (it will be ultimately very painful for you). If someone is calling you, they are asking for our help. We never wait for a consult to be seen until the next day, even if the service requesting a consultation approves. There is no *silly* consult, only your ego and ignorance that will get you into trouble.

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- In EPIC, it's very easy to fall into the trap of relying on the history listed within the system to populate your note and your mind. So please keep the following things in mind:
    - If this is the patient's first visit to Upstate, they may have a complicated medical history that makes no appearance in EPIC.
    - Meds/PMH/PSH are often written into EPIC by busy nurse professionals. A patient with a history of bowel resection secondary to mesenteric ischemia will be listed in EPIC as "bowel surgery" and the transsphenoidal skull base tumor biopsy as "bone biopsy".
    - If you choose to use the history in EPIC to aid your H&P, please be sure to verify these details with the patients (and obtain a medication list copy if they are admitted).

- When admitting patients, keep in mind that the primary team does not have as many details about the patient as you do so write as complete a set of orders as you can (i.e., include home meds, activity, etc.). It is also your responsibility to call necessary consults on these patients. If you determine that a patient needs to go to the OR from the ER, get blood and procedural consents, and call the OR to post the case.

- Follow-up on your care plans for patients that you had assessed, it will develop your clinical acumen. Simple ER procedures – peripheral IV access, chest tubes, central lines, abscess drainage etc. must become second nature. There are senior residents who are around and are always willing to help.

- Respond to all Trauma activations. Consult residents do primary/secondary surveys and/or procedures.

INTERN RESPONSIBILITIES (PGY-1):

The intern is the member of the team most responsible for the floor management of patients. The major thrust of the first year is not operative experience on complex cases, although substantial operating room experience is desirable. Service must be balanced with education.

- Round with team daily.
- Share in call responsibility.
- Discharge and follow up planning in conjunction with case manager.
- Dictate discharge summaries in a timely manner.
- Routine management of floor patients. Daily assessment and documentation.
- Know daily lab data, radiologic data, and clinical information such as fevers, hypotension, low urinary output, deviations from expected laboratory values, deviation from expected clinical pathways, etc.
- Preoperative preparation of patients, including lab work, radiographs, and consent.
- Attend one half-day clinic session per week.
- Contact more senior residents for any problems or concerns.
- Go to the OR once all floor work is completed or at direction of the chief resident.
- Maintain op log and duty hour log.
- Ask to see ER patients, as well as assist in the management of ICU patients, as directed by the chief resident and senior resident.

MEDICAL RECORDS:

- **EPIC**

  EPIC is the electronic medical records (EMR) system Upstate Medical University uses.
  To access more information on the rules and regulations of our medical records,
  please see page 8 of the Resident and Fellow Handbook located under Resources/Documents
  on Medhub **https://upstate.medhub.com**

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- **SYNAPSE**

  This is the system for viewing radiographs at University Hospital. An orientation will be available for its use. If questions arise, please consult one of the more senior residents. Entry passwords will be provided at the institutional orientation.

To access SYNAPSE:

1- You will need to read through PACS 5 Tip sheet
2- Please complete this form to request access: PACS Account/Request

ROTATION SCHEDULES - AMION:

- PGY-1 AMION Schedule
- PGY-2 AMION Schedule
- PGY-3 AMION Schedule
- PGY-4 AMION Schedule
- PGY-5 AMION Schedule

THE CALL SCHEDULE AND NIGHT FLOAT TEAM:

In general, there are very few rotations in the training program that require in-house night coverage. Trauma, Acute Care Surgery, and the ER consult service will be covered by a "night-float" system. PGY-2 level residents rotating at Crouse Hospital may be expected to do an infrequent 24 hr., in-house shift. Occasionally, for vacation coverage, there may be short periods of change to the typical schedule.

The call schedule will be developed so that all residents will get a minimum of four days off per month. On his/her day off, the resident will have no clinical responsibilities, including rounds. If this is not occurring, it is the resident's responsibility to bring it to the attention of the Program Staff.

NIGHT CALL SLEEPING ROOMS:

Call rooms are provided by the hospital for use by residents rotating on the 6:00 p.m. to 6:00 a.m. shifts. These rooms are in the following areas: (Key code entry necessary for all rooms listed below, EXCEPT sicu)

- Administrative Chiefs - Room 5232A - 5th Floor (North Wing).
- Surgery Junior Resident Lounge - 8th Floor (North Wing) of UH Main.
- Senior Resident Lounge - Room #8802 on the 8th floor of UH Main (South Wing).
- SICU Resident - Room #8407, 8F (East Tower) in NP/PA SICU office suite. (Access by Key).

IX. RESIDENT SUPERVISION

OPERATIVE PROCEDURES:

Attending surgeons must participate in all operative procedures performed, as well as supervise other aspects of each patient's care. This participation is important, not only in the context of patient care and administrative responsibility, but also in fulfilling the educational mission of the Department.

All consultations, admissions and changes in patient status MUST be immediately communicated to the appropriate attending physician. There will be no excuses or exceptions.

However, under appropriate circumstances, senior residents may benefit from the experience of assuming responsibilities for independently executing surgical procedures.

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The following three conditions MUST ALWAYS apply:

1. Every patient undergoing an operative procedure must have an assigned attending surgeon, identified by name in the medical record.
2. Only the responsible attending surgeon may empower a senior resident to proceed with an operative procedure in the attending physician's absence. However, the attending surgeon must remain available to respond in a timely fashion should assistance by the resident be requested.
3. Operating room personnel may, at any time, request verification of the attending physician's permission to proceed. Concerns regarding the appropriateness of that decision or the subsequent execution of the procedure are to be discussed with the attending surgeon, the Section Chief, or the Department Chair.

AMBULATORY CARE:

The residency program requires that all residents who are assigned to rotations in the core surgical areas attend an equivalent of one-half day a week in the outpatient clinic or surgeon's office. To facilitate this requirement, a monthly schedule has been developed to make residents aware of available outpatient experience. Residents should familiarize themselves with the clinic schedule and adapt their activities to facilitate the timely participation in their required clinic experience.

- Be on time!!!
- Participation in clinics and ambulatory care is mandatory. No excuses except for extreme emergencies are acceptable. If necessary, you should be able to find someone to cover your hospital duties.
- Sometimes you may be asked to participate in the clinic of an attending on a different clinical service. Our goal is to provide you with adequate experience among a representative group of patients that you will be seeing in the outpatient environment.
- Scrubs are only allowed in Burns. Please dress like a physician. The typical excuse for wearing scrubs ("I am going to get blood on me!") is not very applicable in the clinic setting. Remember – you seldom, if ever, will wear scrubs in your office when you are in private practice.
- Get to know the office staff. You are a member of the team. Be observant as to the organization and responsibilities among the staff. Pay attention to the flow of patients and how the office is organized. You might have to run your own office one day.
- In general, the resident will see the patient first, without the attending. Introduce yourself as a resident working with Dr. (your attending). In many cases, the patients did not come to see you. You need to use your best professional demeanor to make it work. If, for some reason, the patient doesn't want to see you, back off. It is then up to the attending to make it work.
- Perform an *appropriate* history and physical. Remember – this is a surgical clinic and patients have to flow. On the other hand, if the patient needs some attention, spend some extra time with them.
- After you finish seeing the patient, review any and all pertinent documents.
- Get your thoughts together! The attending is going to want to hear about your formulation and plan.
- Present the patient to the attending. Be firm … don't let the attending go into the room until you have finished your presentation.
- Generally, the resident and the attending will return to see the patient together.
- After the encounter, ask the attending any questions that you might have. It is OK to inquire about why the attending made certain decisions.
- Clinic dictation will be done by the resident unless the attending wants to dictate their own note.
- Stay until the clinic is finished or your half-day is complete. If the resident leaves before the end of clinic, she/he must inform the attending.
- Prior to leaving the clinic, have the attending initial your orange attendance card.

Each resident is required to turn in an orange card documenting clinic attendance monthly. This is required of ALL residents. If a resident is on a night rotation, is on vacation, or is on a rotation that does not have a clinic, he/she should note this on the card and turn it in at the end of the month. The VAH residents should attend office hours with an attending physician at that location.

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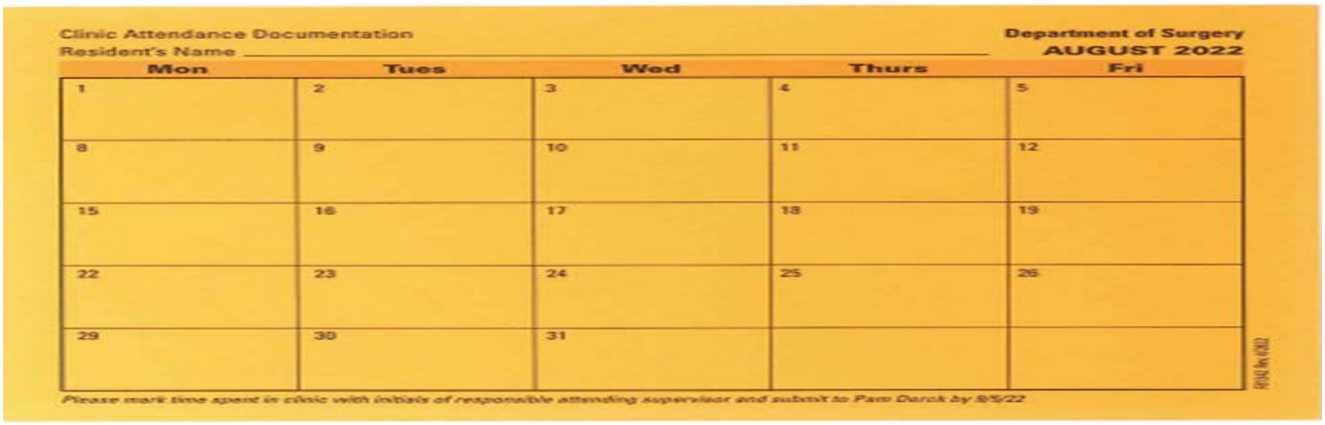
SAMPLE OF CLINIC CARD:

At the end of every month, each resident is required to hand in their completed clinic card. This is an ACGME requirement. A copy of the clinic card can be seen below.

Clinic Attendance Documentation
Resident's Name _____
Department of Surgery
JULY 2022

Mon	Tues	Wed	Thurs	Fri
				1
4 • HOLIDAY	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

Please mark time spent in clinic with initials of responsible attending supervisor and submit to Pam Darck by 8/5/22



Clinic Attendance Documentation
Resident's Name _____
Department of Surgery
AUGUST 2022

Mon	Tues	Wed	Thurs	Fri
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

Please mark time spent in clinic with initials of responsible attending supervisor and submit to Pam Darck by 8/5/22

CONSULTATIONS/ADMISSIONS:

- Consults must be documented EPIC. This should be performed by or reviewed with a senior resident.
- Consults in the ED are to be seen within thirty minutes.
- Attendings must be notified of consults within 60 minutes of being seen by the resident.
- Attendings must see the consult and confirm the resident's findings and plan within 24 hours of the consult being called. The patient's condition may warrant a more rapid response.
- ED consults must be documented and must identify the attending involved in the care.
- Residents may see patients admitted through the ED. Findings documented in an EPIC. This should be performed by or reviewed with a senior resident.

SEEING HOSPITALIZED PATIENTS:

- Residents will see hospitalized patient daily and document their progress and plan in EPIC.
- Attendings will see each patient daily and review the residents' documentation. Evidence of the attending physician's concurrence with the resident's findings should appear in EPIC.
- Attendings should take the opportunity to utilize the inpatients as a teaching occasion and round with the resident's as often as feasible in order teach as much as possible from the experience with each patient.
- If an attending disagrees with the Resident's plan, then the attending should contact the resident as quickly as possible to discuss the differing opinion to enhance the learning experience.

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DAILY SIGN-OUT:

Sign-outs will occur between residents in person at the end/beginning of each shift change. These lists need to be updated prior to sign-out, at the end of each shift. For additional details concerning the sign-out procedure, please consult your chief resident.

INVASIVE BEDSIDE PROCEDURES:

- The attending surgeon has responsibility for all invasive procedures performed their patients outside the OR.
- Most procedures are performed either in the Intensive Care Unit or in the Emergency Department although on occasion these procedures are performed in other hospital units, e.g., surgical wards.

ROTATION CONTACTS:

Contact the chief resident, attending for each rotation at least one week prior to the beginning of that rotation. First line of defense is the chief resident. If you are unable to reach the chief resident, the following list contains alternate contact persons along with the subspecialty chief residents.

ROTATION	CONTACT PERSON	OFFICE / PAGER/ CELL Number
ACS	Moustafa Hassan, M.D., FACS	315-380-2287 cell
BURNS	Joan Dolinak, M.D., FACS	330-310-1795 cell
COMMUNITY HOSPITAL	Jeffrey Albright, M.D., MBA	205-529-8762
CRITICAL CARE (SICU)	Amie Lucia, D.O.	315-525-1616 cell
CROUSE ROTATIONS	Benjamin Sadowitz, M.D.	470-2735 off.
PEDIATRIC SURGERY	Andreas Meier, M.D.	217-801-6696 cell
SURGICAL ONCOLOGY I (Hepatobiliary)	Mashaal Dhir, M.B.B.S. Thomas VanderMeer, M.D. Kristen Kelly, M.D.	443-468-4653 cell 607-731-8285 cell 505-239-7243 cell
SURGICAL ONCOLOGY II (Colorectal)	Joseph Valentino, M.D. Kristina Go, M.D.	895-492-9405 cell 814-233-5887 cell
THORACIC	Jason Wallen, M.D.	909-553-9929 cell
TRANSPLANT	Reza Saidi, M.D.	315-464-7329 office
TRAUMA	Roseanna Guzman, M.D., MPH, FACS	310-701-3682 cell
VAH	Amit Goyal, M.D.	315-727-6714 cell
VASCULAR	Michael Costanza, MD, FACS	315-416-2727 cell
ANESTHESIA	Corey Austin, Interim Program Administrator	315-464-4889 office
ED	Cynthia Sidari, Program Administrator	315-464-6211
ENT	Geoffrey Ameele, Program Administrator	315-464-7281 office
ORTHOPEDIC SURGERY	Kristen Hyer, Program Administrator	345-464-6448 office
UROLOGY	Susan Schulze	315-464-6102 office

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X. THE DIDACTIC EDUCATIONAL PROGRAM OF THE RESIDENCY

M&M and Grand Rounds information can always be found on the Surgery Events Calendar:
Surgery Events Calendar | Department of Surgery | SUNY Upstate Medical University

There are many components of the didactic curriculum. The agenda of conferences has been designed to provide a balanced educational experience to supplement the residents' clinical experiences. It is expected that all surgical residents will attend conferences except in the case of surgical emergencies. All residents, regardless of General Surgery or Specialty services must follow the guidelines below.

1) When on the general surgery service, residents are required to attend General Surgery conferences. You may attend your "home specialty" conferences if they do not conflict with morning rounds.
2) When a resident is on nights, they must attend educational conferences via WebEx.
3) Residents on vacation are not required to attend.

MORTALITY AND MORBIDITY CONFERENCE (M & M):

- Wednesday 7:00 a.m., Dept. Of Surgery M & M Conference, room 2231 WSK, (Attendings & residents)

Senior residents on each service are required to maintain a list of all cases scrubbed by any resident as well as all the complications. If there are no complications, senior residents must still be prepared to present a list of cases performed in which residents were involved.

Each service will be scheduled to present **M&M** approximately every 1-2 months. The senior residents will be contacted in advance of their scheduled presentation date. The choice of which case to present will be left to the residents and the attendings on the presenting service. The residents must be prepared to present the case in detail along with pertinent literature to illustrate teaching points.
M&M lists must be presented using the Excel Spreadsheet via the Dept. of Surgery

a. Reports must be appropriately titled so that they can be downloaded and saved.
b. The titles must follow the format "Service Name_MM-DD-YYY_**M&M"**
   i. E.g., "VAH_07-23-2013_M&M"
   ii. Improperly formatted and/or titled files will not be accepted

After M&M conference, the completed power point presentation should be emailed to the M&M Surgical Education Administrative Assistant, Pam Derck.

GUIDELINES FOR PRESENTATIONS

- Expect to have no more than 30 minutes for your entire presentation
  - Limit your slides accordingly.
  - Have your presentation loaded and ready to go prior to 07:00 start.
- Anticipate questions, answer them as you present - the best defense is a good offense! Questions you must answer as you present:
  - What was the indication for the procedure? What went wrong?
  - How could the complication have been avoided? How was it handled?
  - Should it have been handled differently?
  - What would YOU do differently the next time?
- Have references for the research you've done.
- Summarize the results and conclusions of any cited studies. Do Not reproduce the data, charts, statistical analysis. Give a one sentence summary of the quality of the report: "level I b", etc.
- All presentations should include a slide of "Analysis" in which the error (if present) is classified.
- All presentations should include a slide of "Recommendations".

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GRAND ROUNDS:

- Wednesday 8:00 a.m., Dept. Of Surgery Grand Rounds, room 2231 WSK (Attendings & residents)

Grand Rounds are held weekly September – June. The scheduled speaker and topic will be announced approximately one to two weeks prior to the presentation. A majority of the presentations will be named lectureships and visiting professors as well as annual scheduled presentations (i.e. chair's presentation). The remaining twenty presentations will be given by the faculty, residents, and invited local "experts" in an area of broad surgical interest. Presentations will be approximately one-hour in length. The PGY-5 residents will be asked to present a Grand Rounds presentation on a current topic in general surgery that will be of interest and of educational value to the general surgery residents and staff. Please place your pagers on vibrate mode during Grand Rounds.

SURGICAL CORE CURRICULUM:

- Wednesday 9:00 a.m. Resident Didactic Sessions, room 2231 WSK (All Residents)
- Wednesday 11:00 a.m. Residents will be required to return to their clinical duties.

These sessions consist of various formats (interactive lectures, skills labs, etc.)

XI. DEPARTMENT OF SURGERY COMMUNICATION TOOLS

PAGERS:

Each general surgery resident, both preliminary and categorical, will be provided with a pager for as long as they are a resident in the Dept. of Surgery. Most pagers have a (213) prefix followed by the four identifying numbers of your pager. When paging someone, dial 315 plus the seven-digit pager number. When prompted, enter your phone extension number followed by the # sign.
If your pager malfunctions or stops working altogether, please see Kelly Liberati in room 8602, the Office of Surgical Education. Kelly also has a supply of both 'AA' and 'AAA' batteries. Should a problem with your pager occur while you are on call during the night or over the weekend, please contact the Public Safety Office on the first floor of University Hospital. Public Safety has a supply of spare pagers and printed, step by step instructions on how to contact USA Mobility/SPOK to activate a replacement. www.usamobility.com

PAGES TRANSFERRED TO YOUR CELL PHONE:

Residents interested in having their pages sent to their cell phone may do so. Please see Kelly Liberati.

MAILBOXES:

Mailboxes for each house officer are maintained in the Department of Surgery main office, Room 8141, UH, and mail may be picked up at any time. Please check and EMPTY your mailbox regularly.

E-MAIL:

All Upstate employees are issued an Outlook account for hospital communication.
Residents are asked to check their email daily.

COPY MACHINES:

Your employee I.D. # is your access code to use either of the department's photocopying machines located in #8141 UH (main surgery office) and also across the hall from the Resident Lounge, room #8802. This should be used for photocopies related to the residency or patient care.

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XII. APPROPRIATE RESIDENT ATTIRE

The residency training program requires extensive patient contact, and the residents play a significant role in representing the Department of Surgery. Some guidelines have been established for the appropriate dress of the surgical residents.

ON CLINIC AND ROUNDS:

At the start of the residency, each resident will be issued three long, white lab coats, which will have their names, embroidered on them. This lab coat should be worn during all patient contact, at all teaching facilities. The white coat helps identify you as a member of the Department of Surgery to patients and nursing staff.

As with all places in the hospital, your laminated I.D. badge, appropriate to the hospital to which you are assigned, must be worn at all times.

OR ATTIRE:

There are two specific Upstate attire policies for the Operating Rooms on the 3rd and 5th floors.
They are the Scrub Attire Policy and Peri-operative Procedural Attire Policy.

1- Upstate Scrub Attire: https://upstate.ellucid.com/documents/view/1328
Additional information regarding scrubs not listed in the Upstate Scrub Policy

- Everyone is given two scrub credits for the ScrubEx machines.
- ScrubEx machine Dispensary locations:
  - 5th floor, Main OR hallway, Rm E5410A
  - 3rd floor, Peds OR, end of west wing hallway
  - ➢ Swipe ID to get scrubs
    - If size is required, type in desired scrub size
- ScrubEx machine Return locations:
  - 3rd and 5th floor OR locker rooms
  - ➢ Swipe ID to open return drawer
    - Separate top and bottom
    - Check screen to make sure return was registered

2- Peri-Operative Procedural Attire: https://upstate.ellucid.com/documents/view/3874

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XIII. LICENSING AND PRESCRIBING MEDICATIONS

LICENSING AND LOAN FORMS:

Please bring any forms that require the Program Director's signature to Kelly Liberati in the Education Office, #8602 UH.

MEDICAL LICENSE:

Residents are not required to have a medical license in New York State. However, you must remember that your medical practice privileges only apply to your work as a trainee under the direct supervision of a NYS licensed physician as part of your training program.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS:

To write prescriptions for controlled substances you will use the institutional DEA number (AS-0552489) with your personal suffix number which can be found on the certification page in Medhub.

SPECIAL AND AUTOMATICALLY EXPIRING ORDERS:

1. **Controlled Substances:** IV narcotics are valid for 72 hrs. Routine orders are valid for 30 days.
2. **Antibiotics**: Antibiotic orders written for presumptive use automatically expire after 7 days and must be renewed. Antibiotics orders written for documented infection expire after 14 days. If you desire an order for a shorter time, so state in the order (e.g., 3 days, 5 days).
3. **Anticoagulants**: Heparin and fractionated heparin for DVT prophylaxis do not need to be renewed. Therapeutic heparin should be ordered according to protocol.

I-STOP:

Prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. The PMP is available 24 hours a day/7 days a week via an application on the Health Commerce System (HCS) at https://commerce.health.state.ny.us.
Patient reports will include all controlled substances that were dispensed in New York State and reported by the pharmacy/dispenser for the past six months. This information will allow practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be abuse or non-medical use.

Your residency program will contact you prior to the start date of your intern year to enroll you in I-Stop.

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XIV. MALPRACTICE AND REPORTING DEATH AND ILLNESS

RISK MANAGEMENT:

If you believe that an adverse event has occurred to a patient for whom you are providing care, please contact your Attending.

If you are served with legal papers indicating that a lawsuit is pending, immediately contact Risk Management. You must also notify the Surgical Education Office. Shortly after notification, you will be scheduled to have a meeting with the hospital's claim manager or the Risk Manager.

MALPRACTICE CONTACTS:

Note: There are specific individuals who've been identified as primary contacts for malpractice or general liability at each hospital.

SUBPOENA:

If you receive a subpoena to testify in a criminal or malpractice case, immediately contact Upstate Risk Management (RM) at 315-464-6177, they will give you with next steps. Also, notify the GME Office and Program Director and provide each of them with a copy of the subpoena.

Electronic Death Registry:

Your program will sign you up for the electronic death registry. The healthcare provider pronouncing the patient dead is responsible for completing the death certificate, in the EDR database, within 72 hours.

Certain categories of deaths (lister below) must be reported to the Onondaga County Medical Examiner's Office of (315-435-3163).

- Violent death--whether by casualty (i.e., accidents), criminal violence, suicide.
  This includes death in the hospital after accidental injury, such as auto accidents.
- Death as a result of unlawful acts or criminal negligence.
- Suspicious, unusual or unexplained death; or sudden death while in apparent good health.
- Death by poisoning, or suspicion of poisoning.
- Death while unattended by a physician.
- Death while confined in a public institution other than hospitals (i.e., jail, etc.)
- Death on the operating table or while under anesthesia.

If in doubt as to these categories, notify the Medical Examiner's Office anyway and abide by their decision.

REPORTABLE ILLNESSES:

The New York State Sanitary Code requires the reporting of certain illnesses to the County Health Department. These are primarily infectious diseases (including venereal disease), hospital associated infections, and malignancies. The Ward or ER secretaries can obtain the cards required for these reports. If you have further questions regarding this procedure, contact Hospital Administration at 315-464-4240.

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XV. RESIDENT BENEFITS

PRESENT SALARIES 2022-23:

Pay scale is determined by year of clinical service. SUNY UMU resident salaries are among the highest in the U.S. Employees are encouraged to take advantage of direct deposit. If you do not use direct deposit, checks for house officers are available for pickup in the Payroll Office located on the 1st floor of Jacobsen Hall, on alternate Wednesday's beginning at 7:00 a.m. Deductions are made for Federal and New York State income taxes, Social Security (FICA), the TIAA-CREF retirement plan, and hospitalization insurance.

PGY I	$56,263	**PGY IV**	$65,905
PGY II	$60,498	**PGY V**	$68,961
PGY III	$63,310		

HEALTH INSURANCE:

Health insurance is provided at a minimal charge; an optional family plan can be purchased. Dental insurance is provided for the resident and family for a small fee. Life insurance is provided at no cost; additional coverage may be purchased. Disability insurance is provided at no cost. Additional disability insurance is available.

PROFESSIONAL LIABILITY INSURANCE:

Residents are NYS employees and are covered under Section 17 of the Public Officer's Law of New York State. In lieu of commercially purchased professional liability insurance, New York State provides for defense and indemnification for employees who are sued for actions arising from and within the course of their duties. This self-insurance program does provide for "tail coverage" following their discharge from service.

CATEGORICAL RESIDENT MEMBERSHIP, EQUIPMENT, AND TRAVEL:

RESIDENT LEVEL	BENEFIT
PGY-1	SCORE, ACS Membership
PGY-2	SCORE, ACS Membership, Surgical Loupes
PGY-3	SCORE, ACS Membership
	Travel and expenses to meeting with a podium presentation ($1,000 max)
PGY-4	SCORE, ACS Membership
	Surgical Text Reimbursement ($300 max- One time)
PGY-5**	SCORE, ACS Membership
	ACS Annual Clinical Congress or specialty meeting ($1,000 max)
	Travel and expenses to a meeting with a podium presentation ($1,000 max)
	Captain's Chair and Graduation Dinner
**	Residents requiring ABSITE remediation will be sent to a review course in lieu of a national meeting

MEAL ALLOWANCE:

Kelly Liberati will be submitting the information to have a meal allowance loaded onto your badge.

PGY – 4 & 5: $266.00 semi-annually
PGY – 1-3: $210.00 semi-annual

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VACATION RULES AND REGULATIONS (exempt: family illness, death):

- Vacation request **green sheets** must be submitted to Program Administrator (Kelly) and have administrative chief approval for any time off. If you don't, you will be expected to work.
- Vacation request should be submitted by July 31st. If they're not, vacation time will be assigned according to when it will fit in best with rotation coverage. If you need to chance a vacation later in the year, we will try to accommodate it, but it will not be guaranteed.
- Vacations are Monday - Sunday. The Sunday prior to your vacation off is not guaranteed.
- Do not make plans (buying plane/bus tickets, hotels, etc.) until your vacation has been approved by the chief resident or the schedule published in AMION.
- Delinquent medical records, at all hospitals, must be complete and before vacation leave begins!!
- Vacation assignments will be given priority based on date received, and level of seniority.
- Vacations will be denied to senior residents if more than two seniors are already scheduled off, or if more than three junior residents are already scheduled off on a given week at Upstate.
- Vacations will be denied to Jr. residents if more than three Jr.s are already scheduled off on a given week at Upstate.
- Request to change a vacation for a specific golden weekend must be submitted at least six weeks in advance. No changes will be made once the schedule has been published.
- You may not take more than one week off on a given rotation. If you need to take two weeks off, it should be done at a time that straddles two rotations.
- VACATIONS ARE NOT ALLOWED on Trauma, Nights, Consults, SICU, Burns
- VACATIONS ARE NOT ALLOWED IN JULY.
- Only one individual at a time may have vacation at Crouse, CGH, VA.
- Vacations will not necessarily be granted during the last two weeks of June. Exceptions will be made for the outgoing PGY-5 class and undesignated preliminary residents who may take the last week off.
- Vacations will not necessarily be granted during the week of Thanksgiving or the two weeks around Christmas and New Year's. Requests will be reviewed on a case-by-case basis. All residents will receive 2 days off during the week of Thanksgiving and 3 days off during the time around Christmas and New Year's. If you take vacation during this time, no additional days off will be granted.
- You are allowed one conference/educational event exempt from vacation time. All subsequent conferences count towards vacation time (even if you are presenting). You must still ask in advance for the time off and we reserve the right to deny requests if we determine there is a concern that it will compromise service coverage.
- When scheduling Step 3, ATLS, ACLS, and PALS, etc., please verify with the administrative chief resident that there is appropriate coverage available PRIOR to scheduling. Do not schedule in the last two weeks of June or while on a rotation in which you're not allowed to take vacation. If you have chosen to take a vacation week during the time of an exam (Step 3, ABSITE), this will count as a vacation day. Otherwise, these days do not count as vacation days.
- For those individuals expecting to interview during the year, you should still request vacations early, but they may be retracted later.
- It is expected that senior residents will find case coverage for their scheduled cases PRIOR to leaving for vacation. It is expected your colleagues will help to cover work and cases while you are away. Similarly, you are expected to help when they are on vacation. If any individual is not willing to allocate resources to help others, residents will be assigned to cases, clinics, and to help round with services.
- Notify your attendings (and the rest of your team) of your vacations early on (both juniors and seniors). Additionally, notify the other seniors that you will be absent, so they know to help cover "add on" cases.
- Please be respectful of your colleagues. Vacations are a right, but also a privilege. Consider how your vacation will impact the service and strive to allocate case coverage for the week you are away.

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WEEKENDS OFF:

Having a golden weekend off is a privilege we try to provide when feasible. Please keep in mind that time off requests must be viewed considering the overall schedule and how many people are out for various reasons. There are certain rotations for junior residents where it simply is not feasible to provide an entire weekend off. This includes Trauma, Nights, SICU, Burns, and Consults.

For those on Upstate general surgery services not listed above, you may submit your request for a weekend off no less than thirty days prior to the time off requested. If you submit a request any later than thirty days prior, then the time off will not be given.

While we will try to provide for weekends off, they are not guaranteed.

ACADEMIC TRAVEL POLICY:

Residents in good standing are encouraged to attend and/or present at national and regional meetings focused on general surgery and the surgical specialties. We believe that these meetings will help enhance the educational opportunities for the resident and provide the opportunity to experience the fellowship of the surgical community.

The following policy applies for all residents – educational leave will be granted in the following circumstances:

- The resident presents or has a poster display of original research, at a national meeting.
- The resident defines a meeting that substantially contributes to their educational experience or helps to define a career choice.
- The resident attends a board review course to help improve academic deficiencies.

The General Surgery Residency Program has developed a policy concerning the support of travel to meetings in the upcoming academic year.

The policy for funding of travel to educational meetings is as follows:

- The department will fund the expenses of a resident who presents original research at a national meeting for work performed while the resident is in this program.
- Prior to submitting the abstract or other academic material that will be competitive for a presentation at a meeting, the resident must submit a copy for approval by the Surgical Research Council. If the resident does not gain approval of the SRC prior to submitting the abstract for consideration, travel funding will not be considered. The following considerations will be undertaken:
  -Is the selection of the presentation competitive and subjected to peer review?
  -Is there value of presenting at the meeting? What is the academic impact?
- If the resident's abstract has been accepted for presentation as a poster, educational leave will be granted. The resident will be given $500 for travel and registration expense. Other funding can be requested from the primary sponsoring laboratory.
- If the resident's abstract has been accepted for podium presentation, educational leave will be granted. The resident will be given $1000 for travel and registration expense. Other funding can be requested from the primary sponsoring laboratory.
- The residency program will pay up to $2,000 for educational meetings or a board review course for each (PGY-V) resident in good standing. It's common that the PGY -5 resident will attend the fall Clinical Congress of the American College of Surgeons. If the resident picks a different meeting/board review, it must occur while the resident is active in the program and must be approved by the Program Director.
- All educational leave and travel reimbursement must have prior approval by the Dept. Chair in the form of a signed travel authorization. No funding for travel will be allowed for a resident who is not in good standing. Due to NYS rules, we are unable to give travel advances.
- Requests for reimbursement must be validated by appropriate receipts in accordance with UMU policy.

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FAMILY AND MEDICAL LEAVE:

Per Federal regulations a resident may be permitted to take up to twelve (12) weeks, per 12-month period of family and medical leave without compensation (other than paid vacation and/or sick leave) in accordance with the Family and Medical Leave Act of 1992, state law, and the policies of the Affiliated Hospital. However, please remember that taking an extended leave will jeopardize meeting the American Board of Surgery guidelines for the Qualifying Examination and may delay a resident's graduation date. The resident shall make requests for family and medical leave (including maternity and paternity leave) by first notifying Kelly in the Education Office, who will then contact Human Resources at 315-464-4943. **Eligibility for this benefit occurs after one year of continuous employment.**

MILITARY LEAVE:

If military leave is required, your position and benefits will be preserved. You must work with the employing hospital to ensure that appropriate paperwork has been completed. If you have planned guard or reserve duty or obligations, the program will require that you use vacation time for this activity.

JOB SEARCH LEAVE (INTERVIEW TIME):

Time off will be granted for job search (interviewing) activities. This scheduled interview and travel time off will be charged to vacation/holiday comp.

EDUCATIONAL LEAVE:

Educational leave per year, per resident, other than those residents in a dedicated research year, must be valid and will be limited at the discretion of the Program Director. There is always the option of using vacation days to attend meetings, courses, etc. Examples of educational leave include (SAGES Course, FLS testing, specialty meetings w/presentation). Residents will be responsible to find their own coverage, with the assistance of the administrative chief resident. Coverage needs to be in place prior to requesting the time off. Time spent attending this meeting will not be charged as vacation time.

Should a resident be invited to present at a meeting for which a paper or abstract has been accepted, they may request permission to attend by submitting a "Resident Time Away Request" and Travel Authorization form to the Education Office for approval. If you are presenting,

USMLE STEP III LEAVE:

Please coordinate with the Program Administrator, Kelly Liberati, if you wish to take off for Step III exam **PRIOR** to finalizing the dates, this is to ensure adequate coverage and to avoid conflicts with previously scheduled time off.

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XVI. THE RESEARCH EXPERIENCE

The Upstate Surgery Residency Program offers the opportunity to provide an experience in surgical research for the interested resident. This experience is not required. Residents interested in a research position must contact the Program Director, as soon as possible, so it can be verified that their research experience will not conflict with the number of residents coming in and out of the program each year.

The Department of Surgery has several surgical laboratories where research is performed. Research opportunities outside of Upstate will be considered as well.

The following guidelines have been established:

- The basic or clinical science research experience will be taken after the PGY-II or PG-III year.
- For each year, one or two of the five categorical residents may be eligible to participate in a research experience.
- Research experience typically lasts anywhere from one to three years in duration.
- The selection of the individual resident to do research will be based on:
  - The academic and clinical performance of the resident in the first two years of the residency program.
  - The consistency of the research experience in the overall career goals of the resident.

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XVII. FACULTY ADVISORS AND ASSIGNED RESIDENT

Each resident has a Faculty Advisor (FA) during their general surgery residency training. They should meet with their advisor at least twice a year: Fall (around October or November) and Spring (around April or May). The purpose of these meetings is to review recent rotation evaluations, discuss concerns or problems, discuss plans for participation in a clinical research project, and most important of all MILESTONE evaluation. The FA will have access to their resident's evaluations, operative assessments, ABSITE scores, etc.

During biannual MILESTONE evaluations, the Clinical Competency Committee (CCC) will discuss residents. If a resident is noted to be having academic or clinical difficulty, the advisor and CCC will work through a remedial action plan. The PD and FA will then follow the resident's progress as the deficiencies are corrected. Residents should feel free to discuss problems concerning the residency, faculty, or hospitals with his/her advisor.

Department of Surgery Resident Advisors 7/1/22 - 6/30/23					
PGY-1		**PGY-2**		**PGY-3**	
Resident	**Attending**	**Resident**	**Attending**	**Resident**	**Attending**
Abi-Aad, Karl	Dr. Kelly	Ellis, Jarrod	Dr. VanderMeer	Farhat-Sabet, Ashley	Dr. Hassan
Cammisa, Allison	Dr. Luca	Francois, Jean Luc	Dr. Kelly	Iyer, Advait	Dr. Archer
Eccleston, Catherine	Dr. Kollisch	Laskar, Sahib	Dr. Crye	Mahendran, Karthika	Dr. Costanza
Lee, Jamie	Dr. Kollisch	Pinkes, Katherine	Dr. Stanger	Marmor, Hannah	Dr. Dhir
Melnyk, Brooks	Dr. Whitney	Read, Sydney	Dr. Dolinak	Okoye, Amara	Dr. Valentino
Peet, Gideon	Dr. Costanza	Sykes, Alexis	Dr. Go	Pruekprasert, Napat	Dr. Cooney
Quatela, Olivia	Dr. Go			Ramcharran, Harry	Dr. Lai
Schumacher, Katherine	Dr. Rabach			Samuel, Ankhita	Dr. Wallen
Steinmetz, Emma	Dr. Guzman				
Weintraub, Collin	Dr. Cooney				
Wilson, Danielle	Dr. Meier				
PGY-4		**PGY-5**		**Research**	
Resident	**Attending**	**Resident**	**Attending**	**Resident**	**Attending**
Arul, Manu	Dr. Shahbazov	Hargis-Villanueva, Angela	Dr. Lucia	Dimmer, Alexandra	Dr. Meier
Beaulieu, Daphnee	Dr. Cooney	Magowan, Elizabeth	Dr. Wallenstein	Sporn, Matthew	TBD
Bieterman, Andrew	Dr. VanderMeer	McElfresh, Megan	Dr. Hanlon		
Chen, Alexander	Dr. Feghali	Quinzi, Allison	Dr. Wallen		
Khan, Asama	Dr. Albright				
Mana, Gary	Dr. Dudhani				
Rahman, Naveed	Dr. Feghali				
Senay, Ayla	Dr. Hanlon				

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XVIII. EVALUATION AND TESTING

ABSITE:

Each year, in late January, the program will administer the five-hour multiple-choice ABS In-training Exam. that tests resident knowledge of surgical basic and clinical science. All general surgery residents must take this test and no vacations will be allowed at the time it is administered. Scores are available in early March. Performance is benchmarked to all surgical residents in the country who have taken the exam.

While the ABSITE is not the only assessment of the resident's cognitive knowledge base, it is a good indicator of each resident's ability to pass the Qualifying Exam (QE) of the ABS. Published reports show that residents who score below the 30th percentile in the ABSITE have a predictable high failure rate on the QE. Therefore, we have set the lowest acceptable limit of performance on this exam at this level.

MOCK ORAL EXAMS:

Each year, in May, all Surgery residents will take a mock oral exam that's similar to the Certifying Examination (CE) of the ABS. In Oct/Nov, all senior residents will participate in mock oral exams. Two examiners will question each resident, in two 30-minute clinical scenarios sessions that represent broad areas of surgery including GI, endocrine, oncology, trauma, critical care, breast, hepatic, pancreatic, and vascular areas. The purpose of the exam is to define the resident's clinical approach to common surgical problems. Each session, residents will be given evaluations to help determine whether the resident has the skills to pass the CE. Feedback about oral test taking skills will be provided individually after the exam.

USMLE STEP III AND COMLEX III:

To view the "policy on united states medical licensing examination (USMLE)/comprehensive osteopathic medical licensing examination of the United States (COMLEX)" please use https://upstate.medhub.com/.

You will find this policy by accessing the following:

- Medhub left navigation section "Resource/Documents"
- Then "Policy/Guidelines"
- Then "Selection Criteria"

XIX. ASSESSMENT AND ADVANCEMENT

In addition to the ABSITE, Mock Orals exams, listed above, other assessment processes will be considered in resident advancement.

PURPOSE OF THE EVALUATION SYSTEM:

- To provide information on the quality of the residents.
- To make decisions on promotion.
- To provide data to specialty boards for certification.
- To write letters of recommendation.
- To Identify performance deficits to improve the quality of the resident's patient care.
- To Identify program strengths and weaknesses and target areas for modification in the curriculum.

ACGME MILESTONES:

As mentioned under "XVI. Faculty Advisors and Assigned Resident," Milestone evaluations are performed twice annually. This forum will allow the attendings to share information and experiences that provide additional information on resident performance. The Chair and PD will decide on the promotion status of each resident.

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ATTENDANCE:

Attendance at resident educational forums is mandatory. The program administrator will maintain a log of attendance of the resident at each meeting. Low attendance will be considered as reflecting lack of interest and motivation in the resident's self-study curriculum.

MEDICAL RECORD COMPLETION:

Repeated episodes of delinquent medical record completion at any participating hospital will not be tolerated. Delinquencies will be considered deficiencies in communication skills and professionalism.

MEDICAL STUDENT EVALUTIONS:

Medical students will be offered the opportunity to provide feedback to the program on the performance of each of the residents they work with. This will be used not only to assess the teaching capabilities of each resident, but also will contribute to the assessment of the resident's communication skills and professionalism.

OPERATIVE LOG REVIEW:

Periodically, the PD and/or administrator will review each resident's ACGME Operative Logs to verify current entries. Review will focus on two areas:

- The completeness of the log, (i.e., Are the residents current in their entries?)
- The breadth of experience, (i.e., Are the residents performing the appropriate number and variety of cases for the year of training?)

ROTATION EVALUATIONS:

At the conclusion of each rotation, every resident is evaluated, in MedHub, by the teaching attending, staff, and senior resident of that service. The evaluations, which include several criteria encompassing various aspects of clinical performance, are compiled, and summarized biannually. The resident has full access to these completed evaluation forms. These evaluations are strategic in determining the biannual Milestones evaluation meeting.

PERFORMANCE FEEDBACK - Residents will receive feedback on their performance by several avenues:

- Advisor meetings – (See "XVI. Faculty Advisors and Assigned Resident.") The advisor and resident will review the Milestones, discuss academic and clinical progress as well as other issues including career choices, satisfaction, and any other important issues that may require the help of the mentor. The resident will sign all the Milestones to demonstrate that they have been reviewed. The adviser will be asked to provide the program documentation of this meeting so that it can be used as part of the bi-annual Milestone report to the ACGME. The adviser will be the resident's advocate at CCC meetings.
- Oral test taking skills will be provided individually after the Oral Exam.
- Residents will always have access to their ABSITE scores, quiz scores, and other materials. These files must be reviewed in the Residency Office to maintain confidentially of the records.
- Review of Evaluations – Residents can review their evaluations in MedHub.
- Program Director meetings – Each categorical resident will meet with the PD at least twice a year. A summary of the evaluations and the outcome of the CCC meetings will be discussed with the resident. Issues requiring remediation will be defined and expectations of resident performance will be established. Written documentation of these meetings will be kept in the resident's file.

ADVANCEMENT DISAGREEMENT RESOLUTION PROCESS:

If a resident disagrees with a decision concerning advancement or retention in the residency program, they should follow process below:

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- The resident should first discuss the situation with the Program Director. All contributing factors to the decision should be made available in writing to the resident. The Program Director will outline the logic and rationale behind the decision including any possible corrective action that would be necessary to reverse the decision. The Program Director will review the resident's concerns and reply to them in writing within seven (7) working days. This response must be shared with the Department Chair. The Program Director will discuss the situation with the Associate Dean for Graduate Medical Education if early termination or non-renewal are being considered
- If the resident is not satisfied with the resolution within the Department of Surgery, they may file an appeal to the Associate Dean for Graduate Medical Education within 10 working days according to page 41 of the Resident Manual (https://upstate.ellucid.com/documents/view/4915), APPENDIX 1: "Standard Operating Procedures (SOP) for the Eligibility, Selection, Appointment, Evaluation and Dismissal of Residents."

If the program determines that the resident's contract will not be renewed, the resident will be notified by April 1, unless the decision is due to a sentinel event following that date.

XX. OPERATIVE CASE DOCUMENTATION

OPERATIVE NOTE DICTATION:

In general, if the surgical resident has done 50% or more of the operative procedure, they will be requested to dictate the operative report. If there is any question, ask the attending before the end of the operation. The operative note MUST ALWAYS be dictated immediately following completion of the operation. Outlines and forms are available at all hospitals, which indicate the format for this dictation. The format is as follows:

- Give your name, surgical resident, and appropriate year, dictating operative note for Dr._____.
- Patient's name
- Date
- Preoperative diagnosis
- Postoperative diagnosis
- Operative procedure
- List the names of the surgeons, surgical assistants (including scrubbed students)
- Details for operative procedure *(The operative procedure includes the dictation of)*:
  - The type and induction of anesthesia
  - The type of prepping and draping
  - The manner and location of the incision
  - The intra-operative findings
  - The operative procedure including types of sutures used
  - Closure technique
  - The details of number of transfusions and placement of drains
  - Statement that "sponge" and instrument count was correctly noted at the end of the procedure.
  - A final line noting the status and condition of the patient at the end of the operative procedure
- A reference to the attending involvement in the case.

ACGME RESIDENT CASE LOG SYSTEM: ACGME Help Desk (312) 755-7464

The case log system utilizes CPT codes to track resident experience. The Residency Review Committee (RRC) have indexed these codes into categories for evaluation. Only the RRC codes are used to evaluate experience. Residents are responsible to entering and maintaining procedures on a regular basis.
Entry can be done from any device connected to the internet. Residents are responsible for maintaining their own logs and entering their critical care index cases into the ACGME Operative Case Log at (www.acgme.org). Failure to stay current with your operative case logging has the potential to:

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- **Hurt the program.** Delays may minimize the number and volume of reported cases for the program.
- **Hurt resident colleagues.** We have petitioned the ACGME to have extra residents stay in the training program as PGY4 and PGY5 categorical residents. Failure to document sufficient OR case volumes (by all residents) will impact the ACGME's decision on whether to allow us to do this.
- **Hurt yourself.** By failing to present an accurate record of the number/variety of cases completed, you may impact your eligibility for the ABS examination or surgical privileges when you seek credentials in your first job.

NON-OPERATIVE TRAUMA:

- The tracking of non-operative trauma will be entered in the ACGME surgical log reports by using the CPT Code 99199 with all the data elements required for identifying the patient encounter.
- The essential criterion to receive credit for the management of non-operative trauma is the patient had to be admitted to a special care unit (SICU). The 3rd resident on the trauma service should take credit for these patients. Non-operative trauma includes all patients who do not require a surgery, who are admitted to SICU for management of their injuries.

XXI. SUPERVISION OF MEDICAL STUDENTS (MS) & MS POLICIES

MEDICAL STUDENT INSTRUCTIONS:

In a university training program, all members of the attending and house staff have certain teaching responsibilities. Residents play an integral role in the medical students' education and are often considered the primary teaching resource. As a result, they are expected to help guide students through several clinical areas that include an introduction to the medical management of surgical disease and an explanation of the principals of caring for the surgical patient. Residents are also expected to provide students with support in non-clinical areas in the form of guidance in a respectful positive learning environment.

Residents will be assigned one to two students, depending on service, each ten-week EM/Surgery clerkship block. Students are advised to contact their Chief Resident before their rotation begins, via text, to verify reporting instructions. Student hours are 6:00 am - 6:00 pm. The students are given expectations for each service. However, the residents may add additional expectations if they are clearly defined to the students. The Resident on service will also be responsible for assigning each student one to three patients. It is recommended that equitable distributions of various types of patients, in terms of diagnosis, are assigned. The resident is primarily responsible for the practical daily instruction of students on the floor. Residents should also review at bedside with the student, individually or as a group, physical findings, treatments, diagnosis, and procedures

Students must be directly observed taking a history and performing a physical exam to complete their Mini CEX form. They are required to have at least one of the H & P completed by an attending However, residents may now also sign-off on one of the two required H&P's. Students should always be encouraged to participate in all team functions including rounds, clinics, and the Operating Room.

Residents will be asked to complete MedHub evaluations on students and provide formative performance feedback. Residents should encourage student questions and independent thinking by asking questions that require reasoning and allowing students time to think and respond. Residents need to encourage self- directed learning by permitting students to investigate a variety of learning experiences (i.e., participating in surgeries, reviewing MRI, CT, or X-ray imaging, observing a radiographic study ultrasound, observing an interventional radiology procedure, fluoroscopy, or adult endoscopy, practice an IV placement in the pre-op area, or spend time in Pathology reviewing specimens and discussing findings.

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MEDICAL STUDENT POLICIES:

The LCME requires that residents have access to pertinent medical student polices and educational program objectives.

- Blood and body fluids exposure policy: https://www.upstate.edu/currentstudents/support/health/exposures.php
- Clerkship Absence Policy: https://upstate.ellucid.com/documents/view/10213/?security=891ea092c454d5b375959404ea867f1acc21e127
- Clinical Evaluation Policy: https://upstate.ellucid.com/documents/view/10232/?security=0d5c7f13a6d33a4165e368fbd75181f0c53d11ca
- Direct Observation Policy: https://upstate.ellucid.com/documents/view/10218/?security=54c3c96d2ed60f455186c89a8110bb586f68d7f0
- Duty Hours Policy: https://upstate.ellucid.com/documents/view/10628/?security=a5b954894e7dfd54453b333bbf76411c4e2ea4c3
- Resident and Non-faculty Instructors as Teachers Policy: https://upstate.ellucid.com/documents/view/11767/?security=91557485d3774b5304351ec0623fcbd6e0d4125c
- Policy and Procedures on Learning Environment & Mistreatment: https://upstate.ellucid.com/documents/view/10247/?security=2ff36a5960054c097e50f58d56b5ebfe2d75a980
- Policy on Professionalism: https://upstate.ellucid.com/documents/view/10248/?security=6a3ae136424a83589521f872cfb214c3c98c6a07
- Gold Star Program: https://www.upstate.edu/currentstudents/support/rights/goldstar.php
- Competencies and Objectives (GC EPOs):
- http://www.upstate.edu/com/curriculum/objectives.php

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XII. THE CORE COMPETENCIES

Patient Care and Procedural Skills:

Residents are expected to:

- Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- Perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.
- Demonstrate competence in manual dexterity appropriate for their level, develop competence in and execute patient care plans appropriate for the resident's level, including management of pain.

Medical Knowledge:

Residents are expected to:

- Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care.
- Demonstrate competence in the critical evaluation and knowledge of pertinent scientific information.
- Demonstrate knowledge of the fundamentals of basic science as applied to clinical surgery.
- Participate in an educational program that includes applied surgical anatomy and surgical pathology; the elements of wound healing; homeostasis, shock and circulatory physiology; hematologic disorders; immunobiology and transplantation; oncology; surgical endocrinology; surgical nutrition, fluid and electrolyte balance; and the metabolic response to injury, including burns.
- Demonstrate knowledge of the principles of immunology, immunosuppression, and the management of general surgical conditions arising in transplant patients.

Practice-based Learning and Improvement:

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.
Residents are expected to develop skills and habits to be able to meet the following goals:

- Identify strengths, deficiencies, and limits in one's knowledge and expertise.
- Set learning and improvement goals.
- Identify and perform appropriate learning activities.
- Systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement.
- Incorporate formative evaluation feedback into daily practice.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; use information technology to optimize learning.
- Participate in the education of patients, families, students, residents, and other health professionals.
- Participate in mortality and morbidity conferences that evaluate and analyze patient care outcomes.
- Utilize an evidence-based approach to patient care.

Interpersonal and Communication Skills:

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

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.

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- Communicate effectively with physicians, other health professionals, and health related agencies.
- Work effectively as a member or leader of a health care team or other professional group.
- Act in a consultative role to other physicians and health professionals.
- Maintain comprehensive, timely, and legible medical records, if applicable.
- Counsel and educate patients and families.
- Effectively document practice activities.

Professionalism:

Residents are expected to demonstrate:

- A commitment to carrying out professional responsibilities and an adherence to ethical principles.
- Compassion, integrity, and respect for others.
- Responsiveness to patient needs that supersedes self-interest.
- Respect patient privacy and autonomy.
- Accountability to patients, society, and the profession.
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
- High standards of ethical behavior.
- A commitment to continuity of patient care.

Systems-based Practice:

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

Residents are expected to:

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty; coordinate patient care within the health care system relevant to their clinical specialty.
- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.
- Advocate for quality patient care and optimal patient care systems.
- Work in interprofessional teams to enhance patient safety and improve patient care quality.
- Participate in identifying system errors and implementing potential systems solutions practice high-quality, cost-effective patient care.
- Demonstrate knowledge of risk-benefit analysis.
- Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management

XXIII. EDUCATIONAL GOALS AND OBJECTIVES

The following pages include the EDUCATIONAL OBJECTIVES for each surgical rotation. Please become familiar with these *before* starting the service and review them periodically as the rotation progresses.

The goals of each service objective are to expand the resident's overall knowledge and operative experience and provide concentrated exposure to clinical conditions.

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EDUCATIONAL OBJECTIVES FOR THE ACUTE CARE SURGERY (ACS) SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY I	The resident is expected to: - Attend morning and evening sign-out - Gather essential and accurate information about the patients including obtaining a history, performing a physical exam, and review of appropriate laboratory and radiology data. - Begin to develop care plans with the support of senior residents. - Attend daily rounds with the senior resident and attending staff. - Carry out patient management plans, update patients and their families. - Be able to evaluate and manage simple/common postoperative course/problems - Facilitate discharges - Attend weekly ACS clinic	The resident is expected to: - Understand the pathophysiology and management of common surgical diseases/problems - Be able to identify normal anatomy in the operating room Be able to articulate the steps of common operations	The resident is expected to: - Practice cost-effective healthcare and resource allocation that does not compromise quality of care. - Identify impact of complications on recovery of the surgical patient. - Use information technology to assimilate current medical literature as it relates to emergency general surgery. Understand the value of an interdisciplinary approach to healthcare for the surgical patient	The resident is expected to: - Demonstrate respect, compassion, integrity and ethical behavior consistent with the values of the department and institution - Develop and sustain sensitivity toward differences of age, gender, culture, religion, ethnicity or other diversities in both coworkers and patients - Demonstrate respect for patient privacy and autonomy. - Remain honest with all individuals at all times in conveying issues of patient care. Demonstrate a commitment to continuity of patient care.	The resident is expected to: - Present clinical information on work rounds clearly and concisely. - Ensure that the attending is aware of the progress of all patients on the service. - Clearly, accurately, and respectfully communicate with all hospital staff, patients and family members - Ensure that clear, concise, accurate, and timely medical records are maintained on all patients. Perform face-to-face hand-offs.

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EDUCATIONAL OBJECTIVES FOR THE AUBURN SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 3	Participation in the outpatient experience will be possible in the private offices of the general surgeons in Auburn. Please make sure that the residency coordinator is aware of your rotation.	For General Surgery, residents should be knowledgeable in the principles of pre-op assessment, operative intervention, and post-op care and follow-up in patients presenting with a wide variety of surgical diseases. This knowledge base should include the etiologic and pathologic basis of the disease process as well as the physiologic basis of fluid and electrolytes, wound healing, nutrition, and organ function (cardiac, pulmonary, renal, gastrointestinal, and endocrine) that is important for post-op follow up. The resident will be developing an increasing knowledge base in elective surgical disease including concepts of the management of postoperative fluid and electrolyte abnormalities in patients. The resident will have a deeper understanding of the perioperative management of general surgery patients in a community environment. The resident should also develop skills in the interpretation of radiologic studies both in the outpatient and inpatient setting. The residents will continue to participate in the educational activities at Upstate.			

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EDUCATIONAL OBJECTIVES FOR THE ADLAP SERVICE, AT COMMUNITY GENERAL HOSPITAL (CGH):

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-4 & -5 Ad Lap	This service includes both emergency general and advanced laparoscopic/bariatric surgery for the bariatric surgeons. Please refer to the expectations for the CGH senior resident goals and expectations for non-ad lap/bariatric goals and expectations. Develop and demonstrate and understanding of the preoperative evaluation for patients pursuing metabolic and bariatric surgical evaluation in the clinic. This would include understanding the approach toward the history and physical, lab testing, nutritional and psychological counseling, and appropriate preparation for surgical intervention. Recognize patients who are or are not appropriate surgical candidates. Recognize indications and contra-indications for specific surgical procedures. Develop and demonstrate an understanding of the alterations in normal physiology associated with obesity. This includes but is not limited to cardiac considerations, sleep apnea and obesity-hypoventilation syndrome, VTE prophylaxis, and evaluation of the gastrointestinal tract. Participate in advanced laparoscopic and bariatric surgical procedures as performing surgeon or as first assistant, under the supervision of the attending surgeon. Based on your skill level, experience, and complexity of the case, you are expected to perform at the direct or indirect supervision level or practice-ready level. Participate in the perioperative and postoperative care of surgical patients as a member of a team of physician and non-physician providers. Develop and demonstrate an understanding of the normal recovery process following bariatric surgery in order to better recognize when patients are deviating from the expected path. Recognize and treat common postoperative conditions. Develop and demonstrate an understanding of the evaluation and management of late complications related to bariatric surgery, including fistulas, obstruction due to internal hernias and intussusception, bleeding, marginal ulcers and perforation, and nutritional complications.	Understand the pathogenesis, diagnosis and principles of surgical management of most common advanced laparoscopic and bariatric surgical practice. Develop and demonstrate an in-depth understanding of the anatomy associated with the surgical fields in which the procedures are performed and recognize rationale for selection of one surgical approach over another. Demonstrate practice-ready tissue handling during open, laparoscopic, and robotic procedures.	The resident should demonstrate effectiveness and efficiency in planning the diagnostic and therapeutic management of patients with bariatric and other surgical illness and in providing consultation to Emergency and Hospitalist providers. Lead the coordination of multidisciplinary care for perioperative conditions. Demonstrate ownership of the clinical service. Perform effective patient care hand-offs with the surgical APP's Demonstrate leadership on the surgical team, including junior residents, APP's and medical students. Communicate and collaborate with the CGH residents to ensure comprehensive management of patients on both the CGH and Ad Lap rotation.	Demonstrate knowledge related to patient consent, joint and surrogate decision making, and protection of protected health information Recognize potential ethical situations as they occur in patient care Work respectfully and effectively as a team member with the APP's to provide excellent and efficient patient care in a seamless fashion.	Communicate effectively in the receipt and request for consultations. Communicate effectively with other services to coordinate the care for surgical patients. Demonstrate effective communication with patients and their families regarding care plans and informed consent.

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EDUCATIONAL OBJECTIVES FOR THE BREAST SERVICE, AT COMMUNITY GENERAL HOSPITAL (CGH):

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-3 & -4 Breast rotation	This patient service includes breast and plastic surgery. You are expected to be an active participant in outpatient benign and multidisciplinary malignant patient management in the clinics, as well as participation in operative cases. Develop and demonstrate a strong understanding of scope of both benign and neoplastic the preoperative evaluation for patients needing surgical evaluation in the Emergency Department, hospital wards, and the clinics as it relates to the above specialties. This would include understanding the approach toward the history and physical, lab, and radiologic evaluation of the patient. Develop understanding of the disease processes treated in the community surgical practice and if/when/how to treat surgically. Develop understanding of the anatomy and pathophysiology of surgical diseases being treated. Participate in surgical procedures appropriate to your level as performing surgeon or as first or second assist. Begin developing tissue handling and other basic surgical skills. Participate in the perioperative and postoperative care of surgical patients as a member of a team of physician and non-physician providers. Develop understanding of the normal recovery process following surgery in order to better recognize when patients are deviating from the expected path. Recognize and treat common postoperative conditions	Understand the pathogenesis, diagnosis and principles of surgical management of most common general, colorectal, ad lap/bariatric, plastic, breast, vascular, and thoracic surgical practice. Develop an understanding of the anatomy associated with the surgical fields in which the procedures are performed, and recognize rationale for selection of one surgical approach over another.	The resident should demonstrate effectiveness in planning the diagnostic and therapeutic management of patients with surgical illness and in providing consultation to Emergency and Hospitalist providers. Participate in coordination of multidisciplinary care for perioperative conditions. Perform effective patient care hand-offs with the surgical APP's	Demonstrate knowledge related to patient consent, joint and surrogate decision making, and protection of protected health information Recognize potential ethical situations as they occur in patient care Work respectfully and effectively as a team member with the APP's to provide excellent and efficient patient care in a seamless fashion.	Communicate effectively in the receipt and request for consultations. Communicate effectively with other services to coordinate the care for surgical patients. Demonstrate effective communication with patients and their families regarding care plans and informed consent.

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EDUCATIONAL OBJECTIVES FOR GENERAL SURGERY, AT COMMUNITY GENERAL HOSPITAL (CGH):

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-1 & -2 CGH	The patient services are varied, including general, colorectal, vascular, and thoracic surgery. For that reason, your expectations cover a variety of fields. Develop understanding of the preoperative evaluation for patients needing surgical evaluation in the Emergency Department, hospital wards, and the clinics as it relates to the above specialties. This would include understanding the approach toward the history and physical, lab, and radiologic evaluation of the patient. Develop understanding of the disease processes treated in the community surgical practice and if/when/how to treat surgically. Develop understanding of the anatomy and pathophysiology of surgical diseases being treated. Participate in surgical procedures appropriate to your level as performing surgeon or as first or second assist. Begin developing tissue handling and other basic surgical skills. Participate in the perioperative and postoperative care of surgical patients as a member of a team of physician and non-physician providers. Develop understanding of the normal recovery process following surgery in order to better recognize when patients are deviating from the expected path. Recognize and treat common postoperative conditions Develop an understanding about the presentation of nutritional problems for bariatric surgical patients and the emergency conditions that may arise associated with their immediate and late postoperative care	Understand the pathogenesis, diagnosis, and principles of surgical management of most common general, colorectal, ad lap/bariatric, plastic, breast, vascular, and thoracic surgical practice. Develop an understanding of the anatomy associated with the surgical fields in which the procedures are performed and recognize rationale for selection of one surgical approach over another.	The resident should demonstrate effectiveness in planning the diagnostic and therapeutic management of patients with surgical illness and in providing consultation to Emergency and Hospitalist providers. Participate in coordination of multidisciplinary care for perioperative conditions. Perform effective patient care hand-offs with the surgical APP's	Demonstrate knowledge related to patient consent, joint and surrogate decision making, and protection of protected health information Recognize potential ethical situations as they occur in patient care Work respectfully and effectively as a team member with the APP's to provide excellent and efficient patient care in a seamless fashion.	Communicate effectively in the receipt and request for consultations. Communicate effectively with other services to coordinate the care for surgical patients. Develop effective communication with patients and their families regarding care plans and informed consent.

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EDUCATIONAL OBJECTIVES FOR THE BURN SERVICE:

RESIDENT	KNOWLEDGE BASE AND CRITICAL THINKING	CLINICAL DIAGNOSIS AND MANAGEMENT	OUTPATIENT EXPERIENCE & CONTINUITY OF CARE	PROCEDUREAL SKILLS
PGY I, II	Understand the pathophysiology and treatment of thermal injury including skin anatomy, sequella of burns including fluid shifts, electrolyte imbalance, wound healing, infection, antimicrobials, and wound coverage. Understand the abnormalities associated with inhalation injuries, electrical burns, and chemical burns. The resident will also learn the sequella of burns including scarring and wound contracture.	The resident will be able to provide the initial evaluation of the thermally or electrically injured patient and be able to estimate burn depth and burn wound size. The resident will be able to initiate and plan an aggressive fluid resuscitation and understand the appropriate use of invasive monitoring for large burns. The resident will have an understanding of the treatment of respiratory failure, sepsis, and organ dysfunction associated with the injury. The resident should be able to define indications for wound coverage including the most appropriate resurfacing material and prepare the patient for surgery and provide post-op care. The resident should understand the principles of burn rehabilitation and order appropriate consultation when needed.	Within the limits of time availability, the resident will attend the clinic of one of the burn surgeons at least one day a week in order to experience the follow-up care of the patient who have survived burns.	The resident will become comfortable with the following procedures: • Escharotomy • Tangential debridement of burn wounds • Full-thickness debridement of burn wounds to fascia • Split thickness skin grafting • Bedside placement of monitoring lines • Complex burn wound dressing changes

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EDUCATIONAL OBJECTIVES FOR ED CONSULT, EMERGENCY SURGERY & TRAUMA "NIGHT FLOAT" SERVICES:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY I					

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EDUCATIONAL OBJECTIVES FOR ED CONSULT, EMERGENCY SURGERY & TRAUMA "NIGHT FLOAT" SERVICES:

Goals: To expand the	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 2 & 3					

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EDUCATIONAL OBJECTIVES FOR ED CONSULT, EMERGENCY SURGERY & TRAUMA "NIGHT FLOAT" SERVICES:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 4 & 5					

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EDUCATIONAL OBJECTIVES FOR THE CROUSE SURGERY SERVICE - PGY 1:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY I	The intern should be an active participant in all aspects of both pre- and postoperative care for general surgery, colorectal surgery, vascular surgery, and thoracic surgery patients. As much as time allows, the intern should be participating in surgical cases in the outpatient setting and main operating room. This can be with an attending on the teaching service, or with a more senior resident and attending on the teaching service.	The intern should understand the pathogenesis and surgical management of the most common/ basic disease processes within the fields of general surgery, colorectal surgery, vascular surgery, and thoracic surgery. The intern should begin to develop their gestalt/strategy to working up surgical consults including pertinent laboratory interpretation and imaging interpretation. The intern will begin to develop a knowledge base with regard to the management of infectious disease in the surgical patient and the available therapeutics	The intern should be able to describe the diagnostic and therapeutic approach and management of basic surgical disease processes in general surgery, colorectal surgery, vascular surgery, and thoracic surgery.	The intern should be able to describe and demonstrate professional interactions within their own team and with the NP and PA staff, along with the other providers in the hospital including the ER, ICU, and hospitalist staff.	The intern will need to work with both the NP and PA services along with their own resident team to assist with the pre- and postoperative care of surgical patients on the teaching service - this includes patients on the general surgery, colorectal surgery, vascular surgery, and thoracic surgery services. Although there may be some overlap of these service lines between hospitals, there will be Crouse-specific and teaching attending specific management protocols that the resident will learn over time during their first Crouse rotation. In addition, they may be required to see surgical consults for the various service lines they cover and will have to interact with the ER, ICU, and hospitalist staffs.

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EDUCATIONAL OBJECTIVES FOR THE CROUSE SURGERY SERVICE - PGY 2 & 3:

Goals: To expand the	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 2 & 3	The resident should be an active participant in all aspects of both preand postoperative care for general surgery, colorectal surgery, vascular surgery, and thoracic surgery patients. The resident should be participating on a daily basis in surgical cases in the outpatient setting and main operating room. This can be with an attending on the teaching service, or with a more senior resident and attending on the teaching service.	The resident should understand the pathogenesis and surgical management of the most common/ basic disease processes along with more complex disease processes within the fields of general surgery, colorectal surgery, vascular surgery, and thoracic surgery. The resident should continue to develop their gestalt/strategy to working up surgical consults including pertinent laboratory interpretation and imaging interpretation. The resident should continue to develop a knowledge base with regard to the management of infectious disease in the surgical patient and the available therapeutics. The resident should be able to disseminate this information to their junior residents in a productive and professional manner at all times.	The resident should be able to describe the diagnostic and therapeutic approach and management of basic surgical disease processes in general surgery, colorectal surgery, vascular surgery, and thoracic surgery. The resident should be able to demonstrate leadership skills by assigning and providing mentorship for their junior residents/interns with regard to patient care tasks, bedside procedures, and assisting in the operating room. The resident should be able to discuss/describe the risks and benefits of basic surgical procedures across the service lines they are covering with their peers and teaching attending	The resident should be able to describe and demonstrate professional interactions within their own team and with the NP and PA staff, along with the other providers in the hospital including the ER, ICU, and hospitalist staff.	The resident will need to work with both the NP and PA services along with their own resident team to assist with the pre- and postoperative care of surgical patients on the teaching service - this includes patients on the general surgery, colorectal surgery, vascular surgery, and thoracic surgery services. In addition, they may be required to see surgical consults for the various service lines they cover and will have to interact with the ER, ICU, and hospitalist staffs. In addition, they may be required to see surgical consults for the various service lines they cover and will have to interact with the ER, ICU, and hospitalist staffs

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EDUCATIONAL OBJECTIVES FOR THE CROUSE SURGERY SERVICE - PGY 4 & 5:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 4 & 5	The chief resident should be an active participant in all aspects of both pre and postoperative care for general surgery, colorectal surgery, vascular surgery, and thoracic surgery patients. The chief resident should be participating on a daily basis in surgical cases in the outpatient setting and main operating room. This can be with an attending on the teaching service, or with a more junior resident and attending on the teaching service.	The chief resident should have a complete understanding of the pathogenesis and surgical management of the most common/ basic disease processes along with more complex disease processes within the fields of general surgery, colorectal surgery, vascular surgery, and thoracic surgery. The chief resident should have a well-defined gestalt/strategy to working up surgical consults including pertinent laboratory interpretation and imaging interpretation. The chief resident should have a broadly-based fund of knowledge with regard to the management of infectious disease in the surgical patient and the available therapeutics. The chief resident should be able to disseminate this information to their junior residents in a productive and professional manner at all times.	The chief resident should be able to describe the diagnostic and therapeutic approach and management of basic and complex surgical disease processes in general surgery, colorectal surgery, vascular surgery, and thoracic surgery. The chief resident should be able to demonstrate leadership skills by assigning and providing mentorship for their junior residents/interns with regard to patient care tasks, bedside procedures, and assisting in the operating room. The chief resident should be able to comfortably discuss/describe the risks and benefits of basic surgical procedures across the service lines they are covering with surgical patients, their colleagues, and the teaching attending	The chief resident should be able to describe and demonstrate professional interactions within their own team and with the NP and PA staff, along with the other providers in the hospital including the ER, ICU, and hospitalist staff.	The chief resident of the service will need to work with both the NP and PA services along with their own resident team to assist with the pre- and postoperative care of surgical patients on the teaching service - this includes patients on the general surgery, colorectal surgery, vascular surgery, and thoracic surgery services. As chief of the service they will assist with making case coverage assignments for both the outpatient setting and main operating room on a weekly basis in conjunction with the chief of the PA staff. In addition, they may be required to see surgical consults for the various service lines they cover and will have to interact with the ER, ICU, and hospitalist staffs

***Robotic surgical case participation, in particular sitting at the console, is at the discretion of the teaching attending. It varies considerably depending on the service line and teaching attending. If residents are interested in participating in the operating room for these cases, they will need to discuss with the service teaching attending and reach out to our credentialing office/Annie Agrasto (315-470-7183), AnnieAgrasto@Crouse.org) to confirm they have they requisite material done in MedHub to beside assist and/or sit at the console. There will be times when they will be asked to assist bedside for cases depending on PA staff coverage for the teaching attending.**

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EDUCATIONAL OBJECTIVES FOR ROTATIONS ON THE CRITICAL CARE (SICU) SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-1					

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EDUCATIONAL OBJECTIVES FOR ROTATIONS ON THE CRITICAL CARE (SICU) SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-2					

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EDUCATIONAL OBJECTIVES FOR THE (SURG ONC 1) HEPATOBILIARY SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY I					

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RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 5					

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EDUCATIONAL OBJECTIVES FOR THE (SURG ONC 2) COLORECTAL SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY I					

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RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 5					

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EDUCATIONAL OBJECTIVES FOR THE PEDIATRIC SURGERY SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 1	Outline pain management options for pediatric surgical patients after both minor and major surgery. Demonstrate proficiency in the management of nutrition in the perioperative period for pediatric surgical patients. Understand similarities and differences between adult and pediatric physiology, pharmacology, pathology, and anatomy. Be able to assess the initial presentation of children with common non-emergent problems Understand the appropriate evaluation to help define the need for surgery. Participate in circumcisions, line placements, herniorrhaphies and appendectomies at the direct supervision level Participate in complex pediatric surgical procedures as a first or second assistant.	Understand the pathogenesis, diagnosis and principles of surgical management of most common and some unusual disease processes falling within the scope of general and thoracic pediatric surgical practice. Describe intravenous fluid management in pediatric surgical patients of all ages. The resident should possess a working knowledge of the application of various imaging modalities to the diagnosis of surgical disease in infants and children, particularly as they might differ from their application in adult patients.	The resident should demonstrate effectiveness in planning the diagnostic and therapeutic management of children with severe surgical illness and in providing consultation to pediatric primary care providers.	Appreciate the unique psychosocial needs of the families of children with conditions requiring surgical correction. Proficiency in the physical examination of the anxious, frightened child should be developed.	The resident should understand and become proficient in the pre- and post- operative management of the surgically ill infant and child. In so doing, the resident will work with neonatal and pediatric intensivists in the special care units, as well as in the outpatient setting caring for the less severely ill pediatric patient.

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RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 3 & 4	Have a clear understanding of the following and be able to teach to junior residents and students: Describe pathogenesis, diagnosis and principles of surgical management of most common and some unusual disease processes falling within the scope of general and thoracic pediatric surgical practice. Describe and manage intravenous fluid management at the independent practice level The resident should: Perform incision and drainage at the independent practice level Participate in appendectomies, umbilical hernia repairs, cholecystectomies, and hernia repairs at the indirect supervision level. Participate at more complex pediatric surgical procedures at the direct supervision and occasionally the show and tell level, based on complexity of the case	Have a clear understanding of the following and be able to teach to junior residents and students: Demonstrate proficiency in the management of nutrition in the perioperative period for pediatric surgical patients. Understand the pathophysiology surrounding the following pediatric diseases: - Appendicitis - Pyloric Stenosis - Esophageal Atresia - Congenital anomalies of GI tract and lungs - Cystic hygroma - Omphalocele/gastroschisis - Undescended testicle - Hernias - Chest wall deformities - Pediatric malignancies	The resident should demonstrate effectiveness and efficiency in planning the diagnostic and therapeutic management of children with severe surgical illness and in providing consultation to pediatric primary care providers. The resident should demonstrate leadership skills guiding the team of junior residents and students by assigning cases and tasks and providing a positive learning environment.	Have a clear understanding of the following and be able to teach to junior residents and students: Describe and apply the psychosocial needs of families or children requiring surgical correction. Describe and demonstrate professional interaction with other pediatric providers in the NICU, PICU, ER, as well as pediatric nursing staff and residents and attendings	The resident should understand and become proficient in the pre- and post-operative management of the surgically ill infant and child. In so doing, the resident will work with neonatal and pediatric intensivists in the special care units, as well as in the outpatient setting caring for the less severely ill pediatric patient.

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EDUCATIONAL OBJECTIVES FOR THE THORACIC SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 2	1. Evaluate and treat patients with basic post-operative complications form thoracic surgical operations 2. Assess and treat patients with newly diagnosed pneumothorax, pleural effusion and empyema 3. Evaluate new clinic patients with benign and malignant disorders of the thorax. 4. Successfully complete an upper GI endoscopy. 5. Become certified as a robotic surgical first assistant.	1. Accurately stage a new lung cancer patient 2. Detail treatment options for a patient with stage 1 non-small cell lung cancer 3. Detail treatment options for a patient with gastroesophageal reflux disease. 4. Detail treatment options for a patient with achalasia.	1. Coordinate multidisciplinary care for patients with post-discharge care needs. 2. Perform safe and effective handoff of thoracic surgical patient care to the night team.	1. Treat colleagues and other professionals and staff members with respect, valuing their input and contributions to care. 2. Arrive to clinics, OR and conferences on time and prepared.	1. Call and receive consults to and from other services in a cordial manner. 2. Counsel patients about basic thoracic surgical problems and procedures.

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EDUCATIONAL OBJECTIVES FOR ROTATIONS ON PEDIATRIC TRAUMA

Goals: To expand the resident's overall knowledge and operative experience and provide concentrated exposure to clinical conditions related to **PEDIATRIC TRAUMA**

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 1	The resident is expected to: Attend morning and evening sign-out Participate in trauma resuscitations with graded responsibilities. Perform a focused, efficient, accurate initial history and physical of a full spectrum of pediatric trauma patients. Gather accurate and relevant information and begin formulating care plans along with senior residents. Carry out patient management plans with appropriate follow up. Counsel and educate patients and their families. Become familiar with workup for pediatric non-accidental trauma patients	The resident is expected to: Successfully complete an ATLS provider course prior to the start of residency with specific focus on pediatric trauma patients. Be familiar with ATLS principles as they apply to trauma resuscitation, including mechanism of injury, pathophysiology of shock, resuscitation and evaluation techniques in the trauma bay, optimal timely treatment of a variety of injuries with specific focus pediatric trauma patients. Understand the physiologic derangements of the trauma patient and perioperative management focusing on specific differences in the pediatric population. Develop a basic understanding and basic knowledge the overall management of pediatric trauma patients.	The resident is expected to: Practice cost-effective healthcare and resource allocation that does not compromise quality of care. Identify impact of complications on recovery of the pediatric trauma patient. Use information technology to assimilate current medical literature as it relates to pediatric trauma. Understand the value of an interdisciplinary approach to healthcare for the pediatric trauma patient. Understand the importance of communication between the pediatric clinical team and the administration of the pediatric trauma program (include trauma nurse managers on rounds). Understand the basic principles of the pediatric trauma QI process.	The resident is expected to: Demonstrate respect, compassion, integrity, and ethical behavior consistent with the values of the department and institution. Develop and sustain sensitivity toward differences of age, gender, culture, religion, ethnicity or other diversities in patients and their families. Demonstrate respect for patient and family privacy and autonomy. Always remain honest with all individuals in conveying issues of patient care. Demonstrate a commitment to continuity of patient care. Be familiar with the principles of LEAP to minimize pain and discomfort in pediatric trauma patients	The resident is expected to: Present clinical information on work rounds clearly and concisely. Ensure that the attending is aware of the progress of all pediatric trauma patients on the service. Clearly, accurately, and respectfully communicate with all hospital staff, patients, and family members. Ensure that clear, concise, accurate, and timely medical records are maintained on all pediatric trauma patients. Perform face-to-face hand-offs with emphasis on trauma related issues that could require interventions.
PGY-3	The resident is expected to: See PGY-1 objectives. Perform independent morning rounds on all pediatric trauma	The resident is expected to: See PGY-1 objectives. Have a deeper understanding of ATLS principles as they apply to pediatric trauma	The resident is expected to: See PGY-1 objectives. Oversee complex discharge planning in interdisciplinary	The resident is expected to: See PGY-1 objectives. Provide professional leadership and education to	The resident is expected to: See PGY-1 objectives. Function as the liaison between the pediatric trauma resident

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
	inpatients and develop initial treatment plans. Discuss treatment plans with pediatric trauma attending before implementation. Have greater responsibilities for management and resuscitation of the trauma patient under supervision of the pediatric trauma attending. Share initial daily management plans with the PICU team on pediatric trauma patients. Be the "team leader" for pediatric trauma resuscitations under the guidance of the pediatric trauma attending. Perform common procedures (laceration repair, chest tube placement, central line placement etc.) on pediatric trauma patients after being certified to do so. Perform trauma related operations with the pediatric trauma attending.	resuscitation, mechanism of injury, concern for non-accidental trauma, pathophysiology of shock, resuscitation, and evaluation techniques in the trauma bay as well as optimal timing of treatment for a variety of injuries. Develop skills in the interpretation of radiologic studies in the trauma patient. Have a comprehensive understanding and knowledge of the symptoms, signs, and treatments of the core surgical diseases as well as the core surgical operations for trauma.	collaboration with other surgical subspecialties, social services, CPS and the pediatric trauma outpatient clinic.	the more junior residents and medical students on the pediatric trauma service.	team and the attending Take responsibility to assure optimal information flow to the pediatric trauma attending

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EDUCATIONAL OBJECTIVES FOR THE THORACIC SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 4	1. Evaluate and plan treatment of patients with new lung cancer, esophageal cancer, GERD, achalasia and other benign esophageal disorders 2. Perform robotic assisted thoracoscopic lymphadenectomy	1. Detail the treatment options for a patient with stage II or stage III non-small cell lung cancer 2. Detail the treatment options for a patient with locally advanced esophageal cancer 3. Describe the steps of a right upper lobectomy	1. Present thoracic surgery cases at the Surgery Department Morbidity and Mortality conference. 2. Assign articles and guide junior residents and students in the analysis and presentation of articles for thoracic surgery journal club.	1. Treat colleagues and other professionals and staff members with respect, valuing their input and contributions to care. 2. Prepare pre-op conference 3. Plan coverage for cases and clinics, informing other team members when adequate staffing is unavailable or problematic.	1. Call and receive consults to and from other services in a cordial and constructive manner. 2. Counsel patients about thoracic diseases and advanced thoracic operations. 3. Communicate bad news to patients and families.

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EDUCATIONAL OBJECTIVES FOR THE TRANSPLANT SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 1	-Perform H & P as requested in clinic -Attend and participate in Transplant conference (Friday a.m.) and all Departmental conferences. -Complete daily care of all in house patients, entering orders, coordinating care delivery and the evaluation and assessment of all potential organ recipients. -Organize of flowsheets, coordination of daily lab values and immunosuppression orders, in preparation for attending rounds. -Collaborate on discharge plans with other health care providers (Coordinators, Social Work, and PA or Nurse Practitioners). -Demonstrate basic surgical skills (knot tying, suturing etc) in transplant setting (organ recovery, back table etc) -Evaluate and manages routine post kidney and pancreas transplant problems (oliguria, hyperglycemia, hypotension etc) -Appreciate the complexities of planning and implementing living donor or cadaveric renal transplantations	-Demonstrate understanding of pathophysiology and clinical manifestations of the more common diseases causing end stage renal and pancreatic disease. Identify normal anatomy of abdominal wall, kidney, pancreas. -Understand referral timing of for transplant evaluation based on the natural history and clinical manifestations of those diseases commonly resulting in the need for liver or kidney transplantation. -Be cognizant of the various clinical problems specific to transplant patients.	-Demonstrate knowledge of transplant patient's safety -Demonstrate how to report patient safety events -Demonstrate transplant knowledge of care of coordination. -Perform safe transitions of care -Demonstrate basic health payment systems including govt, private in transplant medicine -Ability to discuss the process of organ allocation and prioritization. -Perform safe and effective handoffs in transplant patients.	Demonstrates knowledge of the ethical principles of in informed consent error disclosure, related topic in transplant field. Completes patient care tasks and responsibilities Recognizes limits in the knowledge /skills of self and seeks for help in complex transplant patients Demonstrate knowledge of the principles of physician well-being and fatigue mitigating (example after long transplant surgery)	Communicates with transplant patients and their families in an understandable and respectful manner. Provides timely updates to patients and families in transplan service. Respectfully requests and receives a consultation for transplant patients. Uses language that values all members of the health care team.
PGY-2	-Understand the utilization of the clinical examination, as well as diagnostic, biochemical and microbiological tests, and radiological intervention, in the management of the immuno-compromised patient. -Consistently recognize common clinical problems in the pre-transplant patient with end stage disease. -Construct appropriate diagnostic and treatment algorithms for each condition. -Perform bedside procedures for transplant patients (CVP, art line etc.) -Teach basic skills to junior residents -Competently manage the following in transplant patients: hyperkalemia, fluid balance, diabetes, fever of unknown origin, hypertension, sepsis, wound infection, and malnutrition. -Attend at least one half-day clinic per week	-Demonstrate an understanding of pathophysiology and treatment of common conditions after kidney and pancreas transplant. -Identify variations of kidney, pancreas, liver anatomy during the abdominal organ recovery	-Identify systemic factors that leads to patient safety events -Describe in local quality improvement initiatives in the transplant division. -Coordinate multidisciplinary care for transplant patients -Evaluate self- practice -Document the key components required for billing and coding.	-Demonstrate knowledge of common ethical principles of organ donation -Performs transplant patient care tasks on time. -Recognize limits in the knowledge and seek help. -Performs transplant related administrative tasks in a timely manner. -Manage own time and assures fitness even during the long transplant cases.	-Communicate risks effectively to patients and their families re. transplantation, dialysis access and living organ donation. -Actively listens to patients and families to elicit patient preferences and expectations. -Communicates information effectively with all transplant related health care team members. -Demonstrates efficient use of EMR to communicate with the health care team in transplant.
PGY-3	-Consistently evaluate the suitability for transplantation of a patient referred to the transplant center with end stage kidney disease in accordance with accepted listing criteria -Perform back table, organ recovery procedures, PD cath. placement -Teach bedside procedures (CVP, art line etc.) to JR residents -Demonstrate careful tissue handling. -Develop competence in the longitudinal management of renal patients' post-transplantation including immunosuppression and expected medical and surgical disease.	-Demonstrate understanding of impact of patient comorbid to pathophysiology and transplant outcome -Appreciate normal anatomy during kidney and pancreas transplant operations. -Articulate the steps of kidney transplant operations	-Lead multidisciplinary care of transplant patients in complex situations. -Supervise safe and effective transitions of handoffs of junior residents in transplant service. -Analyzes how personal practice affects the transplant surgery outcome (length of stay, readmission rate, graft and patient survival etc.).	-Performs patient care tasks in a timely manner with appropriate attention to detail -Demonstrate professional behavior. -Perform administrative tasks. -Model appropriate management of personal health issues, fatigue, and stress.	-Deliver complex and difficult information to kidney and pancreas patients and families. -Use active listening to adapt communication style to fit team in transplant service. -Integrates and synthesizes all relevant to transplant data from outside systems and prior encounters into the health record.

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PGY 4	Supervision of the intern, second year resident, and medical students. Understanding the rationale and treatment plan for all patients on the service and to coordinate of all inpatient care with the nephrologists, hepatologists, social workers and inpatient nurse coordinators. Liaison with the operating room and posting of all operative cases. Primary liaison of care for all transplant recipients in the ICU. Coordinate daily educational activities for the students and residents with attending surgeons Communicating with the attending on service in a timely manner. Compiling and submitting the list of transplant M&M cases on a weekly basis. Presenting complications for non-operative patients or for patients on whom they have operated at departmental conferences Collaborate with the attendings in the implementation of resident and student educational objectives under the supervision of the program director and clerkship directors. Attendance and participation in Transplant conference (Fri am) and all departmental conferences Participate as first assistant or primary surgeon where appropriate based on case complexity and surgeon experience Consistently develops appropriate management plans for patients with end-stage kidney disease who develop common general surgical problems	Demonstrate detailed knowledge of various manifestation of transplant related complications. Appreciate variations in anatomy (replaced right hepatic artery, left hepatic artery, retro aortic left renal vein etc.) in organ procurement procedure Articulate the steps of abdominal organ recoveries (DBD, DCD).	Leads care of transplant patients with barriers to healthcare access (e.g. transplant patient without insurance for IS medications) Resolves conflicts in transition of care between teams whose taking care for sick transplant patient. Identify resources and plan for use transplant patients (IT, financial, personnel, etc.)	Recognizes and uses appropriate resources for managing and resolving transplant related ethical dilemmas, as needed (e.g., ethics consultations, literature review, risk management/legal consultation). Recognizes situations that may impact others' ability to complete transplant patient-care tasks and Responsibilities. Aids junior learners in recognition of limits in knowledge/skills Recognizes situations that may impact others' ability to complete administrative tasks and responsibilities in a timely manner	Facilitates difficult discussions specific to patient and family conferences, (e.g., failed kidney or pancreas transplant, resistance for antirejection therapy). Effectively negotiates and manages conflict among transplant patients, families, and the health care team. Maintains effective communication in crisis situation (e. g.) adverse events in living donors, patient death).
PGY-5	Develops a clinical pathway for management of transplant patients. Performs all organ procurement procedures. All laparoscopic donor nephrectomy procedures Alternate deceased donor/living donor kidney recipient cases. All pancreas transplants. Vascular access and PD cath insertion and removal procedures All general surgery procedure in Transplant Division. Teaches kidney and pancreas transplant operations to junior residents. Identify innovative surgical techniques, operative approaches in established transplant procedures	Contribute literature on a varying pattern of post kidney and pancreas transplantation complications and treatment options. Develops simulation models for teaching abdominal organ recovery, kidney and pancreas transplantation.	Coordinate and leads improvement of care of transplant patients in service Coordinate in the formulating system for improvements of transition of transplant care for patients Leads change to systems for more efficient and effective patient care for transplant patients Participate in different advocacy activities for health policy in transplant field to increase donation rate and remove barriers for transplant access.	Identifies and seeks to address system-level factors that induce or exacerbate ethical problems in living and deceased donor kidney and pancreas transplantation or impede their resolution in transplant field.	Leads others in the facilitation of crucial conversations in transplant patients. Helps other team members in conflict solution in transplant patients. Facilitates regular health care team-based feedback in complex transplant situations

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EDUCATIONAL OBJECTIVES FOR THE TRAUMA SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY I	The resident is expected to: - Attend morning and evening sign-out - Attend table rounds at 8am - Participate in trauma resuscitations with graded responsibilities - Perform a focused, efficient, accurate initial history and physical of a full spectrum of trauma patients - Gather accurate and relevant information and begin formulating care plans along with senior residents - Carry out patient management plans with appropriate follow up - Counsel and educate patients and their families - Attend trauma clinic weekly - Become familiar with and perform, under direct senior resident or attending supervision, basic bedside procedures (laceration repair, chest tube placement, central line placement etc.)	The resident is expected to: - Successfully complete an ATLS provider course prior to the start of residency - Be familiar with ATLS principles as they apply to trauma resuscitation, including mechanism of injury, pathophysiology of shock, resuscitation and evaluation techniques in the trauma bay, optimal timely treatment of a variety of injuries - Understand the physiologic derangements of the trauma patient and perioperative management. - Develop a basic understanding and basic knowledge of the symptoms, signs, and treatments of the core surgical diseases as well as a basic knowledge of the core surgical operations for trauma	The resident is expected to: - Practice cost-effective healthcare and resource allocation that does not compromise quality of care. - Identify impact of complications on recovery of the trauma patient. - Use information technology to assimilate current medical literature as it relates to Trauma. Understand the value of an interdisciplinary approach to healthcare for the trauma patient	The resident is expected to: - Demonstrate respect, compassion, integrity and ethical behavior consistent with the values of the department and institution - Develop and sustain sensitivity toward differences of age, gender, culture, religion, ethnicity or other diversities in both coworkers and patients - Demonstrate respect for patient privacy and autonomy. - Remain honest with all individuals at all times in conveying issues of patient care. Demonstrate a commitment to continuity of patient care.	The resident is expected to: - Present clinical information on work rounds clearly and concisely. - Ensure that the attending is aware of the progress of all patients on the service. - Clearly, accurately, and respectfully communicate with all hospital staff, patients and family members - Ensure that clear, concise, accurate, and timely medical records are maintained on all patients. Perform face-to-face hand-offs.

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EDUCATIONAL OBJECTIVES FOR THE TRAUMA SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY 3	The resident is expected to: - Attend morning and evening sign-out - Attend table rounds at 8am - Perform a focused, efficient, accurate initial history and physical of a full spectrum of trauma patients - Gather accurate and relevant information to make complex decisions along with the attending - Carry out patient management plans with appropriate follow up - Counsel and educate patients and their families - Have greater responsibilities for management and resuscitation of the trauma patient, including critical care - Be the "team leader" for trauma resuscitations under the guidance of the attending - Attend weekly trauma clinic - Independently perform and supervise junior residents with common bedside procedures (laceration repair, chest tube placement, central line placement etc.) - Perform common operations with attending assistance	The resident is expected to: - Successfully complete an ATLS provider course prior to the start of residency and maintain certification - Have a deeper understanding of ATLS principles as they apply to trauma resuscitation, including mechanism of injury, pathophysiology of shock, resuscitation and evaluation techniques in the trauma bay, optimal timely treatment of a variety of injuries - Understand the physiologic derangements of the trauma patient and perioperative management. - Develop skills in the interpretation of radiologic studies in the trauma patient - Have a comprehensive understanding and knowledge of the symptoms, signs, and treatments of the core surgical diseases as well as the core surgical operations for trauma	The resident is expected to: - Practice cost-effective healthcare and resource allocation that does not compromise quality of care. - Identify impact of complications on recovery of the trauma patient. - Use information technology to assimilate current medical literature as it relates to trauma. Understand the value of an interdisciplinary approach to healthcare for the trauma patient	The resident is expected to: - Demonstrate respect, compassion, integrity and ethical behavior consistent with the values of the department and institution - Develop and sustain sensitivity toward differences of age, gender, culture, religion, ethnicity or other diversities in both coworkers and patients - Demonstrate respect for patient privacy and autonomy. - Remain honest with all individuals at all times in conveying issues of patient care. Demonstrate a commitment to continuity of patient care.	The resident is expected to: - Present clinical information on work rounds clearly and concisely. - Ensure that the attending is aware of the progress of all patients on the service. - Clearly, accurately, and respectfully communicate with all hospital staff, patients and family members - Ensure that clear, concise, accurate, and timely medical records are maintained on all patients. - Perform face-to-face hand-offs.

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EDUCATIONAL OBJECTIVES FOR ROTATIONS FOR THE VETERANS' ADMINISTRATION HOSPITAL (VAH) SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-1	The resident should be able to: -perform a basic history physical and gather information for a differential diagnosis in uncomplicated surgical patients. - manage simple postop problems like electrolyte imbalance, nutrition, wound management, fever, hypotension etc. -manage routine postoperative care. - develop basic surgical skills including knot-tying. -Identifying appropriate planes.	The resident should have basic knowledge of anatomy and pathophysiology of common surgical conditions.	The resident should be able to: -coordinate care with other services -discharge patients in a safe manner with appropriate handoff and instructions	Resident should be self-aware and know when to ask for help both for self-help as well as in situations of patient care/ethical issues. They should follow ethical principles and disclose any issues with regards to unprofessional behavior. The resident should complete all administrative tasks in a timely manner	Resident should be respectful and professional when interacting with other members of the healthcare team. Resident should also be able to communicate with the family members in a respectful manner and provide timely updates.
PGY-2	The resident should be able to evaluate most general surgery patients and ordered appropriate testing and formulate the plan of care. Resident should be able to: -evaluate complex postop problems, -do procedures like chest tubes and I&D's. -demonstrate careful tissue handling and -maintain appropriate tissue planes. -perform bedside assist in robotic cases	The resident should have adequate knowledge of anatomy and pathophysiology of complex surgical patients. They should be able to describe steps of the common general surgical procedures.	The resident should be able to: -coordinate complex clinical situations as well as difficult dispositions. -navigate of the resources available for complicated discharges and transition of care. -develop an awareness of and follow quality and improvement initiatives	Resident should be self-aware and know when to ask for help both for self-help as well as in situations of patient care/ethical issues. They should follow ethical principles and disclose any issues with regards to unprofessional behavior. The resident should complete all administrative tasks in a timely manner.	Resident should be respectful and professional when interacting with other members of the healthcare team. Resident should be able to customize communication with patient's and family taking into consideration patient and family social/educational/cultural situation.
PGY-3	Resident should be able to: -evaluate, diagnose, and manage most general surgical patients -evaluate complicated general surgical patients -manage noncomplicated postop complications. -perform basic general surgical procedures with some assistance. -do basic maneuvers on the robotic console-like simple suturing.	Resident should be able to translate understanding of anatomy and pathophysiology into clinical scenarios. They should be able to articulate the steps for complex procedures. They should be aware of the anatomical variations in different common general surgical procedures	The resident should be able to: -help the team navigate difficult clinical scenarios with available resources. -identify significant rate-limiting steps in inpatient care and outpatient co-ordination of care. They are encouraged to participate in VA hospital quality improvement projects	Resident should be able to: -find resources available in complex ethical situations. -demonstrate professional behavior in difficult situations -follow ethical principles and disclose any issues regarding unprofessional behavior -complete all administrative tasks in a timely manner	Resident must demonstrate a high level of professionalism while interacting with patients and the care team. Resident should be able to navigate challenging discussions with families' patients and address patient concerns respectfully and in a timely fashion.
PGY-4	Resident should be able to: -manage complicated surgical patients. -evaluate and manage complex postop issues. –perform complex operations with some assistance -teach junior residents' simple operations. –adapt to unexpected Intra-Op findings. -perform basic robotic surgeries procedures with minimal assistance.	Resident should be able to demonstrate comprehensive knowledge of disease presentation and management and alternative treatments for various surgical conditions. Resident should be proficient in the steps of the common as well as complicated general surgical procedures.	The resident should be able to: -identify and analyze areas of improvement in challenging inpatient admissions -navigate complex social issues for outpatient -facilitate pre & post-op continuity of care. -engage resources like home-based nursing and primary care for patients -participate in VA quality improvements projects	Resident should be able to: -set a good example of professionalism -address issues of burnout/ for themselves and their junior residents.by being flexible and modify schedules accordingly. -intervene & report lapses in professionalism - complete all administrative tasks in a timely manner.	Resident will be looked at as an example of professionalism. They should be able to tactfully talk to patients and their families about adverse events and be able to establish trust and honesty. They should treat the junior members of the healthcare team with respect and maintain open lines of communication to help the team.
PGY-5	The resident should be able to: -evaluate & manage complicated general surgical patients and postop complications. -perform most general surgical operations including robotic cases without assistance -perform difficult complicated operations with minimal assistance.	The resident should be able to teach the anatomy, pathophysiology, clinical management and recent advances for various general surgical conditions to junior residents and medical students,	Resident should be: -a resource that the team can rely on to provide solutions for most difficult scenarios of inpatient and outpatient care. -able to resolve conflicts that arise with patient care teams -ready to participate in quality improvement projects and mobilize junior residents	Resident should be able to identify system level issues that impede professionalism. Resident should be a good example of professionalism as a team leader. Resident should be able to coach juniors when their behavior is not professional. Resident should complete all administrative tasks in a timely manner.	Resident is expected to: -embody the highest level of professionalism. -handle complex discussions with patients and their families. -offer constructive solutions while communicating to patients, families and the health care team. -lead by example and be experts at conflict resolution. –identify break downs in communication

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EDUCATIONAL OBJECTIVES FOR THE VASCULAR SERVICE:

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
PGY-1 /PGY-2	Residents should be able to: -Understand the appropriate indications, interpretation, and limitations for vascular non-invasive diagnostic exams including ankle brachial index, duplex venous and arterial ultrasound, duplex carotid ultrasound, venous insufficiency, vein mapping, and renal/visceral/aorta ultrasound. -Demonstrate competency in the initial emergency management of vascular conditions including bleeding, arterial insufficiency, venous thrombosis, aneurysm rupture, stroke, and vascular trauma. -Manage relevant vascular issues in post-operative patients including bypass graft evaluation and monitoring, infection prevention, neurologic assessment, hemodynamic adjustments, and pain control. -Recognize the indications for surgery for common vascular conditions including carotid artery stenosis, abdominal aortic aneurysm, arterial occlusive disease, deep venous thrombosis, varicose veins, and hemodialysis access. -Participate in the following procedures under direct supervision: central venous line placement; tunneled dialysis catheter placement; stab phlebectomy; toe amputation; lower extremity amputation; arteriovenous fistula/graft placement; diagnostic angiography; fistulogram with intervention; IVC filter placement; arterial embolectomy; arterial endarterectomy -Participate in complex vascular and endovascular procedures at the first or second assistant level: -Apply manual pressure to obtain hemostasis after percutaneous arterial access sheath removal. -Use the handheld Doppler to evaluate for peripheral pulses	Residents should be able to: -Describe the normal anatomy of the arterial and venous systems. -Understand the pathogenesis, diagnosis, and principles of surgical management of most common and some unusual vascular disease processes. -Recognize the risk factors for arterial and venous disease. -Identify appropriate prevention strategies for arterial and venous disease. -Assess the anti-thrombotic needs for patients with vascular disease and initiate appropriate therapy. -Appreciate the advantages and disadvantages of endovascular and open vascular surgery for the most commonly encountered vascular conditions including arterial occlusive disease, aortic aneurysms, and carotid stenosis. -Apply non-operative management guidelines to appropriately selected patients including patients with moderate claudication, asymptomatic carotid stenosis, varicose veins, and small abdominal aortic aneurysms. -Describe the handheld Doppler signals as one of the following: absent, monophasic, or multi phasic	Execute the planned diagnostic and therapeutic management of patients with vascular disease. Provide vascular consultation for selected inpatients referred for vascular access or IVC filter placement. Contribute to vascular team rounds by gathering patient information and relevant diagnostic exams and images. Attend weekly outpatient vascular clinics. Assist in wound care of vascular inpatients including dressing changes and arrangement of outpatient follow up	Appreciate the psychosocial needs of patients who are facing or who recently experienced lower extremity amputation. Perform an accurate and focused exam on patients with acute vascular conditions including arterial insufficiency, venous thrombosis, compartment syndrome.	Counsel patients with vascular disease abou the risks of cigarette smoking and the benefits of smoking cessation. Interact with other health care professionals on the vascular surgery team including vascular technologists, radiology technologists, advanced practice providers, and intensivists. Provide clinical updates to patients and their families for straightforward vascular conditions and procedures including endovascular peripheral interventions, varicose veins, deep venous thrombosis, an vascular access.
PGY-3/PGY-4	Have a clear understanding and be able to teach junior residents and students in the following areas: • Diagnosis and management of common vascular conditions • Anti-thrombotic therapy for patients with common vascular conditions • Post-operative care of patients with common vascular procedures Perform the following procedures at the independent practice level: • central venous access placement • non-tunneled catheter placement for hemodialysis • removal of tunneled hemodialysis catheter • incision and drainage of hematoma or abscess after amputation Perform the following procedures at the independent practice level: • Ultrasound guided vascular access for arteriography and venography • Selective cannulation of secondary arterial branches during arteriography • Balloon angioplasty during endovascular intervention • Exposure of the common femoral artery	Understand the vascular pathophysiology: • Carotid artery stenosis • Thoracic aortic aneurysms • Abdominal aortic aneurysms • Peripheral arterial disease • Diabetic foot ulcers • Venous thromboembolism • Varicose veins • Venous insufficiency • Access for hemodialysis • Hemodynamic steal syndrome • Mesenteric ischemic (acute and chronic) • Peripheral artery aneurysms • Traumatic vascular injury • Lower extremity amputation • Thoracic outlet syndrome • Non-atherosclerotic vascular disease • Arterial pseudoaneurysm • Phlegmasia cerulea dolens • Compartment syndrome	-Lead the vascular team by organizing morning rounds, assigning cases and tasks, and triaging vascular consults. -Provide a positive learning environment for junior residents, medical students, and advanced practice providers. -Formulate the diagnostic and therapeutic plan for patients with vascular disease. -Provide in patient consultation for patients with common and complex vascular conditions including arterial disease, acute limb ischemia, deep venous thrombosis, iatrogenic and traumatic vascular injury, aortic aneurysms, and carotid stenosis. -Participate in pre-operative planning and decision making by attending weekly outpatient clinics.	Have a clear understanding of the following and be able to teach to junior residents and students: • Psychosocial impact of lower extremity amputation • Behavior factors contributing to vascular disease (cigarette smoking, Type 2 diabetes, medical non-compliance) • Long term surveillance needs for patients with previous endovascular AAA repair	Provide clinical updates to patients, family members, health care professionals for patients undergoing simple and complex vascular procedures. Relay information about the details and urgency of vascular procedures and diagnostic exams to the relevant health care professionals including physicians, vascular technologists, radiology technologists, OR scrub techs and nurses, intensivists, advanced practice providers, and social workers Provide detailed and clear discharge instructions to patients and family members after vascular procedures. Engage with referring providers requesting consultation for emergency and inpatients with suspected acute vascular issues.

RESIDENT	PATIENT CARE	MEDICAL KNOWLEDGE	SYSTEMS BASED PRACTICE	PROFESSIONALISM	INTERPERSONAL & COMMUNICATION SKILLS
	• Stab phlebectomy • Oversewing of the saphenofemoral confluence during saphenous vein harvest. • Suture placement for sheath removal after AV fistulogram with intervention Participate in the following procedures at the indirect supervision level: • Peripheral endovascular intervention • Saphenous vein harvest • Proximal anastomosis for bypass • Carotid artery patch placement • Femoral anastomosis during aortobifemoral bypass Participate in more complex vascular surgery procedures at the direct supervision and occasionally the show and tell level based on case complexity.	Demonstrate proficiency in the anti-thrombotic management of patients with vascular disease in the peri-operative period. Have a clear understanding and be able to teach junior residents and students about the following common vascular conditions: • Arterial occlusive disease • Venous disease • Aortic aneurysms • Traumatic vascular injury • Hemodialysis access • Mesenteric ischemia Recognize and initiate appropriate management for the following post-operative issues: • Bypass graft thrombosis • Hemorrhage • Suspected wound infection near vascular bypass • Hemodynamic steal syndrome • Stroke or transient ischemic attack • Spinal cord ischemia • Colon ischemia following aortic intervention • Groin hematoma or pseudoaneurysm		• Treatment decision making issues for patients with peripheral arterial disease and claudication Provide guidance to other health care professionals contributing to the care of the patient with a vascular condition including physicians, advanced practice providers, nurses, technologists, and social workers. Recognize the rehabilitation and home care needs of patients recovering from vascular procedures.	

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XXIV. DEPARTMENTAL/INSTITUTIONAL POLICIES

Please click on the any of the four policy names listed below to access the specific policy.

1. **Credentialing Procedure Policy**
2. **Moonlighting Policy - Dept. of Surgery**
3. **Supervision Policy**
4. **Breast Milk Expression (Breast Feeding) Policy**

The following five institutional policies are listed in the pages below**:**

1. Competency Policy including image of Upstate PGY-1 Competency Card
2. Work Hour Policy
3. Exception to Work Hour Policy
4. Fatigue and Sleep Deprivation Guide
5. Are you Fatigued? Guide

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Department of Surgery
750 East Adams
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13210

UPSTATE MEDICAL UNIVERSITY

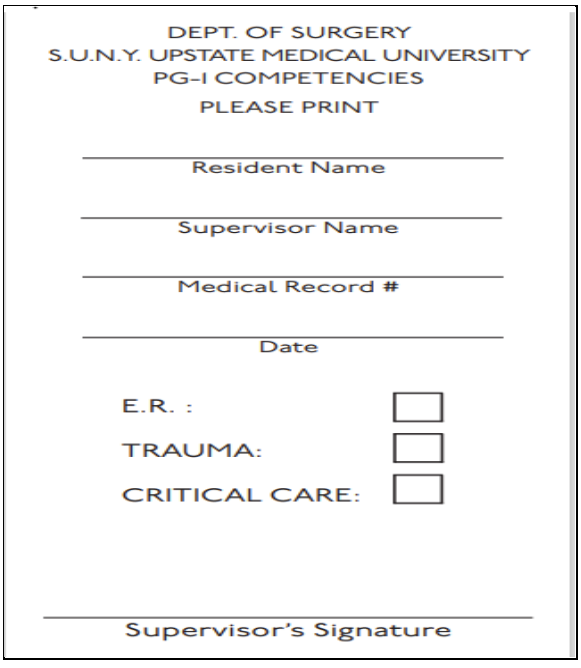
PGY-1 COMPETENCY POLICY:

Introduction: The ACGME and the Surgery RRC have declared that PGY-1 residents need direct supervision (a qualified practitioner must be physically present) evaluating patients with acute surgical problems (Program Requirement VI.D.5.a.1). They must demonstrate that they are competent before they can be certified to evaluate such patients independently.

Each resident must complete five evaluations of surgical patients while being directly observed by a credentialed provider (a more senior resident or attending). The three categories of evaluations that must be observed are the following:

1. ER - Acute surgical consults - This would be a new inpatient consultation or an ER Department consultation.
2. Trauma patients – This would be a patient for whom the trauma service has been called and would typically be a patient in the emergency department.
3. Critical care patients – These are patients with hypertension, severe oliguria, unexpected chest pain, respiratory distress, sepsis, etc. They might be in the ED or on the ICU floor.

The PGY-1 resident's evaluation, must include a differential diagnosis and care plan. If the senior person is satisfied that the PGY-1 did a competent job, the intern will ask the senior person to check the category box and sign the red card indicating he/she has successfully completed one of the designated supervised evaluations. These cards will then be turned into the Education Office and be compiled. Once all the PGY-1's requirements are met, an email will be sent to you, Program Directors, Program Administrator, and the Chief Residents and you will be cleared to independently evaluate patients in each of the categories listed above.



DEPT. OF SURGERY
S.U.N.Y. UPSTATE MEDICAL UNIVERSITY
PG-I COMPETENCIES
PLEASE PRINT

Resident Name

Supervisor Name

Medical Record #

Date

E.R. :

TRAUMA:

CRITICAL CARE:

Supervisor's Signature

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WORK HOUR POLICY - RESIDENT (please click on title to access this policy)

EXCEPTION TO WORK HOUR POLICY:

State University of New York

Upstate Medical University

Exception to Work Hour Policy
Department of Surgery

On (date), (Resident name) exceeded the 24-hour of continuous duty of the Dept. of Surgery Resident Work Hour Policy to remain on duty to care for a patient due to the following circumstance:

- Required continuity of care for a severely ill or unstable patient, or a complex patient with whom I was involved.
- Events of exceptional educational value.
- Humanistic attention to the needs of a patient or family.
- Other (please explain below)

Comments:

The faculty member working with me at this time was (Attending Name).

_____ _____
(Resident) (Date)

_____ _____
(Faculty) (Date)

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FITNESS FOR DUTY POLICY:

A resident or fellow who does not feel fit for duty should consult with their current program director or Employee Health. Additionally, a supervisor who has concerns regarding a trainee's fitness for duty should also consult with the Program Director and/or Associate Dean for Graduate Medical Education

SUNY UPSTATE MEDICAL UNIVERSITY
FITNESS FOR DUTY/RESIDENT BACK-UP POLICY - GENERAL SURGERY

The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate (Common Program Requirements VIA.5):

VIA.5.a) assurance of the safety and we (fare of patients entrusted to their care; VIA.5.b) provision of patient- and family-centered care;
VIA.5.c) assurance of their fitness for their duty;
VIA.5.d) management of their time before, during, and after clinical assignments;
VIA.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

Residents must be educated about their self-reflection on "Fitness for Duty". It is clear that current alcohol or illicit substance use is incompatible with fitness to provide medical care to others. Excess fatigue, medical or psychiatric illness may also preclude participation in the workplace. Examples of additional situations in which a resident or fellow may not be fit for duty include but are not limited to - the use of medications that impair dexterity significantly, excessive stress due to personal or family situations, grief that precludes concentration or acute illness that would make the physician a risk to others (ex. infectious illness).

THIS POLICY IS DESIGNED TO:

a. Provide guidance to both residents and supervisors when a resident is unfit for duty
b. Provide coverage for clinical duties if another resident is ill or has a family emergency.
c. Ensure the availability of coverage for residents who call-in ill.
d. Delineate the resident's responsibility for coverage.
e. It is not designed to change definitions of time off for human resources/payroll purposes. These remain unchanged.

BACK-UP SUPPORT:

Appropriate use of sick call includes unexpected illness, death in the family or other personal emergency leaving the resident unable to perform his/her duties. Sick call is not to be used for scheduled absences, (e.g., doctor's visits, family responsibilities, interviews, etc.). For such scheduled absences, the resident will request time off following departmental procedures in compliance with human resources/payroll policy.

PROCEDURE:

The resident will call the Administrative Chief Resident and the Program Coordinator to inform them of his/her illness or situation. The resident will talk directly to the Chief. No voicemail messages should be left. A voicemail message or email is acceptable to notify the Program Coordinator. When paging the Chief, a resident must leave a phone number where they can be reached (cell phone and/or home number, not a pager).

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The resident will discuss the service and duration for which coverage is needed. The Administrative Chief will ascertain what responsibilities need to be covered to ensure safe, comprehensive transfer of duties to the covering colleague. This will occur prior to each shift for which the resident is unable to report for duty unless otherwise determined by the Administrative Chief.

As a rule, each resident will be expected to complete an equal share of weekend and holiday calls. If the resident is unable to meet this responsibility due to illness or another situation as listed above, the resident will complete the requisite number of calls later as determined by the Program Director or Administrative Chief. Receiving return coverage is a courtesy but is not an absolute requirement and may not be possible in all situations. Any discrepancies or disagreements will be resolved by the Program Director. SUNY Upstate Medical University's institutional policy allows employees to be out for a number of sick days without consequences. It is in this regard that professionalism and courtesy should exist.

NOTE: Repayment of coverage may never result in an ACGME or New York State duty hours regulation violation, no matter what the circumstances.

1. If a resident is unable to perform his/her duties because of illness, for greater than three days, documentation must be brought to the Program Director/Program Coordinator's attention within 24 hours of returning to work. Documentation needs to show the name, date, time, and place where the resident was seen. Diagnosis does not need to be disclosed as this information is confidential. Failure to comply with the documentation requirement could lead to comments regarding professionalism in the final evaluation of the resident and/or disciplinary action.

2. For extended absences/illness, please refer to the institutional policy on Leaves of Absence available on SUNY Upstate's website. Residents and fellows should be mindful of individual Board requirements that may set limits on the amount of leave one may take at any level. In most cases, vacation time cannot be forfeited for leave.

3. While every attempt will be made to cover a resident or fellow with another resident or fellow, the final authority for patient care and supervision lies with the attending. In all cases when another resident or fellow cannot cover or cannot be reached, the attending on service will provide this coverage.

SUPPORT FOR IMPAIRED PHYSICIANS:

Because of the high level of stress associated with residency training, physicians are not immune to the risks of impairment from addictive drugs and alcohol. Stresses surrounding the responsibilities of being a physician and related personal issues can manifest themselves in many ways including, but not limited to: alcohol abuse and dependency, chemical l and drug abuse and dependency, and/or psychological changes. If you know of someone who may be impaired or who may need assistance, please contact one of the confidential sources below. It may be the best referral you ever make. http://www.mssny.org/cph/ or (800) 338-1833 NYS Committee on Physician Health.

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FATIGUE & SLEEP DEPRIVATION:

Fatigue is a theoretical construct. Fatigue is typified by symptoms of inattention, degraded judgment, poor motor skills, exhaustion, confusion and other effects.

THERE ARE FOUR MAIN CAUSES OF FATIGUE

1. Inadequate rest.
2. Desynchronized physiological circadian rhythms
3. Weariness following physical activity
4. Impaired judgment following prolonged mental activity.

FATIGUE INDUCED ERRORS ARE OF TWO TYPES

Errors of Commission - doing something incorrectly

Errors of Omission - not doing something that should be done.

Errors of Omission are the most common errors made by fatigued individuals.

Selected References:

Gaba DM, Howard SK. Fatigue among clinicians and the safety of patients. NEJM 2002;347:1249-1254.

Haines RF. Night Flying. McGraw-Hill 1992.

Malmstrom FV. You might be fatigued if. ... Flying Safety. 1997.

Smakoff JS, Jacques CHM. A review of studies concerning effects of sleep deprivation and fatigue on residents' performance. Acad Med. 1991; 66:687-693.

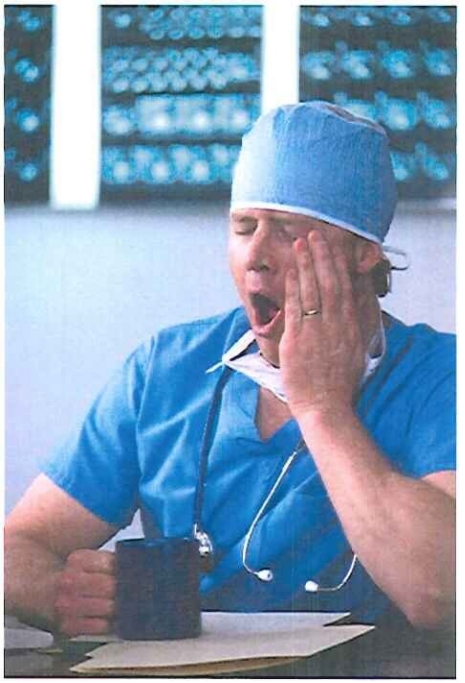
Veasey s, Rosen R, Barzansky B, Rosen I, Owens J. Sleep loss and fatigue in residency training: A reappraisal. JAMA 2002; 288:1116-1124.

For a bibliography of articles on the effect of sleep loss and performance as prepared by the ACGME contact the GME Office. 315-464-5136-

State University of New York
Upstate Medical University

SUNY Upstate Medical University
Office of Graduate Medical Education
750 East Adams Street UH 1814
Syracuse, NY 13210

ARE YOU FATIGUED?



A Guide for Residents and Attendings

FATIGUE - YOU CAN'T WISH IT AWAY!

- It tends to sneak up on you.
- Fatigued individuals tend to be in denial about their own functioning and will not always recognize their own fatigue.
- Recognizing and addressing fatigue must be done in a supportive and non-punitive environment.
- Given this, both residents and faculty have specific responsibilities
- If you believe that you are fatigued or if you observe another individual who is clearly fatigued, the following actions should be taken:

RESIDENTS

1. Immediately contact the attending on call.
2. Request that you or the other individual be relieved from duty immediately after assuring a smooth transition of patient care.

FACULTY

1. Immediately relieve the resident from patient care duties after assuring a smooth transition of patient care.

YOU MIGHT BE FATIGUED IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING:

Physical Symptoms:
- -Frequent, unexplainable headaches
- -Muscular aches and pains
- -Breathing difficulties
- -Blurred/double vision
- -Burning urination
- -Loss of appetite

Mental Symptoms:
- -Attentional narrowing
- -Easily distracted
- -Feeling of depression
- -Poor visual perception
- -Lack of interest and drive
- -Worried and anxious

YOU MIGHT SEE THE FOLLOWING IN SOMEONE WHO IS FATIGUED:

Physical Symptoms:
- -Degraded motor skills
- -Tenseness and tremors
- -Intolerant / irritable
- -Poor visual perception
- -Increased reaction time

Mental Symptoms:
- -Absentmindedness
- -Reduced short-term memory
- -Reduced performance standards
- -Impaired judgment
- -Easily distracted
- -Social withdrawal

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APPENDIX A.

MILESTONE EVALUATION FORM:

Milestone forms can be found on Medhub: (**https://upstate.medhub.com**).
ACGME Surgery Milestones

MEDHUB EVALUATION FORMS:

Milestone forms can be found on Medhub: (**https://upstate.medhub.com**).
Each resident will be asked to evaluate the program, rotations, attendings, and staff in a timely fashion using MedHub. All evaluations, including narrative comments will be extremely useful for the continuing educational development of the program. Without feedback, this program will not make any progress. It is the Program Director's intention to provide each attending with a summary of their evaluations each year.

This is a requirement of the RRC. Please help us by being as honest as possible.

The following eight evaluations are found on the pages below:

1. Concern Card about a Trainee
2. Concern Card about an Educator
3. Evaluation of Clinical Educator
4. Evaluation of a Resident by Faculty/Educator
5. Evaluation of a Rotation
6. Peer Evaluation (Trainee to Trainee)
7. Praise Card about a Trainee
8. Praise Card about an Educator

EVALUATION OF MEDICAL STUDENTS:

Each third-year medical student rotating through the Surgery Clerkship and each fourth-year medical student completing an elective in Surgery will be evaluated by faculty and residents via electronically distributed evaluation forms generated from the online MedHub evaluation database application. These evaluations must be completed within two weeks after the Clerkship block has ended.

The following evaluation is found on the pages below:

1. Student Clerkship - Faculty/Resident Evaluation of Student

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