EVMS

INTEGRATED PLASTIC & RECONSTRUCTIVE SURGERY RESIDENCY

Resident Handbook
Department of Surgery
Integrated Plastic and Reconstructive Surgery ***2021-2022***

Resident Welcome

Welcome to Eastern Virginia Medical School, a School Known for its leadership in community service and medical missions.

At Eastern Virginia Medical School, we strive to maintain the highest professional standards in our training programs to prepare graduates to excel in their chosen profession and to respond to societal healthcare needs.

Included in this manual are the Program's mission, goals and objectives, policies for residents, work hour rules, procedures for disciplinary action and resident grievance procedures.

EVMS
DEPARTMENT OF SURGERY
RESIDENCY TRAINING PROGRAM HANDOOK

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RESIDENCY MISSION

The mission of the EVMS Integrated Plastic and Reconstructive Surgery Residency program is to advance the future of our specialty while honoring our commitment to our community by leveraging our skills to improve the lives of our patients. Our training program is committed to providing the most comprehensive education and experiential training in an environment that fosters personal growth, yet nurtures to cultivate integrity, professionalism, and leadership.

GOALS

The overall goal of our program is to provide comprehensive training in plastic and reconstructive surgery using high clinical volumes, extensive didactics, and use of the anatomy lab so that our graduates may succeed in either academic or private practice. Residents will receive training in all aspects of complex reconstruction, aesthetic surgery, hand surgery, and pediatric plastic surgery, preparing them for successful completion of the board certification process. Residents will train in a variety of settings and experience one-on-one mentoring and work in multidisciplinary teams with our nationally and internationally renowned faculty.

Curriculum Organization and Resident Experiences

Residency training in Plastic & Reconstructive Surgery at Eastern Virginia Medical School is a 6-year integrated program. In each of the first 3 years the residents will spend 8 months on non-Plastic Surgery rotations and 4 months on Plastic Surgery rotations. The non-Plastic Surgery rotations have been chosen carefully in an effort to provide our residents the knowledge base necessary to be a well-rounded plastic surgeon. One resident per year will be accepted into the program through the National Resident Matching Program.

Surgery and patient care are supervised by both the full-time faculty and members of our community faculty. Residents rotate on clinical services covering four hospitals as well as aesthetic clinics in order to maximize exposure to all aspects of our specialty. At Sentara Norfolk General and Leigh hospitals, residents are exposed to a wide variety of disorders emphasizing the areas of trauma (including maxillofacial trauma and hand trauma), post oncologic reconstructive surgery, elective hand surgery, and post-bariatric body contouring procedures, acute and delayed burn care, oculoplastic surgery and complex wound management. The Children's Hospital of The King's Daughters is the region's only full-service children's hospital providing our residents with a full spectrum of pediatric plastic including craniofacial reconstruction of congenital defects. The Naval Hospital in Portsmouth Virginia is only a few miles from the medical school. There, our residents will participate in the care of extremity trauma, post-oncologic reconstruction, skin cancer, orthognathic surgery, and aesthetic surgery. Aesthetic surgery is primarily performed in certified operating rooms within physician's offices. As such, the vast majority of this training will be performed in the "office setting" during the trainee's aesthetic rotations. In the chief resident year, our residents will conduct their own clinic where patients desiring aesthetic procedures will be entirely managed by the resident with attending supervision.

In addition to clinical responsibilities, we plan to have a series of didactic conferences designed to augment the training of our residents. These will include an indications conference where upcoming cases will be reviewed, a morbidity and mortality conference, plastic surgery grand rounds, journal club and a core basic science lecture series.

Goals and objectives by level

PGY-1 year

- To refine skills in history taking and physical examination.
- To understand principles of preoperative and post-operative surgical care.
- To acquire skill in performing basic invasive procedures including phlebotomy, placement of intravenous and arterial lines, minor excisions and wound closures and incision and drainage procedures for superficial soft tissue infections.
- Involvement in the surgical skills laboratory.
- To assist in the performance of more complex surgical procedures.
- To introduce he resident to plastic and reconstructive surgical principals and procedures by spending one month rotations at each of the 4 hospitals in our program.

PGY-2 year:

- Able to perform all tasks of PGY-1 year residents.
- Ongoing exposure to non-Plastic Surgery rotations including OMFS, ENT, Anesthesia, Critical Care, and Non-breast Oncologic Surgery rotations.
- More direct patient care responsibility than in the PGY-1 year.
- To understand basic science concepts that provide a foundation for the clinical practice of Plastic & Reconstructive Surgery.
- To further their understanding of the indications for the use of flaps vs. grafts and continue to improve their skill in proper handling of soft tissues.
- Four months of ongoing training in Plastic & Reconstructive Surgery

PGY-3 year:

- During this year, the resident obtains additional training in the management of the burn and trauma patient. Assumes a more supervisory role in relation to the PGY-1 and PGY-2 residents on the same rotation.
- Exposure to oculoplastic surgery through time spent with the ophthalmology service in their office and their hospital service at SNGH.
- Additional exposure to non-breast oncologic surgery
- To understand the indications and performance of Mohs surgery for the management of skin malignancies.
- Involvement with the breast oncology service learning the principles of breast cancer management.
- Four months of Plastic & Reconstructive Surgery.

PGY-4 year:

- Begin the first of 3 years of concentrated Plastic & Reconstructive Surgery training.
- To assume a leadership role within the Plastic Surgery team and be responsible for the allocation of manpower on those rotations where medical students and plastic surgery residents are present.
- To be able to diagnose and understand the management of acute hand trauma along with both preoperative and postoperative care of these patients.
- To begin training in elective hand and wrist surgery.
- Begin mastering techniques in reconstructive microsurgery.
- To learn the principles in the management of the facial trauma patient.
- To understand the principles and management of the massive weight loss patient.

- To understand the indications for and the performance of both surgical and non-surgical options for the aesthetic patient.

PGY-5 year:

- To further one's knowledge of elective hand and wrist surgery both in the clinic and operating room settings.
- Continue a leadership role in the allocation of manpower to maximize plastic surgery education for the resident and other members of the team.
- Work closely with the PGY-6 to make certain that the operating room cases are appropriately staffed as well as the clinics.
- To further one's experience with the aesthetic surgery patient as well as complex reconstruction.

PGY-6 year:

- Assume the role of chief resident, both administratively and clinically, serving junior residents as the final consultative authority prior to attending involvement, and as the first level in administering call, vacation and conference schedules.
- To acquire advanced skills in craniofacial procedures and pediatric plastic surgery.
- To acquire advanced skills in surgery of the hand and wrist, and microsurgery.
- To be involved in the most complex of reconstructive cases and in the care of patients of the highest level of acuity.
- To independently evaluate and manage all aspects of both aesthetic and reconstructive surgery patients through the "Chief clinic" at Sentara Norfolk General Hospital, with attending supervision. This will include pre-operative, operative and post-operative care of such patients.

Upon completion of training, the resident will be able to:

- Make sound ethical and legal judgments appropriate for a qualified surgeon.
- Manage surgical disorders based on a thorough knowledge of basic and clinical science.
- Utilize appropriate skills in those surgical techniques required of a competent surgeon.
- Use critical thinking when making decisions that affect our patients' life and that of their family.
- Collaborate effectively with colleagues and other health care professionals.
- Teach and share knowledge with colleagues, residents, students, and other health care providers.
- Educate patients and their families about the patient's health needs.
- Demonstrate commitment to scholarly pursuits through conducting and evaluating research.
- Provide cost-effective care to surgical patients and their families.
- Value life-long learning as a necessary prerequisite to maintaining surgical knowledge and skill.

PROGRAM OBJECTIVES

The overall objective of the EVMS Plastic and Reconstructive Surgery Residency Program is to provide an educational and training experience that meets the following criteria:

- Develop a comprehensive knowledge base, clinical decision-making ability, and technical skills in the principal components of Plastic and Reconstructive surgery.

- Develop life-long habits of self-study and continuing education.

- Develop professional habits consistent with the ACGME General Competencies:

    - Patient Care
    - Medical Knowledge
    - Professionalism
    - Systems-based Practice
    - Practice-based Learning and Improvement
    - Interpersonal and Communications Skills

PATIENT CARE

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

-communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
-gather essential and accurate information about their patients
-make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
-develop and carry out patient management plans
-counsel and educate patients and their families
-use information technology to support patient care decisions and patient education
-perform competently all medical and invasive procedures considered essential for the area of practice
-provide health care services aimed at preventing health problems or maintaining health
-work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

-demonstrate an investigatory and analytic thinking approach to clinical situations
-know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

-analyze practice experience and perform practice-based improvement activities using a systematic methodology
-locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
-obtain and use information about their own population of patients and the larger population from which their patients are drawn
-apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
-use information technology to manage information, access on-line medical information; and support their own education
-facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

-create and sustain a therapeutic and ethically sound relationship with patients
-use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
-work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

-demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
-demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
-demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

-understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
-know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
-practice cost-effective health care and resource allocation that does not compromise quality of care
-advocate for quality patient care and assist patients in dealing with system complexities
-know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

FACULTY

The faculty of the Department of Surgery is comprised of full-time academic surgeons who are dedicated to excellence in education. Our faculty adheres to an "open-door" policy, making themselves accessible to residents and students. In addition to the full-time faculty, residents and students work with more than 75 community surgical faculty (please refer to the EVMS website to learn more about these valuable faculty members). Their professional backgrounds encompass a wide range of surgical specialties that provide a valuable resource for our residents and students.

The full-time academic faculty in the Department of Surgery includes the following surgeons:

L.D. Britt, MD, MPH, FACS, FCCM

- Brickhouse Professor and Chairman, Department of Surgery, Eastern Virginia Medical School

Areas of Specialty: Trauma, Critical Care, General Surgery, Endocrine Surgery

Training:
MD: Harvard Medical School, 1977
General Surgery Internship: Barnes Hospital/Washington University, 1977-79
Research Fellowship: Washington University, 1979-81
General Surgery Residency: University of Illinois Hospital, Cook County Hospital, Chicago, 1981-84
Trauma and Critical Care Fellowship: University of Maryland, 1984-86

Lawrence Colen, MD, FACS

- Program Director, Integrated Plastic and Reconstructive Surgery Residency Program
- Professor of Surgery, Eastern Virginia Medical School

Areas of Specialty: Cosmetic surgery of the face, body, and breast. Post-bariatric body contouring. Complex reconstructive surgery, including microsurgery. Reconstruction of the breast. Mohs reconstruction. Limb salvage.

Training:
MD: Dartmouth Medical School of Hanover, 1975
Residency training in General Surgery and Plastic Surgery: University of California, 1975- 1983
Hand and Microsurgery Fellowship with Harry J. Buncke MD, 1978-1979

Lambros Viennas, MD

- Associate Program Director, Integrated Plastic and Reconstructive Surgery Residency Program
- Assistant Professor, Department of Surgery, Eastern Virginia Medical School
- Chief, Division of Plastic Surgery

Areas of Specialty: Plastic and Reconstructive Surgery

Training:
DDS: University of Maryland, 1981-1985
MD: Hahnemann University, 1990
General Surgery Internship and Residency: St. Agnes Hospital, 1990-1993

Oral & Maxillofacial Fellowship: Temple University Hospital, 1995-1988
Plastic Surgery Fellowship: Pennsylvania State University, 1993-1995

Policies

ADMISSIONS

Updated: June 2021

The EVMS Department of Surgery will annually recruit one categorical PGY-1 Plastic Surgery Resident. “Categorical” residents are defined as residents accepted into the program who are expected to complete the 6-year Integrated Plastic and Reconstructive surgery training program.

Eligible applicants will receive, or have received, their MD or DO degree from a medical or osteopathic school approved by the Liaison Council for Medical Education, as well as applicants who have, or will have, received an equivalent degree from a medical school recognized by the World Health Organization with valid possession of a Standard Certificate from the Educational Commission for Foreign Medical Graduates. All applicants must successfully meet the credentialing requirements of Eastern Virginia Graduate School of Medicine, which include, but are not limited to, documentation of graduation from an appropriate professional training program, receipt of credentialing information from previous educational/employment institutions, and, if applicable, confirmation of the Standard Certificate issued by the Educational Commission for Foreign Medical Graduates.

The Department of Surgery participates in the National Residency Match Program. Candidates apply through the Electronic Residency Application Service (ERAS). The Department seeks individuals who excel in all aspects of their undergraduate medical training and demonstrate a level of responsibility and work ethic commensurate with surgical residency training. Applicants with a sincere interest in the program are encouraged to participate in elective opportunities and visit the Department of Surgery to maximize their personal contact with faculty and residents.

The Department of Surgery at EVMS is an equal opportunity employer and considers applicants without regard to race, nation of origin, religion, gender, age, or disability.

Termination/Dismissal of Resident Contract

Updated: June 2021

Residents are expected to successfully complete the clinical and educational requirements at each level of graduate medical education and training. Residents are required to provide safe, effective, and compassionate patient care. Non-compliance with these expectations may result in immediate termination of the contract and dismissal of the resident.

Grounds for termination/dismissal include the following situations:

- Failure to rectify deficiencies for which the resident has been placed on probation within the allotted time of the probationary period;
- Performance that presents a serious compromise to acceptable standards of patient care and/or jeopardizes the welfare of a patient;
- Unethical conduct;
- Illegal conduct for which the resident has pled or been found guilty, pled nolo contendre or has been granted immunity from prosecution; and/or
- Failure to report for scheduled clinical assignments without advanced notice and permission by the Program Director.

Residents subject to termination/dismissal will receive verbal and written notification of the decision and the rationale for pursuing the process of termination. The Surgery Residency Program Director will provide written recommendation of termination to the Associate Dean for Graduate Medical Education. The Associate Dean for Graduate Medical Education will then notify the Dean for Graduate Medical Education. A resident subject to termination/dismissal of his/her contract will receive formal notification from the Dean of Graduate Medical Education indicating specific reasons for the decision. Such formal notification will indicate the due process policy and grievance procedure available to the resident.

Per the Office of Graduate Medical Education, a resident has the right to appeal any adverse decision made regarding their professional and educational development.

Office of Graduate Medical Education
Eastern Virginia Medical School

Due Process
Performance Deficiencies and Probation Procedures

Approved GMEC: 10/17/96
Amended: 11/ 20/97
Reviewed GMEC: 6/19/03
Amended: 10/05
Amended May, 20, 2010

Eastern Virginia Medical School provides resident, fellow, and intern (trainee) contracts on an annual basis commensurate with the respective Board guidelines and appropriate educational progress of the trainee. Procedures for addressing academic and non-academic deficiencies which may impede trainee progress in the program or prohibit the trainee from successfully completing the program are defined below. A process for appealing adverse decisions affecting trainee is

provided to ensure appropriate due process. In the procedures described below, the committee responsible for oversight of the educational program within individual departments is referred to as the Education Committee
The processes described below provided for the establishment of documentation demonstrating due process.

Deficiencies:

Deficiencies which may result in probation or dismissal/termination of a trainee contract include both academic and nonacademic areas. In addition, for academic deficiencies, trainees may be placed on formal academic remediation including a learning contract.

Academic Deficiencies include but are not limited to *an inadequate knowledge base*, *the lack of information gathering, problem solving, clinical skills and judgment, technical skills relating to patient care and/or professional relationships which include moral and ethical values unacceptable to the profession.*

Nonacademic Deficiencies include but are not limited to *any professional action or behavior which is considered unacceptable to the residency program faculty, failure to comply with the rules, regulations and bylaws of Eastern Virginia Medical School, the affiliated institutions of Eastern Virginia Medical School or laws of the Commonwealth of Virginia which govern the healing arts, and/or lack of certain abilities or talents which are necessary for the performance of expected duties for that specialty.*

Stages of Intervention:

Intervention strategies for addressing academic deficiencies are classified into three stages: Stage 1 - Notification, Stage 2 – academic remediation, and Stage 3 - Probation. For non-academic deficiencies, trainees may be provided a warning with a remediation plan, or placed directly on probation.

Stage 1 Notification: Stage 1 deficiencies are those which, while not currently impeding the progress of the trainee, have the potential to create obstacles to professional development and are severe enough to warrant counseling by the program director or early disciplinary action. A Stage 1 intervention does not require, but may include written documentation in the trainee's file.

Stage 2 Academic Remediation: Trainee already under Stage I Notification who are unable to remediate a problem within the given time period may be continued in the Stage 1 status or be placed on Stage 2 Warning. Trainee may also be placed directly on Stage 2 Warning for academic deficiencies for which the program director and/or the Education Committee believe severe enough to warrant Stage 2 Academic Remediation. These areas relate to deficiencies which are impeding the professional development of the trainee and/or compromising the quality of patient care and require immediate intervention. The trainee must be notified if non-remediation of the Stage 2 deficiency may result in probation.

Stage 3 Probation: Trainees who fail to remediate an area of weakness under Academic Remediation may be continued in that stage or may be placed on Probation. Under special circumstances trainee may be placed directly on probation where the conduct of the trainee warrants such an action. If the program director feels that probation is warranted the issue should be presented to the departmental Education Committee for discussion and confirmation of the disciplinary action. The Associate Dean for Graduate Medical Education must be informed of any pending probationary actions and must be present at the departmental Education Committee meeting where the pending probationary status is discussed. Where the conduct of a trainee represents a serious compromise to acceptable standards of patient care or jeopardizes the welfare of patients under his/her care, the program director has the option of immediately suspending the trainee from clinical duties until such time as an appropriate investigation of the allegations or situation may be conducted. The trainee must be informed in writing if termination of his/her

educational contract or non-renewal of future contracts is a potential outcome of the probationary status. The chair of the concerned department and the Assistant Dean for Graduate Medical Education must be notified when a trainee is placed on probation.
Probationary status will be defined by the concerned training program's Education Committee. While on probation the trainee will be provided close faculty supervision, may be removed from all supervisory responsibilities for other trainee and medical students, and may or may not give credit for the time period during which the probationary status is in effect. If the probationary period is not creditable toward the required time for the educational program, the necessary extension of training time may be required without additional stipend.

Identification and Remediation of Deficiency Areas

Faculty and other professional staff should promptly notify the program director of areas of concern regarding trainee professional behavior and development. Upon notification of a potential problem, the program director or a designee will investigate the report and if the concern appears to be warranted will proceed with the formal procedures below described.

Stage 1 deficiencies may be addressed through informal counseling or other informal disciplinary actions which do not require formal procedures or written documentation, however, the program director may elect to use the formal procedure. Academic Remediation and Probation must address formally using the mechanisms described below; however, the order and use of events may vary according to need and nature of the identified problem(s). Trainee problems, subsequent supervision meetings, remediation plans, and progress reports should be documented in writing and trainee signatures obtained where indicated. The subscripts after the steps described below refer to areas for which sample forms are provided.
Upon successful remediation of a Stage 1 or Stage 2 (Academic Remediation) deficiency, the written documentation may be deleted from the trainee's permanent file if so decided by the Education Committee. Documentation for Stage 3 deficiencies (Probation) must remain as a part of the permanent evaluation file.

Step 1. Issue is reported and investigated
Step 2. A remediation plan is developed.
Step 3. Program director or designee meets with the trainee to discuss the issue(s), remediation activities, plan schedule, and potential outcomes.
Step 4. The remediation plan is implemented, supervision meetings are conducted to review progress, and progress report(s) are written·
Step 5. At the agreed upon time, the progress of the trainee is evaluated and a determination of the success of remediation is determined. The program director or designee meets with the trainee to review the remediation and a report is provided to the trainee regarding his/her status. A report (Stage 2 and Stage 3) is provided to the Education Committee. If a Stage 3 (probation) deficiency is not successfully remediated and the Education Committee chooses to terminate the contract with the trainee or non-renew the contract, the trainee must be notified of this in writing and made aware of his/her right to appeal the decision through the Grievance Policy.

Right to Appeal: Trainees have the right to appeal Probationary status. Academic Remediation status is not subject to appeal. Please refer to the Due Process and Grievance Policies in the GME Policies and Procedures Handbook.

Resident Clinical Education and Experience

Updated: June 2021

The Department of Surgery requires that the residency training programs foster both quality resident education and facilitate quality patient care. Overall, resident duty hours in all programs must be consistent with the Institutional and specific program Residency Review Committee (RRC) accreditation requirements established by the Accreditation Council for Graduate Medical Education (ACGME). The structuring of duty hours and on-call schedules focus on the needs of the patient, continuity of care and the educational needs of the residents.

- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in- house call activities
- Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. After 24 hours, up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.
- All residents may be scheduled to a maximum of 24 hours of continuous on-site duty, including in-house call, Residents must not be assigned additional clinical after 24 hour of continuous in-house duty. Residents may remain on duty for up to an additional 4 hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical surgical care. Residents who are post-call are the first to be dismissed when clinical responsibilities allow.
- PGY1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. Adequate time for rest and personal activities must be provided between all daily duty periods and after in-house call.
- PGY2-6 level residents must have at least 14 hours free of duty after 24hours of in-house duty. Residents should have at least 8 hours, free of duty between scheduled duty periods.
- Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

Residents are required to report and log all clinical experience hours on New Innovations. Residents must log in at least once every week. The Program Director and Program Coordinator will run reports on a weekly basis to review each resident's reported hours to ensure compliance and address potential violations.

Duty Hour Noncompliance

In the circumstance where a resident recognizes that he or she will be noncompliant with duty hours, he or she must notify the chief resident, service faculty member, and program director. Accommodation will be arranged immediately to bring the hours back into compliance.

Duty hours are reviewed weekly by the program coordinator and program director. Residents who have not entered duty hour logs will be asked to complete these. Completing duty hour logs is a matter of professionalism and the residents will be rated on this. If a duty hour issue is identified by the program director, the program director will contact the resident in order to understand the circumstances that led to the violation. Corrective action will be arranged with the service in order to bring the resident back into compliance.

Protocol for Episodes When Residents Remain on Duty beyond Scheduled Hours

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled

period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident **must**:

a. Appropriately hand over the care of all other patients to the team responsible for their continuing care

b. Document the reasons/justification in New Innovations

The Program Director will review each submission of additional service for justification and will track both individual resident and program-wide episodes of additional duty in New Innovations.

Fatigue Management

All residents need to have enough time without clinical responsibilities to stay well-rested and avoid fatigue while on duty. Residents receive instruction annually on issues of fatigue, sleep, and napping during their biannually meetings with their faculty advisor.

Residents that have fatigue symptoms at any point could jeopardize patient care. These symptoms include falling asleep, irritability, apathy, and careless medical errors. Residents are required to consult immediately with other members of the team including service faculty, and inform the program director so that the resident may be immediately be relieved of duty. Patient care should then be delivered by other members of the team or by a faculty member. Call rooms at each site are available 24 hours a day for strategic napping. It is the responsibility of the fatigued resident to take advantage of time away for rest.

Didactics & Duty Hours

Residents, regardless of their clinical assignments, are expected to participate in the didactic portion of the residency program. Attendance is mandatory and residents are expected to be on time with the exception of post-call residents who are exempt and/or residents who would exceed hour limitations. Educational conferences are considered “protected time” and alternative coverage should be arranged with the attending faculty. If this cannot be arranged, the resident should contact the Program Director.

Resident Supervision

Updated: June 2021

Resident Supervision

PURPOSE: These guidelines have been established to ensure patient safety, enhance the quality of patient care, and improve the training experience of residents. Consistent with the philosophy of progressively increasing individual responsibility, these guidelines are intended to provide the trainee the opportunity for graded levels of responsibility.

SCOPE: These guidelines apply to all residents enrolled in the Plastic Surgery Training Program, and attending surgeons of all integrated and affiliated institutions who are involved with the EVMS Plastic Surgery Residency Training Program.

Protocols Defining Common Circumstances Requiring Faculty Involvement

1. The supervision and communication between the attending surgeon and any resident/fellow should exceed that required to ensure that the clinical care delivered meets the established community standard of care.
2. The resident/fellow can identify and contact a responsible attending surgeon for a given patient at all times.

3. In the event that an attending surgeon is not available to provide supervision, he or she must designate an alternate or covering attending and identify that person to the resident.
4. For ambulatory or non-urgent care, an attending surgeon is required to be available on-site at the facility during daytime hours of operation.
5. For inpatient admissions, an attending surgeon will be notified of the admission and such notification will be documented in the admitting fellow's admission note. An attending surgeon will personally see and evaluate each assigned inpatient admission within twenty-four (24) hours of admission, and co-sign the resident/fellow's admitting note or create their own written or printed documentation.
6. For inpatients, the resident/ fellow should maintain ongoing communication at least one (1) time per day with the designated attending surgeon. The attending surgeon should document such communication by co-signing the resident/fellow's progress note, or the fellow will include in his progress note that the case has been discussed with the attending surgeon.
7. It is assumed that there is a mutual responsibility on the part of both the resident/fellow and attending surgeon to recognize the need for increased frequency and quality of communication, and attending surgeon participation. The following are circumstances and events where residents must communicate with supervising faculty:

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

b. Procedural Competencies

- Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
- Repair of surgical incisions of the skin and soft tissues
- repair of skin and soft tissue lacerations
- Excision of lesions of the skin and subcutaneous tissues
- Tube thoracotomy
- Paracentesis
- Endotracheal intubation
- Bedside wound debridement

Direct to Indirect Supervision of PGY-1 Residents

After having successfully completed ACS Fundamentals of Surgery Curriculum, ATLS, ACLS, Transition of Care Training, CVL Training, Suturing Basics Workshop, GME & Department orientation along with a month of observed performance and satisfactory evaluations, PGY-1 residents will be deemed "qualified to see patients with indirect supervision" by the Program Director.

Operative Procedures

The Department of Surgery requires that an attending surgeon participate in any operative procedure performed by residents. Attending physicians are also required to supervise other aspects of each patient's care. Such participation is important, not only in the context of patient care and administrative responsibility, but also in fulfilling the educational mission of the Department. Under appropriate circumstances, senior and chief residents may benefit from

assuming responsibility for independent execution of surgical procedures. However, the following conditions MUST ALWAYS apply:

1. An attending surgeon must be assigned to each patient undergoing an operative procedure. The attending-of-record must be identified in the patient's chart.
2. The attending-of-record is the ONLY individual permitted to empower a senior resident to proceed with an operative procedure in the attending's absence. The attending-of-record must be present during the critical phase of the operation. Operating room personnel may, at any time, request verification of the attending's permission to proceed. Concerns regarding the appropriateness of the decision, or subsequent execution of the procedure, may be discussed with the attending surgeon, the Section Chief, or the Department Head.

"Moonlighting"

Updated: June 2021

The EVMS Department of Surgery ***does not*** permit moonlighting due to the potential adverse impact upon residents' clinical and educational performance.

Case Volume

PURPOSE: To ensure adequate operative experience and documentation of cases.

POLICY Residents have a responsibility to enter cases accurately and in a timely manner. It is recommended that residents log cases daily or at least weekly. Residents must continue to log cases throughout the duration of their program, even if the minimum requirements have been met.

Program directors have the responsibility to regularly review and analyze each resident's completed cases. It is recommended that program directors review the Case Minimums Report at least quarterly to ensure each resident is making appropriate progress toward meeting the required minimum numbers. The Accreditation Data System (ADS) Case Log tab includes general references on entering and retrieving information. Each specialty's page on the ACGME-I website contains additional Case Log references, including a Resident Quick Guide with definitions and case entry requirements particular to the specialty and a Faculty and Staff Quick Guide to assist program directors and faculty members choose and evaluate Case Log reports. Residents are encouraged to review these resources prior to their first case entries and to continue to refer to them as needed. Program directors can use information from the reports in ADS to review resident progress toward meeting clinical experience requirements, to set and evaluate curriculum, and to inform clinical faculty members about residents' clinical experience needs

Development of a Personal Program of Learning and Professional Development

Updated: June 2021

The Department of Surgery and its Division of Plastic Surgery seeks to maintain a supportive environment committed to the personal and professional growth of its residents. Opportunities exist within our surgical residency program to ensure residents achieve satisfaction in their personal and professional development as they continue their academic and professional pursuits. Such opportunities include:

- Existence of an “open-door” policy with faculty to discuss personal, as well as academic, Issues

- ***Self-Assessment*-**Self assessment forms are distributed biannually to residents via New Innovations. During Faculty advisor meetings, residents also indicated where he/she feels they are in terms of the program objectives and set goals for the next six months.

- ***Journal Club/Didactics*-**Formal education in the assessment of the validity and reliability of research articles is conducted annually. Attendings and faculty advisors identify strengths/weaknesses and plans for continued growth.

- ***Mentoring*-** Each Plastic Surgery Resident will choose or be assigned a faculty mentor. This person will be the resident’s advocate for both personal and residency issues. The resident and faculty mentor will meet biannually and document the meeting via a mentor meeting record form. The faculty mentor will be provided the resident’s portfolio prior to the semi-annual meeting. More frequent meetings are encouraged as needed.

- ***Educational Travel/Conferences*-** Residents are provided the opportunity to attend meetings of professional societies and conferences.

- ***Patient Safety and Quality Assurance Education*-** Education lectures are given in collaboration with Sentara Norfolk General Hospital during Grand Rounds that addresses the following topics:
  SNGH Quality, Core Measures, HAI Metrics
  Safety Culture, error prevention, Safety habits, Authority gradient, CITs
  Safety & root cause analysis of events
  Value Based Purchasing, Customer Service
  Accreditation: JC, DNV, Iso, Quality Management System- pulling it all together

At least two residents are assigned to the EVMS/SNGH Patient Safety & Quality Improvement Council. The purpose for the council is to have EVMS and SNGH collaborate on efforts to improve patient care through resident physicians integrating into the clinical learning environment’s Patient Safety and Quality Improvement program. This forum will allow the administrative leadership team and residents to exchange information and identify opportunities to improve patient safety and the quality of care to our patients.

Vacation & Leave

Updated: June 2021

- Each resident is permitted three weeks of vacation annually. A week is defined as seven (7) days that includes five (5) business days (Monday through Friday) and one weekend (Saturday and Sunday). Vacations must be taken in seven-day blocks. The weekend being requested must be specified. Vacation requests that fall mid-week must be cleared with the Chief Resident at the time of vacation.

- Seniority is considered in approving vacation requests. Residents submit 5 options for vacation requests in order of importance. Attempts will be made to honor all first choices keeping seniority in mind. The remaining 2 weeks will be assigned according to seniority.

- Residents invited to present papers or posters at professional meetings are not required to use vacation time.

  a. Residents are expected to be away **only for the time needed to travel and present**, and should notify the Chief resident on their service and the Education Specialist of the dates they will be gone.

  b. A travel checklist must be completed 30 days prior to travel and turned in to the plastic surgery coordinator.

  c. Anticipated conference attendance for the upcoming year must be indicated when submitting vacation requests to help minimize scheduling conflicts (i.e. having one resident out on vacation while another is at a conference)

- Residents who anticipate residency, fellowship, or job interviews should request only two weeks of vacation, saving one week to be used for interviews. This "saved" week may be used one or two days at a time, as appropriate for the resident's needs. This must be indicated when submitting vacation requests.

- Only one resident may be on vacation at a time from any service. Residents may not take more than one week of vacation during any rotation. Residents may not take more than one week of vacation per month.

- Vacations are not permitted during the following time frames for 2021-2022:
  a. July 1st – July 31st
  b. Nov 17-Nov 26 (Thanksgiving Week)
  c. December 14 - Jan 5th (Christmas / New Years)
  d. June 15-29 (last 2 weeks of June)

- Vacations are not permitted when assigned to the Trauma or EGS rotations

- Any resident taking vacation that includes the weekend of the Residents' Scientific Forum and/or Graduation banquet is required to attend those functions.
  aChief Residents:
  a. Chiefs cannot take more than one week of vacation during each rotation.
  b. Chiefs are entitled to one Department-reimbursed educational meeting during their Chief year pending approval from the Program Director.
  c. Vacation time must be used for job and fellowship interviews.

  The following policies apply:
  a. Any resident not submitting requests for their three weeks by the deadline will be assigned vacation. No exceptions.

b. Residents will be notified whether their requests were approved, via email.

c. A Google calendar as well as a hard copy of the schedule will be set up and updated to allow all vacation dates to be visible across the residency program at all locations

c. Once the vacation schedule is issued, there will be no changes made, except in the case of an extreme situation or circumstance. All changes must be approved by the chief resident and ultimately the Program Director.

d. *The master vacation schedule will be completed reflecting a schedule that adheres to the ACGME work hour guidelines and provides adequate call coverage. This schedule will be available on-line to residents and site directors.*

e. Any time away for conferences/vacations/interviews are listed on Dr. Britt's calendar so it is important that the information provided is current.

Leave Policies & Procedures

The Department of Surgery recognizes that residents may need to be away from their assigned service for emergency reasons, such as illness, maternity, or family emergency. The Department, however, must be able to account for each resident's whereabouts.

In the event that a resident requests emergency leave, these procedures ***mus***t be followed:

- Discuss the reason for leave with the Site Director or Chief of the Service. (The names of these attendings are indicated on each rotation description.) A resident must never leave the service without directly informing the Chief of the Service or his/her designee

- Discuss the reason for leave with the chief resident and program administrators: email mokdadi@evms.edu

- Be prepared to give the details of the amount of time you are requesting, when you plan to return, and where you will be, including a telephone number where you can be reached.

The Program Director is responsible for knowing the whereabouts of all residents.The Program Director is ultimately responsible for all residents and assuring resident compliance with this procedure. Failure to follow the designated procedures may result in loss of pay or loss of vacation time.

- **Sick Leave:** Sick leave may be authorized for an absence due to medical reasons with full pay and benefits for a period not to exceed four weeks (20 work days). Sick leave may be used for illness, injury, or medical/dental treatment for the trainee, the trainee's spouse, dependent child (or legal ward), or the trainee's or trainee's spouse's parent/step-parent. Each trainee shall immediately notify his/her chief resident and program director of any illness and, if requested by the program director, shall provide physician records to document illness lasting three or more days. Sick leave is not cumulative and unused days are not carried forward into the next academic year.

- **Bereavement Leave:** Leave with pay, outside of vacation or sick leave, may be granted for up to three (3) days when a death occurs in the immediate family. Immediate family is defined as spouse, parent or stepparent, grandparent, child, sibling, guardian or legal ward of the trainee or the parent, stepparent, grandparent, sibling, guardian or legal ward of the trainee's spouse. The trainee must notify the chief resident and the program director prior to taking leave.

- **Maternity Leave:** Maternity leave is provided through the combined use of sick and vacation leave. Trainees considering pregnancy during the training program should plan the use of vacation and sick leave accordingly. Additional time beyond this period may be granted without pay upon recommendation of the program director and approval of the Associate Dean for Graduate Medical Education. Trainees may also qualify for Family and Medical Leave (see Family and Medical Leave Act below). Residents who become pregnant will need to contact Human Resources (446-6043) to start their FMLA paperwork.

- **Paternity and Adoption Leave:** Paternity and adoption leave are provided through vacation leave and three days of sick leave. Trainees considering pregnancy or adoption during the training program should plan the use of vacation leave accordingly. Additional time beyond this period may be granted without pay upon recommendation of the program director and approval of the Associate Dean for Graduate Medical Education. Trainees may also qualify for Family and Medical Leave (see Family and Medical Leave Act below). Residents requesting paternity leave need to contact Human Resources (446-6043) for details regarding the process and necessary paperwork if requesting more than 7 days.

- **Family and Medical Leave Act of 1993:** This Act provides for up to twelve weeks of combined paid and unpaid leaves of absence due to child birth, adoption or serious illness of a spouse, parent, or child. Trainees should be aware that use of this leave category may extend the period of time required to complete the educational requirements for the training program. To be eligible for leave under the Family and Medical Leave Act, the trainee must have been contracted for at least twelve months and actively participating in the educational program for a minimum of 1,250 hours during that time period. For further information contact The Department of Human Resources (446-6043) and the program director.
  (The EVMS GME Policies Handbook is available on the front page of New Innovations upon login)

- **Counseling Services:**
  EVMS offers an Employee Assistance Program which provides 5 free sessions of counseling for any employee. It is an off-campus service and is confidential. The process includes contacting HR to obtain referral information. Several EVMS residents have used this program successfully.

  EVMS health insurance includes mental health coverage. There is a co-pay. This is best for long-term counseling.

Dress & Appearance

Updated: June 2021

Maintain proper hygiene and attire. Hair must be kept clean, and if worn long must be pulled back from the face. Nails must be short. Residents should maintain a clean-shaven appearance. Residents are prohibited from wearing any facial rings or "studs". The stomach and, for the

women, cleavage shall be covered. Dresses or skirts shall be worn so that they hang to the knee, at a minimum.

No "flip flops" sandals or athletic shoes are to be worn. Clothes must be clean, including the resident's white coat. When attending departmental meetings or didactics, residents should be dressed in business attire and their white coat. At these times male residents are to wear a collar and tie, women must dress in appropriate business attire which fully complies with these directives.

The Program Director will have the sole discretion in deciding whether these hygiene and dress requirements are being met. Any instruction offered by the Program Director in these regards must be carried out prior to the resident having further contact with any patient.

Educational Travel

Updated: June 2021

The Department encourages residents to submit their clinical and basic science research efforts to significant meetings in the United States for presentation.

Residents invited to present papers or posters at professional meetings are not required to use vacation time. However, residents are expected to be away **only** for the time needed to travel and present, and should notify the Chief resident on their service and the Education Specialist of the dates they will be gone. **An academic travel checklist must be completed 30 days prior to travel and turned in to the Education Specialist. (See attachment)**

Residents are required to turn in all original receipts (itemized, detailed-for hotel, travel, taxi, parking only) ***within 10 days*** of return to the Residency Coordinator for processing of the travel voucher. Reimbursement for travel will not be made unless the manuscript is turned in at the time of receipts.

Overall Resident Responsibilities

Residents in the EVMS Department of Surgery are required to assume the following responsibilities which contribute to their learning and training:

1. Develop a personal program of self-study and professional growth with guidance from the faculty.

2. Participate in effective and compassionate patient care, under faculty supervision. Such patient care includes spending one half-days per week in an ambulatory setting appropriate for the rotation.

3. Regularly participate in all applicable Plastic Surgery Residency program's educational and scholarly activities.

4. Participate in institutional committees and councils, especially those related to patient care review activities.

5. Participate in evaluating the quality of education provided by the program, which includes the completion of rotation evaluation forms and faculty evaluations.

6. Develop an understanding of ethical, socioeconomic, and medical/legal issues that impact graduate medical education, including knowledge of how to apply cost containment measures in the provision of patient care.

7. Complete medical records in an accurate and timely fashion, inclusive of dictating operative reports.

8. Maintain a log of invasive procedures that lead to credentialing. Interns must submit documentation of their completion of invasive procedures in order to practice such procedures independently.

9. Accurately and **promptly** report all operative cases using the ACGME Resident Operative Log system. Case log reports will be reviewed by the Program Director during individual fall and spring resident review meetings.

10. Consistently, and conscientiously, observe universal precautions and other infection control measures, including immunization against Hepatitis B. All patients are assumed to have infectious blood and bodily fluids that contain transmissible disease. Universal precaution barriers must be used in any patient contact where exposure to blood or other bodily fluids is anticipated. These requirements are Occupational Safety and Health Administration (OSHA) laws.

11. Participate annually in the American Board of Plastic Surgery In- training Examination and score in the 30th%tile or better. Residents in clinical years, four, five and six are additionally required to participate in annual mock oral examinations.

ADMINISTRATIVE DEADLINES

Residents in the Department of Surgery are expected to remain current with various administrative responsibilities that include, but are not limited to, the following:

- Surgical operative experience logs-this must be logged monthly on your current rotation
- Medical record keeping
- Submission of various administrative responsibilities (M&Ms, call schedules, submission of Journal Club articles, weekly SCORE assignments)
- Evaluations (rotation, peer, self, program, faculty, Chief)
- Logging duty hours

In the event that a resident does not adhere to the deadlines for these administrative responsibilities, the Program Director will be notified. Completing responsibilities on time is a matter of professionalism and non-compliance will noted during annual reviews.

Resident Resources:

Updated: June 2021

White Coats

Residents are issued two long, white lab coats, embroidered with their name and "Department of Surgery" at the beginning of their PGY-1 year and at the beginning of their Chief year. Residents also have a *one-time* $80 coat allowance to be used at any time during the residency. This should allow the purchase of two additional coats. A patch representing EVMS is sewn on the left, breast pocket. Coats should appear clean and pressed. Additional coats are available for $30.

Educational Allowance

The Department of Surgery provides each plastic surgery resident with a $500 book allowance annually. This allowance is to be used for educational materials such as textbooks, journals, study guides, and web subscriptions. In addition, residents will receive a one-time $1500 Loupes allowance. Effective July 2010, book funds may no longer be used for PDAs and loupes. All funds are to be used by June 1st. Any remaining balance may not be transferred to the following year. Funds are not transferable among residents.

The Program Director and Director of Education maintains ultimate control over the use of these funds and may determine the appropriateness of expenditures.

Meals

Residents are provided with an electronic meal card that is usable at Sentara Norfolk General. Meal cards will be distributed for CHKD, Sentara Leigh and Sentara Princess Anne Hospitals.

Surgical Library

The Brickell Library, located on the Sentara/EVMS campus, is available to all residents. Refer to the EVMS website for information on library hours and location. Each hospital in which residents rotate additionally house a library that is available to residents. The "Resident Lounge," located in the Department of Surgery provides current texts, journals, *Selected Readings,* and video collections that are available to residents. These materials may be signed out, according to the Honor Code system.

Society Memberships

The Department pays the required fees to ensure that all current categorical residents receive ACS resident membership annually. The Department also pays for female categorical residents' membership to the Association of Women Surgeons.

ID Badges

The EVMS Office of Graduate Medical Education will arrange for residents to receive appropriate ID badges. Peripheral hospitals may require additional ID specific to their institution. IDs must be worn at all times.

Pagers

Pagers are issued to residents when they report to the Department's Orientation Day. If the pager is lost, stolen, or damaged, residents are to contact the Residency Coordinator immediately for a replacement pager. ***With the exception of vacation, residents should never be without their pager.***

Residents are responsible for replacement costs when a pager is lost or damaged (loss and damage must have occurred due to resident neglect).

Resident Committees

Updated: June 2021

The Department of Surgery has residents assigned to the following committees:
RRC (as resident representatives) (2)
Ambulatory Care Clinic (2)
Surgical Critical Care (1)
GMEC Resident Representative (3)
EVMS Resident Council Representative (1)
EVMS/SNGH Patient Safety & Quality Improvement Council (3)

Resident Promotion

Updated: June 2021

The Department of Surgery issues contracts annually to those residents demonstrating clinical and academic performance commensurate with promotion to the next level of training.

Residents who demonstrate deficiencies throughout any year of training are identified through performance evaluations, in-service exam scores, and discussion at faculty and departmental RRC meetings. If serious deficits are identified in a resident's academic and/or clinical performance, the Program Director will meet with the resident to review strategies for improvement. Frequent meetings will then occur with this resident, the Program Director, and the resident's faculty advisor.

Additionally, **residents must complete the USMLE Step III examination prior to promotion to PGY-3 status**. Scores must be submitted to the Residency Coordinator for inclusion in the resident's personnel file.

All residents must also retain licensure throughout their training. Residents may retain a license specific to intern/resident training throughout their five or more years of residency. Residents are encouraged, however, to obtain the full license. This full license that indicates that a resident is allowed to perform medicine and surgery is required for registration for the Boards with the ABS.

Conference Attendance & Didactics

Updated: June 2021

Attendance at all Department of Surgery sponsored conferences is mandatory (within duty hour regulations). Residents on approved leave are excused from conferences. Residents are expected to attend at least 80% of all educational conferences. Residents are required to sign the attendance roster at Friday conferences. **It is the Chief resident's responsibility to ensure that the residents on his/her service attend all educational sessions.**

Such educational conferences include, but are not limited, to the following:

- **Grand Rounds**
    - Consists of presentations by full-time and community faculty, as well as visiting Professors from other institutions. Such lectures include content that provides a multi-disciplinary approach to surgical patient care
    - Held once per month for one hour

- **Mortality and Morbidity conferences**
    - Case presentations that discuss complications and causes of death in patients cared for the plastic surgery service admitted to the surgical teaching services.
    - Held monthly or one hour

- **Indication Conference**

    - Occurs weekly
    - Review the following week's surgery schedule
    - Residents should be prepared to understand the rationale supporting the operative plan

- **Surgical Skills Labs**

- **State-of-the-Art Visiting Professors**
    - Visiting Professors are scheduled during Grand Rounds The Visiting Professor typically presents at Friday Grand Rounds followed by resident case presentations. All residents are expected to attend these two one-hour conferences.

- **Aesthetic Journal Club**
    - Journal Club occurs monthly
      The intention of Journal Club is to provide a scholarly discussion of current topics and procedures from the Plastic Surgery literature. This experience should also assist residents with their understanding of research design and basic statistical concepts. At least two weeks in advance of Journal Club, the chief Resident provides articles for all residents to read. **Following each resident's presentation, the faculty will ask questions to any of the residents. Read and be prepared – taking notes when reading may be helpful.**

GUIDELINES FOR CRITIQUING RESEARCH ARTICLES

The following questions are designed to assist when reading and evaluating research studies. These questions are presented in the same order as the majority of research reports found in journals. These are generic questions and may not be applicable to all research reports.

Rationale/Research Question/Hypothesis:

- What is the major research question or hypothesis presented?
- What is the rationale for this research question or hypothesis?
- Does this rationale have an empirical basis? A theoretical basis?
- Does this study address a relevant issue/problem?
- Are the variables (constructs) under study clearly identified?

Research Design/Data Analysis/Statistics:

- Is the research design clearly described? Does it permit replication?
- Is the research design appropriate for the proposed research question?
- What types of tests (or measurement devices) were used?
- What are the confounding variables and limitations of this study?

- Were the statistical tests appropriate?
- Is the sample size adequate for this study?
- Is the quantity of data appropriate? Insufficient? Too much?
- Are descriptive and inferential data clearly presented? Do the numbers seem to "add up?"
- Does the data make sense?
- Are "statistical differences" distinguished from "meaningful or practical differences?"
- Were the results reported correctly and appropriately?
- Do the tables, graphs, and/or figures agree with the text, data analyses, and reported findings?

Discussion/Conclusion/Interpretation:

- Do the conclusions follow from the design, methods, and results? Why/why not?
- What are the key points? Are these easily identified in the conclusion?
- Are study limitations and loss of data discussed?
- Are alternative interpretations for these findings considered?
- Is the practical significance or theoretical implications presented?
- Are there major problems or fatal flaws that detract from these findings?
- Did such flaws occur during the study? How could these flaws be corrected in a future study?
- How does this study validate, or improve upon, what we already know?

Evaluations:

Updated: June 2021

Evaluation of Residents

Clinical rotation performance: Educational Site Directors/Faculty Attendings, Chief Residents, and peers when applicable, formally evaluate residents' performance on each rotation. Verbal feedback should be given throughout the rotation. These evaluations are submitted to the Chairman/Program Director through New Innovations. Residents are also responsible for completing biannual self-evaluations.

Biannual reviews: Each resident is scheduled for a formal review twice per year. The Program Director, accompanied by one faculty member, will meet with residents on an individual basis. The resident's performance, career goals, operative logs and mutual concerns are discussed. The Chairman and other faculty meet on an ad hoc basis with residents for counseling and resolution of any problems, when necessary.

Residency Review Committee: Each resident's performance is discussed at quarterly meetings of the departmental Residency Review Committee, as well as at regular Faculty and Education Committee meetings. This Committee also reviews the curriculum, noting opportunities for enhancement.

Evaluation of Program

Residents have several structured opportunities to evaluate the program and faculty.

- Upon completion of each rotation, residents are expected to complete an "Evaluation of Service" form and an "Evaluation of Faculty" form in New Innovations. **These evaluations are kept**

anonymous/confidential. The Program Director reviews all evaluations and are used in Faculty evaluations and to improve the content and quality of the residency program.

- Residents are encouraged to discuss any concerns during their biannual reviews.

- Residents are encouraged to discuss concerns with those residents elected to the departmental Residency Review Committee, allowing these representatives to discuss resident concerns at quarterly RRC meetings

Program Evaluation

The last faculty meeting of each year is dedicated to the evaluation of the residency program. This session includes a review of:

- Resident performance
- Faculty development
- Graduation (Board) performance
- Program quality
- Resident/faculty evaluation of program
- Operative logs (volume, breadth & complexity)
- Evaluations
- ABSITE scores
- Strategies for enhancement of the program along with implementation processes

A similar meeting occurs at the departmental RRC meeting during the last quarterly session to incorporate feedback and suggestions from the community faculty members.

Research & Scholarly Activity

Updated: June 2021

The program strongly recommends that the resident participate in ongoing clinical research.

The resident is encouraged to present research results at national surgical research forums and submit at least one manuscript to a peer-reviewed journal.

Residents obtain basic research knowledge through an annual training that utilizes the GME Resident Research Manual, presentation by both an attending and resident, initial/subsequent CITI training (online research training) and by continued partnership with faculty research mentor.

Residents' Day Annual Scientific Forum

A Scientific Forum is held annually in June. Residents at the PGY-4, -5, and -6 levels are **required** to present research resulting from a clinical or basic science project. First, second and third year residents are encouraged to present, although not required to do so. Categorical and preliminary residents are required to attend.

- Only one presentation is allowed per resident unless otherwise approved by the Program Director. ***Each resident is expected to present NEW research each year***.

- In order to meet the requirements of the IRB for our annual research day, residents will be required to submit their IRB submittal letter to the research coordinator and their faculty mentor by *October 1st of the year prior to presentation*.

  If residents have not submitted their proposals by October 1st they will have a meeting scheduled with the Program Director to explain the delay. The resident will have thirty (30) days to obtain a submittal letter from the IRB. No holiday leave time will be allowed for residents missing the October 1st deadline. If the resident fails the extended deadline they will be placed on academic probation.

- The Department of Surgery will formally train all residents regarding the proper processes/timeline requirements of research activities. Training will continue to be conducted annually. The Resident Research Handbook will be distributed at this training and discussed/reviewed at length.

- Residents are to submit their projects to the EVMS Institutional Review Board for approval prior to any data collection as early as possible. Residents can submit all of the documents they submit to the IRB to Sentara at the same time as they submit to IRB. Once approved by the IRB, residents can forward those documents to Sentara. This can all be done via email through Becky Seaman rxseaman@sentara.com

RESIDENT ORDER WRITING

Updated: June 2021

Surgery residents may independently write orders necessary for patient care. Co-signatures are not necessary. All orders are reviewed by senior and chief residents, as well as faculty, during rounds. Junior residents are expected to notify their senior or chief resident of any significant change in a patient's care, at which time orders are renewed.

Medical students may write orders in the patient chart; however, these orders are not activated until countersigned by a resident or attending physician of the Department of Surgery.

Resident Use of Patient Restraints

Updated: June 2021

When patient restraints are deemed necessary to provide appropriate patient care, the following requirements must be met for the resident to order such restraints:

- The resident meets the state's requirements to practice medicine within the auspices of the training program.
- The resident has successfully completed the first year of post-graduate medical education. If the resident has not yet completed this first year of post-graduate medical education, he/she must receive supervision by a senior or chief resident.
- The graduate education program allows the resident to perform this activity.

Guidelines for Medical Records

Updated: June 2021

Copies of all medical records, especially operative reports, are necessary for the timely billing of procedures. Timely dictation of patients' medical reports also ensures appropriate patient follow up. **It is necessary that reports are dictated in a timely manner.**

All dictated reports should include the following:

- Date of surgery
- Attending physician of record
- Procedures performed
- A request that a copy be sent to the attending physician's office

Helpful hints:

- Dictations are legal documents
- Dictations are not to be done by medical students
- Speak clearly and succinctly to avoid transcription error
- Transfer summaries are to be dictated before a patient can be sent to a secondary facility
- Dictate interim/transfer/discharge summaries on long-term patients prior to leaving a rotation
- Document dictation number in progress notes, if possible
- Notice of delinquent medical records will be sent to your Department mailbox
- Call medical records to request that your charts are pulled prior to your arrival

Information required on Operative Notes:

- Resident name
- Attending of record
- Patient name, social security number
- Physician to whom report should be sent
- Date of procedure
- Pre-op diagnosis
- Post-op diagnosis
- Procedure
- Attending surgeon
- Assistants
- Estimated blood loss
- Fluids – cc's, crystalloid, colloid
- Specimen sent, frozen section reports
- Drains
- Complications
- Indications for procedure – short narrative (several sentences only)
- Description of procedure
- Repeat resident name, attending of record, and patient name and SS #
- Write down dictation #

Information required for Discharge, transfer, or death summaries:

- Resident name
- Attending of record
- Patient name, social security number

- Physician to whom report should be sent
- Date of admission
- Date of discharge
- Admission diagnosis
- Discharge diagnosis
- Procedures
- Consults
- Brief medical history
- Brief summary of hospital stay
- Disposition
- Follow up
- Diet
- Activity
- Home health nursing arrangements
- Rx
- Repeat resident name, attending of record, and patient name and SS#
- Write down dictation #

History & Physical (Work Type 1) **Pre-Op History & Physical (Work Type 6)**

1. Your name and type of report being dictated

2. Patient's name (last, first, middle initial, Spell unusual names)

3. Medical record number (From upper left hand corner to face sheet of addressograph)

4. Patient's room number

5. Date of admission

6. Chief complaint

7. History of present illness

8. Past medical history (Medication, immunization, injuries, operation, allergies)

9. Family and social history

10. Developmental age factors (include educational needs)

11. System review (General, Skin, HEENT, Cardiorespiratory, Gastrointestinal, Genitourinary, Gynecological, Neurological, Musculoskeletal)

12. Physical Examination (General appearance, Skin HEENT, Neck, Throrax {breast heart, lungs}, Abdomen, Genitalia, Rectal Examination, Neurological)

13. Impression

14. Plan of treatment

15. State your name and patient's name

Operation (Inpatient Work Type 7; Outpatient 4)

1. Your name and type of report being dictated
2. Patient's name (last, first middle initial – spell unusual names)
3. Medical record number (from upper left hand corner of face sheet or addressograph)
4. Patient's room number
5. Date of Surgery
6. Pre-op diagnosis
7. Post-op diagnosis
8. Name of operation/procedure performed
9. Name of surgeon
10. Full name(s) and title(s) of assistant(s)
11. Anesthesia
12. Description of findings
13. State your name and patient's name

Discharge/Death summary (Work Type 2) Transfer Summery (Work Type 5)

1. Your name and type of report being dictated
2. Patient's name (last, first middle initial – spell unusual names)
3. Medical record number (from upper left hand corner of face sheet or addressograph)
4. Date of admission
5. Date of discharge/expiration
6. Admission diagnosis
7. Reason for hospitalization
8. Hospital course (including consultations, the procedures performed and pertinent lab X-ray data)
9. Disposition

10. Condition on discharge
11. Discharge instructions (Including physical activity, medication, diet, follow-up)

12. Principle diagnoses (Using standard nomenclature, no abbreviations)

13. State your name and patient's name