MEDICAL UNIVERSITY OF OHIO
DEPARTMENT OF SURGERY
RESIDENT MANUAL
2005-2006
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Synopsis of Program

This program is composed of both educational conferences and clinical training activities which are integrated to achieve the goals and objectives of the program. These activities provide both specific clinical information within the broad discipline of surgery as well as the basic background competencies common to all types of medical practices.

This residency program has been designed so that the residents receive a progressive education with increasing responsibilities in the broad field of general surgery over a minimum training period of five years (sixty months). An option exists for the extension of training beyond five years to allow the trainee the opportunity to benefit from interactions with research facilities of the Medical University of Ohio.

Program design characteristics are directed towards providing a program in which the graduate trainee receives an evidence based education for evaluation of surgical patients. Attention is directed to appropriate work-up to establish a diagnosis, management of patients and any complications of the disease or treatment in the broad field of general surgery; diseases of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and endocrine system, the comprehensive management of trauma and emergency operations, and surgical critical care. Over the course of the five year program each graduate trainee will receive education and clinical training in the surgical subspecialties to establish and understand basic principles of pre-, intra-, and postoperative management of patients in cardiothoracic surgery, plastic surgery, pediatric surgery, and transplant surgery, as well as in the overall management of patients with common problems in urology, gynecology, neurological surgery, orthopedics, burns, and anesthesiology.
<table>
<thead>
<tr>
<th>Residents</th>
<th>PGY LEVEL</th>
<th>Designation</th>
<th>PAGER Numbers</th>
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<tr>
<td>Daniel Liesen</td>
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<td>Categorical</td>
<td>419-471-8273</td>
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<tr>
<td>Ami Linder</td>
<td>5</td>
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<td>Amanda Matheny</td>
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<td>Daniel McCullough</td>
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<tr>
<td>Salim Mancho</td>
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<td>Shuab Omer</td>
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<tr>
<td>Chad Patterson</td>
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<tr>
<td>Grant Erickson</td>
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<td>419-539-5628</td>
</tr>
<tr>
<td>Krissie Slam</td>
<td>3</td>
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<tr>
<td>Brian Smith(LOA)</td>
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<td>419-471-6514</td>
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<tr>
<td>Jianlin Tang</td>
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<tr>
<td>Hammad Amer</td>
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<tr>
<td>Yazan Duwyari</td>
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<tr>
<td>Pablo Serrano</td>
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<tr>
<td>Michael Schmidt</td>
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<tr>
<td>Albert Tsang</td>
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<tr>
<td>Babatunde Almaroo</td>
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<tr>
<td>Mario Castillo Sang</td>
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<td>Barbu Gociman</td>
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<td>Mohmmed Margni</td>
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<tr>
<td>Mouchammed Agko</td>
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<tr>
<td>Raja Bhoda</td>
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## Resident Rotations

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<th>PGY Level</th>
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<th>Duration (months)</th>
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<td>First Year</td>
<td>Emergency Medicine</td>
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<tr>
<td></td>
<td>Urology *</td>
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<td>MUOT</td>
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<tr>
<td></td>
<td>Cardiothoracic/Vascular</td>
<td>1</td>
<td>MUOT C</td>
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<tr>
<td></td>
<td>Orthopedics</td>
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<td></td>
<td>Neurosurgery</td>
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<td>General Surgery</td>
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<td>MUOT A &amp; B</td>
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<td>MUOT A &amp; B</td>
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<tr>
<td>Second Year</td>
<td>General/Trauma U</td>
<td>3</td>
<td>MUOT B</td>
</tr>
<tr>
<td></td>
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<td>SVMMC</td>
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<td>MUOT A</td>
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<td></td>
<td>General</td>
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<td>SVMMC A &amp; B</td>
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<tr>
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<td>Night Float</td>
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<td>SVMMC</td>
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<tr>
<td>Third Year</td>
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<td>General</td>
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<td>SVMMC</td>
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<td></td>
<td>General/Trauma</td>
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<td>Night Float</td>
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<td>Vascular</td>
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<td>SVMMC</td>
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<td>Plastics</td>
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<tr>
<td></td>
<td>Night Float</td>
<td>1.5</td>
<td>MUOT</td>
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* Transplant experience obtained on this rotation

- MUOT A Allison, Cason, Chaudhuri, Leninger, Merrick, ENT
- MUOT B Borst, Cerilli, Fath, Naylor, Senagore, Welch (Plastics)
- MUOT C Durham, Shah, Schwann (Cardiothoracic/ Vascular)
- MUOT D Nazzal, Abbas Vascular Surgery
- MUOT Neurosurgery Medhkour, Abumeri
- MUOT Peds Surg Khan
- SVMMC A Dodd, Sferra, Stengle,
- SVMMC B Stark, Wright, BWhite, Sternfeld, Braun, PWhite, Cashen, Roulier, Rosol, Geiger, Polley, Teitelbaum, Bruch, Soldes
- SVMMC Martinez, Clark, Kasper, Sbrochhi
GOALS AND OBJECTIVES

The primary goal of this program is to provide training in the discipline of surgery to graduates of medical schools accredited by the Liaison Committee for Medical Education (LCME), which will allow the successful graduate of the program to function as a qualified practitioner of surgery and exhibit the level of performance necessary to attain board-certification. A successful graduate of this program will have fulfilled all prerequisites and be eligible for certification by the American Board of Surgery® (ABS). A marker of this success and program quality benchmark is an acceptable pass rate among all graduates of this program for both the ABS qualification and certifying examinations. The program has two secondary goals. The first to provide a structured environment for those graduates of LCME accredited medical schools enrolled in preliminary training which will allow them to obtain training common to all surgical subspecialties and the second to provide the highest quality education experience for medical students engaged in clinical rotations within this department.

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

1. To provide a structured progressive educational environment in surgery with emphasis upon training in cognitive and technical skills, development of clinical knowledge, and maturity in the acquisition of surgical judgment for all resident and medical student trainees commensurate with their level of training. Following the conclusion of their training, categorical trainees should be able to function as fully qualified physicians in the field of general surgery.

2. To provide to all trainees the opportunity to learn and understand the fundamentals of basic science as applied to clinical surgery. These fundamentals will include but not be limited to elements of wound healing, homeostasis, hematological disorders, oncology, shock, circulatory physiology, genitourinary physiology, surgical endocrinology, surgical nutrition, fluid and electrolyte balance, metabolic response to injury including burns, musculoskeletal biomechanics and physiology, immunobiology and transplantation, applied surgical anatomy, and surgical pathology.

3. To provide trainees at the completion of their training sufficient knowledge and experience to achieve certification by the ABS. Successful graduates of this program will demonstrate mastery of diagnosis, preoperative, operative and postoperative management, the management of complications and the essential content areas as defined by the ABS. The ABS essential content areas are 1) Alimentary Tract 2) Abdomen and its Contents 3) Breast, Skin and Soft Tissue 4) Endocrine System 5) Head and Neck Surgery 6) Pediatric Surgery 7) Surgical Critical Care 8) Surgical Oncology 9) Trauma/Burns and 10) Vascular Surgery.

4. To instill in all trainees, without regard for level of training, a strong sense of honesty, integrity, and compassion necessary for patient care as well as in professional interactions. To this end specific attention is directed to but not limited to the following areas: 1) Physiology & Assessment of Pain, 2) Relationships between Physicians and the
Pharmaceutical Industry, 3) Patient Confidentiality, 4) Cultural Competency, 5) Fatigue & Impairment, 6) Patient Safety, and 7) JCAHO Principles/Performance Improvement

5. To instill in all trainees an understanding of the dynamic process of surgical knowledge and patient care as well as the creation of lifelong habits essential for both the acquisition and contribution of new knowledge in these fields applying established principles of Evidence Based Medicine.

6. To instill in all trainees a sense of responsibility to disseminate new surgical knowledge and technical advancement in order to efficiently function in a high reliability medical organization for the betterment of all health professionals, colleagues and patients.

7. To foster the lifelong acquisition of skills within the professional competencies in all trainees. Skills acquired in the area of professionalism will assist in the achievement of optimum outcomes, foster practice-based learning and improvement, as well as improve interpersonal and communication skills. To this end specific attention is directed to but not limited to the following areas: 1) Relationships between Physicians 2) Issues specific to Fatigue, Impairment and stress reduction 3) Quality Management Principles and Performance Improvement 4) Practice Management, staffing, scheduling and finances 5) Personal Finance Management

**EDUCATIONAL CONFERENCES**

Attendance at the following conferences is mandatory, unless illness, vacation, absence secondary to 80 hour workweek compliance or prior approval of the Program Director has been scheduled.

1. **Morbidity and Mortality Conference.** The active patient care list will be used to create a list of cases available for presentation at M&M unless an exception is approved by the chairman or program director. A cumulative database of all complications and causes of death in patients admitted to the surgical services is derived from the active patient care list. This database is a tool to facilitate the codification, analysis, trending and prevention of morbidities and mortalities. This tool can assists in the description of natural history and management issues, direct discussions designed to establish the cause of complications or deaths, as well as illuminate potential methods to avoid future reoccurrences. All deaths and morbidities will be discussed, as well as interesting cases on the various services. The senior resident is responsible for ensuring that cases are presented. Every attempt will be made to present cases when the responsible attending is present. The presenter is expected to be prepared to present the entire case, including operative summary and lab/X-ray/pathology data, and to be prepared to discuss the relevant literature. Attendance at the following conferences is mandatory, unless illness, vacation, absence secondary to 80 hour workweek compliance or prior approval of Program Director has been scheduled. All morbidities are to be discussed. **MUOT the first and third Wednesday of each month, 0700-0800 hrs Rm 103 Health Education Building, the second and fourth Wednesday of each month at 0700-0800 at SYMCC CONFENCE CENTER AUDITORIUM**
2. **Grand Rounds.** A series of lectures given by faculty experts or visiting professors, consisting of an in-depth discussion of a subject pertinent to the discipline of surgery. Presentation of subjects will reflect the structured progressive educational environment of the residency and can include items specific to Patient Care, Medical Knowledge, Practice-based Learning/Improvement, Professionalism and Systems-based Practice, *MUOT the first, third and Wednesday of each month, 0700-0800 hrs Rm 103 Health Education Building, the second and fourth Wednesday of each month at 0700-0800 at SVMMC CONFENCE CENTER AUDITORIUM*

3. **Textbook/Case Management Materials** An Internet based online review of both Basic Science and General Surgical topics is employed as maintained by the Association of Program Directors in Surgery (APDS). This online review consists of a series of Flash media® presentations followed by review questions. The course documents time spent on task as well as providing trends in knowledge acquisition. [http://courses.residencycentral.com/index.php/](http://courses.residencycentral.com/index.php/) A schedule of topics as well as expected dates of completion for individual topics is published. In addition to the online review a schedule of readings from standard textbooks associated with weekly written examinations is separately published. These regularly scheduled written examinations generated by faculty members with expertise and interest in the subject material covered will be administered to all surgical residents between Morbidity and Mortality and Grand Rounds conferences. Performance on all exams will be judged by a cumulative average and must be over 70% to avoid the creation of an academic deficiency. These static scheduled textbook type reviews are in addition to the dynamic process of self-designed and self-directed review for patient care demands which is expected of all residents. Periodic supplemental reviews characterized by the presentation of cases and/or subject overviews by senior residents and reviewed by a faculty member may be held.

4. **Journal Club** A topic specific one hour formatted review of current surgical literature held immediately after Grand Rounds. A Scoring tool is employed. (Fig 1) Topics are rotated to include but not be limited to content from the following journals JACS, Archives of Surgery, American Journal of Surgery, Journal of Trauma, Surgery, Annals of Surgery, Journal of Vascular Surgery, Annals of Thoracic Surgery, Critical Care Medicine, and Plastic and Reconstructive Surgery, *MUOT the first, third and Wednesday of each month, 0700-0800 hrs Rm 103 Health Education Building, the second and fourth Wednesday of each month at 0700-0800 at SVMMC CONFENCE CENTER AUDITORIUM Wednesdays 0900-1000hrs*.

5. **Professor Walk Rounds** A conference which employs the Socratic method to hone clinical presentation skills, data acquisition and synthesis of patient work-up, treatment and surgical priorities. Although all levels of residents as well as medical students may benefit from this conference, it is expected that senior level residents may be especially advantaged by this conference to derive skills applicable towards passage of the qualifying exam. This is held after MUOT Monday Trauma clinics in the Department of Surgery Library/Conference Room.
5. **Surgical Residents’ Research Forum** sponsored by the Toledo Surgical Society in March of each academic year. Residents from all surgical disciplines represented at MUOT are encouraged to participate. Attendance is mandatory.

Attendance at the following conferences is strongly encouraged, unless illness, vacation, absence secondary to 80 hour workweek compliance or prior approval of Program Director has been scheduled

1. General Tumor Conference Mondays, 1200-1300 Health Education Building MUOT Rm 105.

2. Toledo Surgical Society which meets in September, November, January, February and May of each academic year. (A Surgical Resident’s Research Forum is held each March.)

**CLINICAL TRAINING**

The clinical portion of the surgical resident’s education is a derivative of and expands the core information a priori knowledge component derived from medical school training and is obtained from multiple sources. These sources include a formalized didactic review of standard textbooks current literature and scheduled conferences (described in preceding sections). Clinical training begins as each resident is integrated into and becomes a functional member of physician teams located at each of the participating institutions. The locations for clinical training are University Medical Center at MUOT, Saint Vincent Mercy Medical Center (SVMMC), surgical clinics (both at MUOT and SVMMC) as well as the offices of individual private practitioners. The clinical portion is by intent, a progressive, experiential exposure. The responsibility for examination, establishment of diagnosis, management of patients and expected outcomes and complications is equally shared by the management team. This pragmatic, progressive and concentrated training is longitudinally balanced so as to assure equality of experience at each level of training. A resident, who successfully completes a five year training period including time designated as Chief Surgical Resident, will become a safe, knowledgeable, and compassionate surgeon. Each service has responsibility for service specific educational rounds and is granted flexibility in their scheduling. The service specific educational rounds include attending staff, all residents and medical students with a goal to maximize the “teachable moments” generated by daily patient contact. These rounds are in addition to the routine daily patient management rounds conducted by residents and staff (Work Rounds). The emphasis of these educational rounds is to provide in-depth bedside education in the pathophysiology of the disease, preoperative work-up, and patient management.

**ACGME General Competencies:**

It is expected that, during the training program, residents will become competent in the following six areas at the level expected of an independent surgical practitioner: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Listed below are specific knowledge, skills, and
attitudes required and defined by the Accreditation Council for Graduate Medical Education (ACGME). The following charts specify the competency, the associated skill(s) required, and the corresponding evaluation methods utilized by the Medical University of Ohio General Surgery Residency Program.

Legend: SP—standardized patient; checklist—performance noted by checklist during OSCE; OSCE—Objective Structured Clinical Examination; global rating—post-rotation evaluations; case log—operative record maintained on ResSolution; MCQ—multiple choice question.

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Surgical residents must demonstrate manual dexterity appropriate for their training level and be able to develop and execute patient care plans.

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<th>Competency</th>
<th>Evaluation Methods</th>
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<tr>
<td>Caring and respectful behavior:</td>
<td>Checklist, SP, patient survey</td>
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<tr>
<td>Interviewing:</td>
<td>Checklist, SP, OSCE</td>
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<tr>
<td>Informed decision-making:</td>
<td>Checklist, OSCE, oral examination</td>
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<tr>
<td>Develop and carry out patient management plans:</td>
<td>Record review, checklist, global rating, simulations/models</td>
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<td>Counsel and educate patients and families:</td>
<td>Checklist, SP, OSCE, patient survey</td>
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<tr>
<td>Perform routine history and physical examination:</td>
<td>Checklist, SP, OSCE</td>
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<tr>
<td>Perform procedures appropriate for level of training and clinical circumstances</td>
<td>Checklist, global rating, simulations/models, case log</td>
</tr>
<tr>
<td>Preventive health services:</td>
<td>Record review, SP, OSCE, case log</td>
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<tr>
<td>Work within a team:</td>
<td>Checklist, global rating</td>
</tr>
<tr>
<td>Possess sufficient manual dexterity for the performance of procedures appropriate for level of training</td>
<td>Global rating, case log</td>
</tr>
</tbody>
</table>

2. **Medical 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. Surgical residents are expected to critically evaluate and demonstrate knowledge of pertinent scientific information.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Surgical residents are expected to critique personal practice outcomes and demonstrate a recognition of the importance of lifelong learning in surgical practice.

- Analyze own practice for needed improvements: SP, OSCE, simulation/models, patient survey
- Use of evidence from scientific studies: SP, OSCE, MCQ examination, oral examination
- Application of research/statistical methods: Checklist, global rating, MCQ examination
- Use of information technology: SP, OSCE, case log
- Facilitate learning of others: Checklist, global rating

4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals. Surgical residents are expected to communicate effectively with other health care professionals, counsel and educate patients and families, and effectively document practice activities.

- Creation of therapeutic relationships with patients: OSCE, patient survey
- Listening skills: Oral examination, OSCE, patient survey

5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to the needs of a diverse patient population. Surgical residents are expected to maintain high standards of ethical behavior, demonstrate a commitment to continuity of patient care, and demonstrate sensitivity to age, gender, and culture of patients and other health care professionals.

- Respectful, altruistic: Checklist, OSCE, patient survey
- Ethically sound practice: Simulations/models, patient survey
- Sensitive to cultural, age, gender, disability issues: Checklist, OSCE, oral examination, patient survey
6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and response to the larger context and system of health care and effectively call on system resources to provide optimal care. Surgical residents are expected to practice high quality, cost-effective patient care; demonstrate knowledge of risk-benefit analysis; and demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>● Understand interaction of their practices with the larger system:</td>
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<tr>
<td>● Knowledge of practice and delivery systems:</td>
<td>OSCE, MCQ examination</td>
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<tr>
<td>● Practice cost-effective care:</td>
<td>Record review, checklist</td>
</tr>
<tr>
<td>● Advocate for patients within the health care system:</td>
<td></td>
</tr>
<tr>
<td>● Timely Completion of Medical Records</td>
<td>Checklist, OSCE, patient survey</td>
</tr>
</tbody>
</table>

**Level Specific Educational Goals and Objectives**

**First Year Residents:**

The residents in the first year have rotations in general surgery and its primary and secondary components. They are expected to be able to take a detailed history, perform complete physical examinations, formulate a preliminary plan for diagnostic evaluation and interpret the significance of pertinent history and physical findings, laboratory and diagnostic studies. Residents should demonstrate knowledge of appropriate therapeutic options and priorities of patient management by this end of this year. In general first year residents will always work under the supervision of a senior resident or attending staff. During their first year, residents do not perform any invasive procedures without direct supervision; All procedures, including the starting of peripheral intravenous lines, insertion of nasogastric tubes, insertion of Foley catheters, management of wound dressing and/or drains, placement of central venous lines and chest tubes are initially performed under direct supervision. After sufficient evidence of competency and compliance with Departmental Guidelines residents may be allowed to perform selected procedures without direct supervision. Residents learn skills necessary for the evaluation of critically ill patients in the intensive care unit, the emergency room and on hospital wards.

First year residents learn basic principles and techniques of surgery and perform biopsies of skin and soft tissues under close and direct supervision. They develop and refine surgical skills and techniques during their role as assistants to senior residents and attending staff in major surgical procedures. The emphasis of the clinical training in the first year is upon evaluation of patients, understanding the rationale for different diagnostic tests, interpretation of results of diagnostic tests, and learning basic surgical principles and techniques.

**First Year Resident Educational Objectives:**
1. Demonstrate proficiency in performance of a detailed history and physical examination under both routine and emergent circumstances.

2. Demonstrate proficiency in formulating and implementing plan for diagnostic evaluation employing established principles of Evidence base Medicine.

3. Demonstrate basic proficiency in interpreting significance of history, physical findings, and laboratory and diagnostic studies.

4. Demonstrate a working knowledge of common surgical problems.

5. Demonstrate basic proficiency in knowledge of therapeutic options and priorities of management.

6. Acquire basic operative skills necessary to perform less complex procedures (i.e., biopsy of superficial lesions, insertion of central lines, repair lacerations).

7. Acquire basic operative skills necessary to assist more senior surgeons in major surgical procedures.

8. Demonstrate interest in teaching medical students and other medical professional trainees.

Second Year Residents:

At this level, the residents are expected to evaluate and formulate a plan for management of more complicated surgical patients by building upon those skills and competencies mastered in the first year of their training. Residents at this level achieve exposure to and perform procedures (under direct supervision of attending surgeons or senior residents) of increasing complexity, such as repair of primary and recurrent hernia, exploratory laparotomy, open and laparoscopic cholecystectomy, and basic vascular surgery. They are further exposed to the nuances of full-time intensive care of critically ill patients on a dedicated SICU rotation which is guided by a multi-disciplinary team of five attendings board certified in critical care. Residents learn techniques in diagnostic and interventional surgical endoscopy. The residents at this level are expected to satisfactorily perform placement of arterial lines, central venous lines, and Swan-Ganz catheters, major debridement, skin grafts, and management of less complicated trauma patients.

Second Year Resident Educational Objectives:

1. Maintain the skill set acquired in the PGY 1 year of training.

2. Demonstrate proficiency in the interpretation of significance of history, physical findings, and laboratory and diagnostic studies of common and more complex surgical problems.

3. Demonstrate proficiency in knowledge of therapeutic options and priorities of management of patients with common and complex surgical problems employing established principles of Evidence Based Medicine.

4. Demonstrate knowledge base and skills necessary to manage critically ill and/or injured surgical patients in a multi-disciplinary critical care setting.

5. Demonstrate proficiency in surgical endoscopy.

6. Demonstrate increased operative skills and judgment necessary to perform surgical procedures of increasing complexity commensurate with their level of training (i.e., hernia repair, complex soft-tissue surgery, basic laparotomy/laparoscopy procedures, and vascular access).
7. Demonstrate interest in teaching medical students and other medical professional trainees and begin to demonstrate knowledge of various teaching techniques lecture, leading discussions and demonstrating problem-solving.

Third Year Residents:

At the PGY3 level, residents receive more intense clinical training and exposure to different and increasingly complex components of surgery. The major emphasis at this level is the development of knowledge, skills and judgment necessary to manage patients with greater autonomy and to refine their surgical skills to the extent that the resident is able to perform procedures of increasing sophistication and technical rigor under the direct supervision of an attending surgeon. Residents at the third year level rotate through vascular surgery, transplant surgery, cardiothoracic surgery, gynecology, and general surgery. They are the most senior residents on all services with the exception of general surgery and gynecology rotations and as such accept increasing administrative and supervisory roles. With the acceptance of increasing administrative responsibility comes the expectation to present all patients from their service at Morbidity/Mortality and Case Management conferences.

Third Year Resident Educational Objectives:
1. Maintain the skill set acquired in the PGY 1 and PGY 2 years of training.
2. Continues to develop technical skills necessary for the performance of more complex surgical procedures in general and minimally-invasive surgery (i.e., laparoscopic cholecystectomy, small bowel resection, surgical ultrasound).
3. Establishes the knowledge base, judgment, and interpersonal skills necessary to function as a surgical consultant (successfully manages simple consults with minimal help).
4. Develops organizational and teaching skills necessary for basic management of a surgical service (manages service administrative duties assigned by chief resident or faculty).
5. Demonstrates proficiency in the rational use of surgical literature and evidence-based medicine (defends discussions and recommendations with scientific evidence).
6. Demonstrate interest not only in teaching medical students and other medical professional trainees but also be able to transfer knowledge to more junior residents through teaching techniques of increasing complexity.

Fourth Year Residents:

The last two years of the residency are considered senior residency. These residents are routinely the senior-most trainee on their service and are not supervised by any other residents. They are expected to manage patients and to perform procedures with increasing independence and to demonstrate discretion and judgment in the solicitation of the guidance and advice of attending staff. During on-call at night and on weekends, the senior residents are the highest-level residents and evaluate and manage patients independently. As they are residents in training they will still require supervision by a staff surgeon for extremely complicated clinical situations and for all surgical procedures performed in the operating theater.

Fourth Year Resident Educational Objectives:
1. Maintain the skill set acquired in the PGY 1, PGY 2, and PGY 3 years of training
2. Demonstrate knowledge and skills necessary for the complete non-operative management of common problems in general surgery, pediatric surgery, and vascular surgery.
3. Demonstrate knowledge and skills necessary to function as the trauma team leader for both adult and pediatric patients.
4. Demonstrate satisfactory performance as a teacher of junior residents and medical students and begin to match specific teaching techniques to learning types.

Fifth Year Residents:

This is considered the final clinical year, and residents are designated as chief residents. The chief residents work more independently and rotate through twelve months of general surgery on four services. The residents at this level are expected to show maturity in patient management, clinical decisions, and surgical procedures, and leadership in clinical skills. The chief resident on the MUOT A service is designated “administrative chief resident.”

Fifth Year Resident Educational Objectives:
1. Maintain the skill set acquired in the PGY 1, PGY 2, PGY 3, and PGY 4 years of training
2. Demonstrate knowledge and skills necessary to assume complete responsibility for the management of the surgical patient, including mastery of the fundamental components of surgery as defined by the American Board of Surgery.

RESIDENT EVALUATION AND PROMOTION PROCESS

Clinical competence is assessed not only in a continuous fashion by direct supervision but also by the use of faculty surveys which are completed at the end of each rotation. It is desirable that a separate faculty survey be generated by each faculty member who interacts with a resident. Level Specific Educational Goals and Objectives, Rotation Specific Goals and Objectives as well as ACGME Competencies are to be used to gauge resident progress. In addition to the established indexes which are used to gauge a residents’ progress, an ad hoc system of timely intervention has been established to allow time critical recall of performance issues utilizing an event specific report. This process of event specific reporting allows both positive and negative aspects of resident performance to be evaluated and included in each resident’s portfolio. The ultimate goal of a time critical recall of performance issues is to allow each resident to remain cognizant of the global aspects of their performance. It is expected that residents are frequently advised of their performance strengths or weaknesses by attendings with whom they have worked. The use of event specific reports is designed so a resident may receive timely feedback and heighten their understanding of expected responses or opportunities for improvement. The performance information is recorded on faculty survey forms and maintained in the resident portfolio. Faculty survey instruments are forwarded to The Department of Surgery Resident Evaluation Committee. The Department of Surgery Resident Evaluation Committee (chaired by the Program Director and comprised of all Department of Surgery faculty educators) reviews the clinical and academic performance and progress towards mastery of general and level specific competencies for each resident. Meetings of this committee will be included as part of routine scheduled Departmental meetings. A Department of Surgery Resident Evaluation Committee
Advisory Committee (chaired by the Program Director and comprised of The Dean of MUOT, selected Department of Surgery faculty educators and Residency Program associated administrative staff) reviews the clinical and academic performance and progress towards mastery of general and level specific competencies for each resident on a quarterly basis. Information is derived from faculty survey forms, minutes of the Department of Surgery Resident Evaluation Committee, and contents of the resident portfolio. A composite quarterly evaluation is generated from the review of all written evaluation instruments available at this meeting by the Program Director. After this meeting the Program Director meets with each resident on an individual basis to discuss the composite performance evaluation. The resident is asked to sign the composite form to signify his/her understanding of the results and findings. Each resident is afforded a one week period to generate a statement to outline additional information to supplement the information contained on the quarterly composite form. In addition to a quarterly review during the fourth quarter Resident Evaluation Committee Advisory Committee meeting, an Annual Review of each resident’s performance will be generated. The Annual Review is used to report the cumulative performance and progress of each resident during the academic year for the purpose of determining resident suitability for promotion or graduation. The Program Director will meet with each resident on an individual basis to discuss the preceding quarter’s composite performance evaluation as well as the annual review. Should a deficit of any degree be identified in the performance of a resident, more frequent meetings with the Program Director may be instituted as outlined in the MUOT GME Policy Manuel #008 related to Due Process. [http://www.meduohio.edu/hosp/gme/pdfs/policy-008.pdf](http://www.meduohio.edu/hosp/gme/pdfs/policy-008.pdf) and (Figure two)

A Summary of the measures that the department of Surgery uses for resident evaluation follows is outlined below. Resident non compliance with published standards is construed as either an Academic Deficiencies or a Non Academic Deficiency by the Department of Surgery at MUOT. Academic Deficiencies (inclusive of items one through eight) and Non Academic Deficiencies (inclusive of items nine and ten) are described below:

**Academic Deficiencies**

1. Patient care and management on each rotation as documented by the faculty survey forms.
2. Attendance at mandatory departmental academic conferences (Morbidity and Mortality, Grand Rounds, Textbook/Case Review and Surgical Residents’ Research Forum will be monitored. Failure to attend more than 75% of any of these conferences is considered a deficiency.
3. Performance will be measured with periodic written examinations. Failure to maintain scores above the 70% will constitute a deficiency.
4. Performance on the American Board of Surgery In Training Examination (ABSITE), which must be taken annually. Failure to score above the 25th percentile will constitute a deficiency.
5. Departmental Mock Oral Examinations and a Departmental Objective Structured Clinical Examination (OSCE) will be administered annually. Failure on either of these examinations is a deficiency.

6. Contributions to the academic and scholarly mission of the department are considered as a component for advancement. Residents are expected to assume a positive and effective teaching role at all times during all departmental activities. Teaching capacity will be evaluated not only by teaching of medical students and lower level residents but will also be based upon conference presentation / participation, and overall faculty assessment surveys. Major performance deficits will be considered a deficiency.

7. In addition to the goals of effective and positive teaching prior to graduation each resident must prepare and submit a manuscript suitable for publication on either a basic science or clinical topic.

Non Academic Deficiencies

1. Compliance with all hospital and departmental record-keeping and documentation requirements. This includes timely completion of operative dictations, medical records, case lists (surgical operative logs), and Morbidity and Mortality reports. Problems with timely completion or noncompliance will be considered a deficiency. Standards are available for review at [http://monitor.meduoiohio.edu/depts/med_staff/index.html](http://monitor.meduoiohio.edu/depts/med_staff/index.html)

2. Residents are expected to model the highest examples of professionalism and personal integrity at all times. A commitment to carrying out professional responsibilities, adherence to ethical principles, sensitivity to the needs of a diverse patient population, high standards of ethical behavior, demonstration of a commitment to continuity of patient care, and sensitivity to age, gender, and culture of patients and other health care professionals is an absolute requirement. Breeches in professionalism are defined to include: theft, lying, cheating, plagiarism, knowingly furnishing false information to the Institution, forgery, alteration or misuse of Institution documents, records, or instruments of identification, criminal conduct, abuse of chemical substances, physical abuse or harassment or threat of physical abuse or harassment to any person on the Institution's premises, refusal to comply with the Institutional policies, or any actions constituting violations of law or Institutional policies, or which pose any risk to patient care or orderly administration of the program on the Institution's premises and unexplained absences. Noncompliance will be considered a deficiency.

**REMEDIATION AND DISCIPLINARY ACTIONS:**

When remedial or disciplinary action for Academic Deficiencies becomes necessary, the Program Director must discuss the matter with the Associate Dean of Graduate Medical Education (GME) before proceeding to any classification of the resident's status. Actions which may be approved by the Associate Dean of GME for academic deficiencies include: Warning Status, Probationary Status, or Dismissal Status. Allegations of a Non-Academic Deficiency are by nature a more egregious affront and will automatically generate evaluation by the Associate Dean of GME as outlined in the MUOT GME Policy Manuel #008 related to Due Process. [http://www.meduoiohio.edu/hosp/gme/pdfs/policy-008.pdf](http://www.meduoiohio.edu/hosp/gme/pdfs/policy-008.pdf).
CALL / WORKING ENVIRONMENT

Each hospital provides residents with on-call sleeping, lounge, library, and meal facilities. In-house resident call will not be more frequent than every third night (calculated on a rolling average) for the duration of the program. Residents are not to average more than eighty (80) hours of work per week, barring exceptional patient care needs. Residents are provided (on average) one day out of seven free of all clinical responsibilities. The program director will function as compliance officer to monitor working hours and will be assisted by a resident self-reporting, internet based system.

ADMINISTRATIVE CHIEF RESIDENT

The chief resident on the MUOT A service is designated “administrative chief resident.” The administrative chief resident is primarily responsible for ensuring timely preparation of the resident call schedule, coordinates the visiting professor Case Management conferences, corrects resident call and coverage conflicts, and is, in general, responsible for addressing administrative duties of the residency program operation under the supervision of the program director. The administrative chief resident sits as a voting member on the Resident Education Committee and is responsible for nominating other residents to appropriate hospital and University committees.

RESIDENT RESPONSIBILITIES

Communication:

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

- Discuss diagnostic and therapeutic plans and risks with patients and their families.
- Communicate plans and progress of all patients with attending surgeons, including any serious problems as they occur (including at night and on weekends).
- Notify referring physicians upon admission, operation, and discharge of their patients from the hospital.
- Promptly answer all pages. It is helpful for the resident to identify him/herself to the person being paged by the addition of the star key and the last four digits of their personal pager number when performing physician to physician paging. This will allow the receipt of the page to identify and assist personnel in reception and routing of phone calls. Pages of extreme urgency can be identified by the inclusion of a second strike of the star key followed by 911. For example, Dr. Slam wishes to page Dr. Tsang. For an extremely important call to extension 1234. After dialing Dr. Tsang’s pager 419-252-1794 she enters 1234*3108*911. In a similar fashion calls of lesser importance can be designated 2, 3 etc.
Medical Records:

Complete patient care documentation is a requirement, and comprise a large aspect of professional behaviors. All dictations are to be done on a timely basis. In addition the outlines of specific medical record requirement contained in both *The Physician’s Manual* of University Medical Center of The Medical University of Ohio ([http://www.meduohio.edu/depts/medstaff/pdf/physmanual.pdf](http://www.meduohio.edu/depts/medstaff/pdf/physmanual.pdf)) and documents contained within the following sections the Medical Staff Office policies: MS002, MS003, MS004 and MS017 ([http://www.meduohio.edu/depts/medstaff/policy.html](http://www.meduohio.edu/depts/medstaff/policy.html)). The following guidelines are not to be construed to supplant those policies but are offered to facilitate medical record keeping by trainees.

1. The history and physical examination must be recorded in the patient’s chart within 24 hours of the patient’s admission.
2. A discharge summary must be dictated within 24 hours after discharge. It should include the following items in the order:
   a. Patient name.
   b. Patient 6-digit number.
   c. Date of discharge.
   d. Narrative summary, which should be a short summary of the patient’s hospitalization; this includes the reason for admission.
   e. Hospital complications.
   f. Consultations obtained.
   g. Condition of patient at discharge.
   h. Disposition.
   i. Recommendations, which should include diet, activity, responsibility for follow-up care, and medications.
3. Copies should be sent to all referring and consulting physicians.
4. All operative procedures must be dictated within 24 hours of surgery. Best practice defines dictation immediately following completion of the procedure.
5. All entries into the medical record must be legible, dated timed and written in black ink.
6. All verbal orders are to be counter signed, dated and timed within 24 hours.
7. All medical student notes must be countersigned dated and timed by the resident or attending physician within 24 hours.

Referrals and Consultations:

Residents should respond promptly to all requests for patient referral or surgical consultations. Residents should promptly contact the responsible attending physician and the hospital Admitting Department, or the Surgery Clinic when appropriate, to facilitate the referral. A faculty attending surgeon is assigned to general surgery call each day. The “on-call” period rotates at 8:00 a.m. For the purposes of assigning a responsible attending, consult or referral is considered to be “received” at the time that a request is made to a member of the Department of Surgery (resident, attending, or office). Consults directed to a specific attending are presented to the requested attending, not the attending on call. Procedures for handling attending assignment on specialty call schedules (trauma, vascular, neurosurgery, and transplant) will be determined by the appropriate division. In-patient consultations are to be seen in a timely fashion by the
most senior resident of the appropriate service on the day of request. After evaluating the patient and writing an initial note, the senior resident should contact the appropriate attending surgeon who will complete the consultation. Emergency Room consults will be seen promptly under the direction of the senior resident and will be discussed with or seen by the responsible surgical attending prior to final disposition. Patients will not be referred to the surgical clinics without first being seen by a surgical resident unless specifically approved on an individual case basis by a surgical attending. Consult/referral patients will remain assigned to the responsible attending surgeon unless responsibility for the patient’s care is accepted by another attending surgeon. Arranging of transfers between attendings in the Department of Surgery will not be delegated to residents, but will be done by direct communication between attendings. Copies of any dictation generated in the course of the consultation should be sent to all referring physicians as well as other physicians involved in the care of the patient.

**Clinics:**

Residents should attend all clinics on services to which they are assigned. Every effort should be made for a resident to see patients, both preoperatively and postoperatively, for whom they are the responsible operating surgeon under faculty supervision. A resident from the appropriate service must be present at the start of all clinics and remain for the duration of the clinic until all patients have been seen, unless otherwise approved by the attending surgeon. Residents should report to the appropriate attending surgeons covering the clinic regarding all diagnostic and therapeutic decisions on outpatients. It is the responsibility of the resident to write or dictate a clinic note, order appropriate diagnostic studies, schedule inpatient ambulatory surgical procedures, and communicate with referring physicians, unless otherwise handled by the attending surgeon. All such notes are to be dated and timed upon completion.

**Orders:**

Residents are responsible for all patient orders, including admission, preoperative, postoperative, and discharge orders. Telephone orders must be signed as soon as possible, and no later than 24 hours after ordered. All orders must be dated and timed. Discharge orders and all paperwork pertinent to discharge should be written on the day prior to the anticipated discharge.

**Rounds:**

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

Daily notes (dated and timed) should be entered into the progress note section of the chart. Progress notes by medical students should be critiqued and must be countersigned by the resident. Notes should be brief but informative about patient condition, planned diagnostic or therapeutic measures, and discharge planning. In all circumstances notes should reflect the highest standards of professionalism.

**Preoperative Notes:**

For elective cases, the operating resident will review the chart (including X-rays, lab, and pathology) and discuss the operative plan with the attending surgeon prior to the operation. A preoperative note must be written by the resident surgeon in the progress section of the chart with 24 hours prior to operation and only after the patient has been examined by the same resident. It should include:
- Preoperative diagnosis and basis for diagnosis.
- Planned operation and indications.
- Surgeon.
- Anesthesia.
- Pertinent laboratory data.
- Blood/X-ray requests.
- Operative risks and indications of risks.
- Potential complications discussed.
- Signed consent.

The resident is also responsible for dictating a complete operative note on the day of surgery unless the attending instructs the resident that they will perform this task.

**Operating Room (OR) Schedule:**

Assignment of OR coverage responsibility is the purview of the most senior resident on a given service. The responsible resident should review the OR schedule daily to ensure that all planned cases are listed. It is assumed that residents will have reviewed the anatomy and technique of elective cases in standard atlases or by videotape prior to presenting to the OR. If it becomes evident that the required reading has not occurred before an elective case, the privilege of the resident to operate can be withdrawn by the attending surgeon. A brief discussion of the case with the attending surgeon should occur on the day prior to the operation.

**Operating Room (OR) Etiquette:**

A resident should be present in the OR area 10 minutes before induction of anesthesia (7:20 a.m. for 7:30 a.m. case). All anticipated instruments, supplies, and special equipment should be requested of the scrub and circulating nurses. The entire operative sequence should be briefly reviewed with the scrub nurse. Special anesthetic needs and patient positioning should be reviewed with the anesthesiologist. The roles of the operating surgeon and first and second assistants should be determined and clearly understood preoperatively. Professional behavior is expected at all times in the OR. Required preoperative preparation includes:
• Preoperative note and consent complete.
• Latest clinic note and lab results on chart.
• Relevant patient X-ray reports on chart.
• X-rays on view box.

Any and all incorrect counts of needles, sponges, or instruments are to be reported immediately to the responsible Staff Surgeon if he/she is not in the room at the time the Resident is made aware of this information. For any missing instruments and sponges, the resident must obtain the appropriate X-ray and have the X-ray reviewed with a Radiology Attending before the patient’s sterile drapes are removed. Findings of the X-Ray must be noted in the progress note, signed, dated and timed.

**Operative Notes:**

Unless otherwise designated, the responsible resident should complete an operative note (dated and timed) immediately following operation, to include:

• Preoperative diagnosis.
• Postoperative diagnosis.
• Operation.
• Surgeons and assistants.
• Anesthesia.
• Operative Indications and Findings.
• Complications.
• Tubes/ Drains
• Implants /Grafts inserted including manufacturers’ catalogue/lot number and expiration date
• Condition upon discharge from OR.

Of note, a simple diagram of the operation performed is very helpful.

**Operative Report Dictation:**

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

• Patient data.
• Preoperative diagnosis
• Postoperative diagnoses.
• Operative procedure.
• Operating surgeon and assistants.
• Anesthesia.
• Operative Indications and Findings.
• Unexpected findings or complications
• Verification of correct Sponge and needle counts.
• Condition of patient upon discharge from the operating room.
• A Statement of attestation that “the attending surgeon was present for the entire procedure” or “for all major portions of the procedure,” as the case may be.
• A request the copies should be sent to the referring physician as well as all consulting physicians completes the dictated operative note.

Operative Experience Record:

The cumulative operative experience of each resident is maintained on an online computer database maintained by the ACGME. Each surgical procedure performed by or assisted by the resident must be entered into the Resident Case Log program. The deadline for entry is seven days after the performance of the procedure. It is strongly suggested that each resident develop a habit of weekly case data entry logging. Data entry is the responsibility of each resident who is charged with logging onto the ACGME website https://www.acgme.org/residentdatacollection/. The procedures will be entered into a personal record and kept on computer file at the ACGME website. The resident may review their experience at any time by means of this site. A prudent resident will maintain backup copies of these important files on permanent media secured in a separate off web location. Assistance with this program can be obtained from the Residency Office.

Please complete these forms accurately, with particular attention to:

1. Listing the appropriate resident as responsible (operating surgeon) with appropriate role code.
2. Date.
3. Service (i.e., MUOT A, MUOT B, etc.).
4. Patient’s last name, first name, and middle initial.
5. Patient’s age and sex.
6. Whether procedure was emergency or elective.
7. Attending physician.

No more than one resident can claim primary credit for performing the operation, although senior (R4 and R5) residents may be listed as “teaching assistant” provided they have performed the minimum number of procedures in the defined category as designated by the Residency Review Committee (RRC) for surgery.
http://www.acgme.org/acWebsite/downloads/oplog/440CatMin.pdf

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

• Periodic reports of resident operative experience, allowing adjustment of caseload allocation for deficient experience.
• Reports for clinical case reviews.
• Reports of operative experience for program evaluation by the Residency Review Committee for accreditation.
• Reports for resident submission to the American Board of Surgery for certification.
SUPERVISORY LINES OF RESPONSIBILITY FOR PATIENT CARE

1. All physicians (including resident physicians) are authorized and expected to do whatever is considered necessary to preserve life in the event of a life-threatening emergency. In the event of a life-threatening emergency, resident physicians should take whatever action deemed necessary to preserve life while someone else summons help from any available senior resident or faculty member.

2. All patients cared for in the MUOT Surgery Residency Program are cared for under the direction of a designated faculty attending surgeon. The specific level of faculty supervision will vary depending on the level of training and skill of the resident, the complexity of the care rendered, and the wishes of the responsible attending surgeon. The level of supervision required for an individual procedure will be determined on an individual basis between the resident and the responsible faculty member unless a defined level of supervision is mandated by institutional or service policy.

3. Significant patient care decisions and events are to be discussed with the appropriate attending surgeon. If the responsible attending surgeon is unavailable, contact the attending surgeon on call for the appropriate service for the day. Although residents are responsible for their individual actions and senior residents are responsible for the performance of their service, overall responsibility for patient care always rests with the attending surgeon. During patient care discussions every reasonable effort should be made for the protection of patient privacy. http://www.hipaa.org/ or http://www.meduoohio.edu/research/hipaa.html

4. Authority for supervision may be delegated, at the discretion of the attending surgeon, to more senior surgical residents. In general, the senior surgical resident assigned to the service will be in charge of the service and is expected to assume a leadership role. Except in emergencies, the “chain-of-command” of junior resident → senior resident → attending surgeon should be followed regarding patient care decisions. Under some circumstances, junior residents may work directly with attending surgeons. In these instances, the junior resident must keep the senior resident informed of significant events regarding the service. Individual resident assignments are to be made by the senior resident at the start of each rotation.

5. Similar to the process in which Attending surgeons are responsible for ensuring that coverage is available for their patients by another attending surgeon during their absence a resident physician if he/she is unable to complete call assignments secondary to illness or permission of the Program Director is required to find a suitable replacement as well a notify the operating and emergency rooms, hospital operator and intensive care unit.

EDUCATION

General:
Residents develop knowledge and judgmental skills through a combination of didactic teaching in conferences and active participation in conferences and seminars, ward rounds, self-directed reading, audiovisual instruction, and attendance at local, regional, and national meetings. Attendance at teaching conferences is mandatory and attendance is documented, as stipulated by the Residency Review Committee for Surgery. All conferences begin and end promptly at the appointed time. Attendance at the following conferences is mandatory, unless illness, vacation,
Conference Schedule:
Attendance at the following conferences is mandatory, unless illness, vacation or absence secondary to 80 hour workweek mandates is in effect.

1. Morbidity and Mortality Conference. The active patient care list will be used to create a list of cases available for presentation at M&M unless an exception is approved by the chairman or program director. A cumulative database of all complications and causes of death in patients admitted to the surgical services is derived from the active patient care list. This database is a tool to facilitate the codification, analysis, trending and prevention of morbidities and mortalities. This tool can assist in the description of natural history and management issues, direct discussions designed to establish the cause of complications or deaths, as well as illuminate potential methods to avoid future recurrences. All deaths, morbidities, and interesting cases will be discussed. The senior resident is responsible for ensuring that cases are presented. Every attempt will be made to present cases when the responsible attending is present. The presenter is expected to be prepared to present the entire case, including operative summary and lab/X-ray/pathology data, and to be prepared to discuss the relevant literature. Attendance at the following conferences is mandatory, unless illness, vacation, absence secondary to 80 hour workweek compliance or prior approval of Program Director has been scheduled. All morbidities are to be discussed. **MUOT the first, third and Wednesday of each month, 0700-0800 hrs Rm 103 Health Education Building, the second and fourth Wednesday of each month at 0700-0800 at SVMMC CONFENCE CENTER AUDITORIUM**

2. Grand Rounds. A series of lectures given by faculty experts or visiting professor, consisting of an in-depth discussion of a subject pertinent to the discipline of surgery. Presentation of subjects will reflect the structured progressive educational environment of the residency and can include items specific to Patient Care, Medical Knowledge, Practice-based Learning/Improvement, Professionalism and Systems-based Practice, **MUOT the first, third and Wednesday of each month, 0700-0800 hrs Rm 103 Health Education Building, the second and fourth Wednesday of each month at 0700-0800 at SVMMC CONFENCE CENTER AUDITORIUM**

3. **Book/Case Management Materials** An Internet based online review of both Basic Science and General Surgical topics is employed as maintained by the Association of Program Directors in Surgery (APDS). This online review consists of a series of Flash media presentations followed by review questions. The course documents time spent on task as well as providing trends in knowledge acquisition. [http://courses.residencycentral.com/index.php/](http://courses.residencycentral.com/index.php/) A schedule of topics as well as expected dates of completion for individual topics is published. In addition to the online review a schedule of readings from standard textbooks associated with weekly written examinations is separately published. These regularly scheduled written examinations generated by faculty members with expertise and interest in the subject material covered will be administered to all surgical residents between Morbidity and Mortality and Grand Rounds conferences. Performance on all exams will be judged by a cumulative average and must
be over 70% to avoid the creation of an academic deficiency. These static scheduled textbook type reviews are in addition to the dynamic process of self-designed and self-directed review for patient care demands which is expected of all residents. Periodic supplemental reviews characterized by the presentation of cases and/or subject overviews by senior residents and reviewed by a faculty member may be held.

4. **Journal Club** A topic specific one hour formatted review of current surgical literature held immediately after Grand Rounds. A Scoring tool is employed. (Fig 1) Topics are rotated to include but not be limited to content from the following journals: *JACS, Archives of Surgery, American Journal of Surgery, Journal of Trauma, Surgery, Annals of Surgery, Journal of Vascular Surgery, Annals of Thoracic Surgery, Critical Care Medicine, and Plastic and Reconstructive Surgery*. **MUOT the first, third and Wednesday of each month, 0700-0800 hrs Rm 103 Health Education Building, the second and fourth Wednesday of each month at 0700-0800 at SVMMC CONFENCE CENTER AUDITORIUM Wednesdays 0900-1000hrs**.

5. **Professor Walk Rounds** A conference which employs the Socratic method to hone clinical presentation skills, data acquisition and synthesis of patient work-up, treatment and surgical priorities. Although all levels of residents as well as medical students may benefit from this conference, it is expected that senior level residents may be especially advantaged by this conference to derive skills applicable towards passage of the qualifying exam. This is held after MUOT Monday Trauma clinics in the Department of Surgery Library/Conference Room.

6. **Surgical Residents’ Research Forum** sponsored by the Toledo Surgical Society in March of each academic year. Residents from all surgical disciplines represented at MUOT are encouraged to participate. Attendance is mandatory. Attendance at the following conferences is strongly encouraged, unless illness, vacation, absence secondary to 80 hour workweek compliance or prior approval of Program Director has been scheduled

1. **Tumor Conference** Mondays, 1200-1300 Health Education Building MUOT Rm 105.

2. **Toledo Surgical Society** which meets in September, November, January, February and May of each academic year. (A Surgical Resident’s Research Forum is held each March.)
<table>
<thead>
<tr>
<th>Conference</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbidity &amp; Mortality</td>
<td></td>
<td></td>
<td>0700 -0800 hrs MUOT 1st,3rd Week SVMMC 2nd,4th week each month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Text Book Exam</td>
<td></td>
<td></td>
<td>0800 hrs MUOT 1st,3rd Week SVMMC 2nd,4th week each month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Rounds</td>
<td></td>
<td></td>
<td>0800-0900 hrs MUOT 1st,3rd Week SVMMC 2nd,4th week each month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Journal Club</td>
<td></td>
<td></td>
<td>0900-1000 hrs MUOT 1st,3rd Week SVMMC 2nd,4th week each month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor Walk Rounds</td>
<td>After Trauma Clinic Surgery Library MUOT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumor Conference</td>
<td>1200-1300 hrs MUOT HEB 105</td>
<td></td>
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</tr>
</tbody>
</table>

**Surgery Library:**

The Department of Surgery maintains a library of major surgical journals and textbooks, instructional videotapes, and a collection of the “Selected Readings” edited by Robert McClelland, M.D., of the University of Texas Southwestern Medical School. All residents are encouraged to use the library as a quiet study room. Materials should not be removed from the library under any circumstance.

Priorities for library use are:
1. Formal resident or student conferences.
2. Scheduled departmental meetings that cannot be accommodated in other areas.
3. Informal educational meetings, lunches, or rounds.
4. Individual study.

Use of the library is scheduled by Karen Reitz at 419-383-6298.

**Residency Office/Lounge:**

The Surgery Residency Office/Lounge is designed for service meetings, teaching sessions, the facilitation of preparation of conference and other teaching materials, not suitable for assignment to the Surgical Library.
Society Memberships:

Residents are encouraged to join appropriate professional societies such as the Candidate Group of the American College of Surgeons. Attendance at Toledo Surgical Society meetings is required; the Department of Surgery underwrites the cost of attendance at TSS meetings.

Resident Research Presentations and Surgery Review Courses:

Resident contributions to the academic and scholarly mission of the department have been previously described and to that end, prior to successful graduation, each resident must prepare and submit a manuscript suitable for publication on either a basic science or clinical topic. Residents are encouraged to engage in clinical or laboratory research. With prior approval, residents will be reimbursed for attending any meeting at which they present a peer-reviewed paper. Second year residents will be reimbursed for travel and expenses to a clinical and/or basic surgery review course. In addition, chief residents will be reimbursed for travel and expenses to a major surgical meeting, preferably the annual Clinical Congress of the American College of Surgeons. Unless specifically approved by the Department, resident travel expenses are limited to $1500 per meeting.

Medical Student Teaching:

Residents have a major role in teaching junior medical students assigned to their service. It is the policy of the Department of Surgery that medical students rotate in the department for an educational opportunity and not in a service role. Every reasonable effort should be made to provide students with time to learn, read, and develop basic skills in evaluation and management of surgical patients. Residents should make an effort to teach students at every opportunity, including rounds, clinics, and in the operating room. In the latter circumstances, students should participate in selected parts of the operation in which they can learn and have demonstrated interest and a level of dexterity appropriate for their training and the task considered. Students are encouraged to perform simple procedures, such as suturing the skin. Students are expected to attend all lectures and major conferences. At no time should a student miss a lecture or conference because of a commitment in the operating room or on the wards.

RESEARCH AND EDUCATIONAL PROJECTS

General:

A formal research rotation is not required during residency training in General Surgery at MUOT; however, each resident is encouraged to carry out clinical research, with a faculty mentor, and submit the work for publication or presentation at a peer-reviewed meeting. Residents who are contemplating a career in academic surgery should consider a year of laboratory research, which would be in addition to the five years of clinical training in General Surgery. One categorical resident from each class may spend a year in a funded research laboratory on completion of the R2 or R3 clinical year. Residents who are contemplating
additional postgraduate training in a surgical subspecialty should strongly consider a research rotation.

Clinical Research:

General Surgery residents are encouraged to engage in clinical research during their training under the supervision of a faculty member of their choice. Such research may involve a chart review of a particular clinical problem, the report of a new operation or therapy, the impact of the surgical skill lab on operative technique, etc. Irrespective of subject chosen, the resident should follow the steps necessary in carrying out good research, including a careful description of the problem, appropriate review of the literature, definition of the variables to be recorded, gathering of data, data analysis, appropriate statistical analysis, generating a paper for presentation or publication, and solicitation of appropriate consultation and critique at each step of the process.

Laboratory Research:

Residents may request and, if approved by the program director, be assigned to take one year of laboratory research following the R2 or R3 year of training. Rarely, additional time may be approved. Elective research experience will prolong the period of surgical training by whatever length of time is spent in research and may require the need for another resident to fill the position vacated by the resident spending time in the research laboratory. Residents should choose a laboratory experience under an experienced investigator in a surgical or other clinical discipline or in a basic science laboratory which will maximize the potential for a significant contribution to the surgical literature. The resident must discuss funding for such research experience with the program director and, if possible, work in a laboratory funded by extramural grant support.

AWARDS

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

- **Outstanding Senior Resident Award:** Presented to graduating chief resident in general surgery for excellence as determined by the surgery residents.
- **Outstanding Resident Teaching Award:** Presented to a resident for excellence in teaching as determined by the medical students.
- **Outstanding Full Time Faculty Teaching Award:** Presented to a full time faculty member for excellence in teaching as determined by surgery residents.
- **Outstanding Volunteer Faculty Teaching Award:** Presented to a volunteer faculty member for excellence in teaching as determined by surgery residents.

RESIDENT SELECTION

Selection:

Residents are selected for admission to the Department of Surgery educational program based on several factors, including:
1. Eligibility for appointment in accordance with MUOT GME policy. [http://www.meduohio.edu/hosp/gme/pdfs/policy-022.pdf](http://www.meduohio.edu/hosp/gme/pdfs/policy-022.pdf)
2. Academic and research achievement.
4. Demonstrated commitment to a surgical career.
5. Proficiency in written and spoken English sufficient for patient care.
6. Personal interview.

Except under special circumstances approved by the program director, all applications for residency training are accepted through the ERAS system. Categorical positions are filled through the NRMP. Preliminary positions may be filled through the NRMP, by agreement with MUOT subspecialty programs, or by direct appointment. A complete application includes a basic ERAS application, three recommendations, Dean’s letter, transcript, USMLE score, ECFMG transcript (if applicable), and previous ABSITE scores (if applicable). Selected applicants are invited for interview by e-mail or mail.

**AMERICAN BOARD OF SURGERY IN-TRAINING EXAMINATION (ABSITE)**

Each year, all General Surgery in the MUOT Surgical Residency must take the American Board of Surgery In-Training Examination (ABSITE) on the last Saturday in January. A junior level (PGY1 and -2) and senior level (PGY-3 to -5) examination is to be administered. The ratio of basic science to clinical management items are somewhat different between Junior and Senior level exams.

<table>
<thead>
<tr>
<th>Examination</th>
<th>No. of Items (approx.)</th>
<th>% Basic Science</th>
<th>% Clinical Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Level PGY1&amp;2</td>
<td>225</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Senior Level PGY3,4 &amp;5</td>
<td>225</td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

The junior level examination will have a slightly increased emphasis on basic science and the clinical management items generally will focus on the diagnosis and evaluation of common surgical problems. On the senior level examination, the basic science items will focus on areas that are deemed important but apparently are not well understood and the clinical management items will have greater depth and breadth than before. Suggested weighting of examination content is as follows:

<table>
<thead>
<tr>
<th>Content Category</th>
<th>Junior Level</th>
<th>Senior Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body as a Whole</td>
<td>66.6%</td>
<td>25%</td>
</tr>
<tr>
<td>Gastrointestinal Tract</td>
<td>10.0%</td>
<td>25%</td>
</tr>
<tr>
<td>CV/Respiratory</td>
<td>7.8%</td>
<td>16.7%</td>
</tr>
<tr>
<td>GU, Head and Neck, Skin, Musculoskeletal, CNS</td>
<td>7.8%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Endocrine, Spleen, Lymphoma, Breast</td>
<td>7.8%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

For purposes of the examination MUOT considers a resident's PG level should correspond to their clinical year and not to the number of years since their graduation from medical school.
Thus, a resident who previously completed two clinical years and spent a year in the laboratory would be considered PG-3 rather than PG-4. This multiple-choice test of approximately 225 questions covers a wide variety of clinical and basic science topics in General surgery and the surgical specialties. The examination permits evaluation of performance as a percentile compared to PGY peers throughout the country. All residents should develop a systematic reading program throughout their training (and professional career). Such self-directed learning, Basic Science conferences, and Clinical Science conferences are all designed to assist residents in solidifying their cognitive knowledge.

It is the goal of the Department of Surgery to have residents perform at or above the national average (50th percentile) on the In-Training Examinations. Residents who perform at less than the 25th percentile are considered to have an academic deficiency and will be placed on academic warning status, following appropriate GME policies. Repeated poor performance may result in grounds for probation, particularly if this occurs in combination with other deficiencies.

**RESIDENT EVALUATION OF THE PROGRAM AND FACULTY**

Each resident is to complete a written faculty and rotation evaluation at the completion of each rotation. These constructive confidential critiques are used to improve educational opportunities and faculty development and enhance resident training. All evaluations by residents are valued and taken seriously and in total confidence. Every effort is taken to protect resident confidentiality, in the evaluation process. Resident evaluations of faculty are handled in a confidential manner and a summary of scores and comments are provided to the individual faculty member devoid of identifying links to residents.

**RESIDENT COUNCIL**

As an adjunct to regularly periodic individual meetings with the surgical residents for the purpose discussion of evaluations, individual meetings may be initiated by the resident for the purpose of information exchange and delivery of constructive recommendations for improving the residency. The Program Director will hold regularly scheduled meetings in a group format with representatives from the surgical residency. The members of the Resident Council are selected by nomination and majority vote from among their peers. One representative is selected for each PGY of the program to exchange information and solicit constructive recommendations for improving the residency. The Program Director serves as an ex officio member of this council. The council is chaired by an elected senior level resident and is charged with maintenance of minutes of all meetings, a copy of which is to be maintained in the residency office.
STIPENDS

<table>
<thead>
<tr>
<th>PG</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PG-1</td>
<td>$40,394</td>
</tr>
<tr>
<td>PG-2</td>
<td>$41,606</td>
</tr>
<tr>
<td>PG-3</td>
<td>$42,854</td>
</tr>
<tr>
<td>PG-4</td>
<td>$44,140</td>
</tr>
<tr>
<td>PG-5</td>
<td>$45,464</td>
</tr>
<tr>
<td>PG-6</td>
<td>$46,828</td>
</tr>
<tr>
<td>PG-7</td>
<td>$48,233</td>
</tr>
<tr>
<td>PG-8</td>
<td>$49,680</td>
</tr>
</tbody>
</table>

LICENSURE

Residents must complete the USMLE examination series (USMLE steps I, II, and III) by the end of the PGY2 year. Residents who have not successfully passed steps I, II, and III by the end of the PGY3 year may not continue on the residency program. A medical license is not required for participation in the residency program, but is necessary for admission to the ABS qualifying examination. All residents must obtain a temporary Ohio license before beginning patient care at the University Medical Center or any of the affiliated hospitals. Temporary licensure packets will be issued in the Spring to allow enough time to process in order to begin residency on July 1 of the next post graduate year in a resident’s sequence of training.

MOONLIGHTING

NO moonlighting is allowed. The only exception is for residents on research rotations and then only at MUOT-affiliated hospitals and with the approval of the Chairman of the Department of Surgery.

CALL ASSISTANCE

Residents doing basic science research may rarely be asked to substitute on clinical services for other residents who are ill or on leave.

IDENTIFICATION

The University Medical Center and all affiliate hospitals require picture-type identification badges to be worn by the house staff at all times. I.D. cards will be issued by the campus police department.

DRESS

The expected dress for surgical residents in the hospital includes:
- *Gentlemen* are expected to wear full-length trousers, dress shirt, tie, and a clean white laboratory coat when not in the operating room or performing ward procedures with the potential for contact with blood or body fluids. PPD’s (Personal Protective Devices) are available and should be consistently employed. Secondary to the risk for inadvertent contact with blood or body fluids shorts are unacceptable.

- *Ladies* are expected to wear dresses, skirts or dress slacks and a blouse, in line with institution accepted standards for modesty and professionalism as well as a clean white laboratory coat. Short-length skirts or immodest garments are not acceptable. Bare legs or open-toed shoes are not appropriate secondary to the risk for inadvertent contact with blood or body fluids.

Scrub suits are not to be worn during the hours of 0800 to 1700 except when occasionally necessary “between cases”. If scrubs are worn outside the operating room a clean white coat must be worn over the scrubs.

**PAGERS**

Pagers will be issued to the residents at the beginning of their residency. If the pager becomes damaged or lost, please contact the Residency Office immediately. It is the responsibility of the resident to notify the operating and emergency rooms, hospital operator and intensive care unit in the event he/she is unable to complete call assignments secondary to illness or permission of the Program Director.

**ROTATION CHANGE DATES**

For the year 2005-2006, the following change-of-service dates have been established:

<table>
<thead>
<tr>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday, July 1</td>
<td>Tuesday, November 1</td>
<td>Wednesday, March 1</td>
</tr>
<tr>
<td>Monday, August 1</td>
<td>Thursday, December 1</td>
<td>Saturday, April 1</td>
</tr>
<tr>
<td>Thursday, September 1</td>
<td>Tuesday, January 3</td>
<td>Monday, May 1</td>
</tr>
<tr>
<td>Saturday October 1</td>
<td>Wednesday, February 1</td>
<td>Thursday, June 1</td>
</tr>
</tbody>
</table>

**VACATION**

Vacation time is granted as follows:

<table>
<thead>
<tr>
<th>Level</th>
<th>Weeks</th>
<th>Working Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY-1</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>PGY 2 or above</td>
<td>4</td>
<td>20</td>
</tr>
</tbody>
</table>

First year residents will take their vacation time in three separate one-week blocks. Second year residents or above will take their vacations in four one-week blocks. For every five weekdays requested, two weekend days of vacation will be granted. All vacation requests may be turned in to the Residency Office as of July 1 and will be granted on a first-come, first-served basis. Only
one resident may be away from a given service during any given period. Deadline for all requests will be November 1. There will be no vacations granted during the months of July, January, or the last two weeks of June (exception may be made for the graduating residents). There will be no vacations on the Trauma service at St. Vincent Mercy Medical Center during the months of July or August.

**INTERVIEW LEAVE**

Residents who choose to interview for jobs or fellowships must do so during their allotted vacation time. It is the residents’ responsibility to budget their vacation time so that they have an appropriate number of days available for interviews. Like vacation time, leave for interviews must be approved in advance with a leave request form. Leave for interviews will not be granted if vacation time has been used up.

**EDUCATIONAL LEAVE**

Educational leave must be approved by the Program Director of the Department of Surgery. Priority will be given to the chief residents, followed by the fourth-year residents, etc. Reimbursement will be based on the availability of funds.

**Americans with Disabilities (ADA) Disclaimer**

Various federal and state laws protect “qualified individuals with disabilities.” If you believe you are a qualified individual with a disability, and if you wish to request a reasonable accommodation, you need to make a written request to the surgery program director. Request forms are available from the Affirmative Action Office. (Reference: Medical University of Ohio’s Americans with Disabilities Act Policy No. 01-061.)
I have read the Medical University of Ohio (MUOT) Department of Surgery Resident Manual, including but not limited to the Goals and Objectives, Clinical Training, and Resident Promotion Process for the General Surgery Residency at MUOT; I agree with and accept these as a prerequisite to my training in this program.

Signature                                      Date

Type or Print Name

Error! Not a valid link.
Figure One
Error! Not a valid link.