

**Tulane Surgery
Resident Policy
and
Procedures Manual**

Updated October 3, 2017

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**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Program Evaluation Committee

Date: 10/3/17

Goal: The Program Evaluation Committee will meet quarterly to evaluate the adequacy of the resident educational opportunities and ensure that clinical and didactic opportunities exist consistent with departmental goals and objectives, as well as with the requirements of the ACGME.

Policy: The Program Evaluation Committee will consist of the Chairman of the Department of Surgery, Residency Program Director and Assistant Program Director(s), the Director of Surgical Clerkship, the Residency Coordinator (non-voting), the Administrative Chief Resident, one resident representative from each post-graduate year, elected by the members of that year, and up to three faculty members appointed by the Program Director.

The Program Evaluation Committee will be responsible for a quarterly comprehensive review of all rotations, resident case volume, clinical, and didactic activities. A formal report of these meetings will be provided semi-annually at the faculty meeting and yearly at the resident retreat.

In addition, the Program Evaluation Committee will be responsible for ensuring that a comprehensive system exists for faculty evaluation of residents, resident evaluation of faculty, resident evaluation of overall program goals and content, and resident evaluation of individual rotations.

Program Evaluation Committee Members

Department Chair	Mary Killackey
Program Director	Rebecca Schroll
Assistant Program Director for Curriculum	Matt Zelhart
Clerkship Director	Christopher Ducoin
Residency Coordinator (non voting)	Lauren Dickerson
Appointed Faculty	Emad Kandil
Appointed Faculty	Anil Paramesh
Appointed Faculty	Clifton McGinness
Chief Resident PGY 5	David Pointer (Meghan Garstka delegate)
PGY 4 Representative	Monica Llado-Farrulla (Alison Smith delegate)
PGY 3 Representative	Angela Volk
PGY 2 Representative	Michelle Moe (Vera Hendrix delegate)
PGY 1 Representative	Erik Green

Comment [RS1]: We need to pick a PGY-1 representative



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Clinical Competency Committee

Date: 6/12/17

Goal: The Clinical Competency Committee will meet at least semi-annually to evaluate the performance of each resident based on the ACGME Surgery Milestones.

Policy: The Clinical competency committee will consist of the faculty members of the resident education committee. These include Chairman of the Department of Surgery, Residency Program Director (non-voting member), Assistant Program Director(s), the Director of Surgical Clerkship, and up to three faculty members appointed by the Chair.

The CCC will:

1. Regularly review the clinical and academic performance, and professional development of all residents based on the ACGME general competencies, surgery milestones, department policies and ABS requirements
2. Complete the specialty specific milestone forms based a consensus of the committee.
3. Identify residents who are experiencing problems with their clinical, academic and professional development and assist these residents in rectifying their problems.
4. Determine what constitutes satisfactory and unsatisfactory levels of performance at each stage of the residents' clinical, academic, and professional development.
5. Make recommendations to residents and their advisors about the actions that should be taken to improve performance.
6. Determine if a resident should be placed on academic probation and make the appropriate recommendations to the Program Director and the Chairman of the Department of Surgery.
7. Identify what actions a resident, with the assistance of his/her advisor, needs to undertake to be removed from academic probation.

The information used in the evaluation process will include materials contained in each resident's file, rotation evaluations, letters and e-mails from various individuals, patient safety net reports, standardized test results, clinical skills tests conducted as part of the resident education process, records of attendance at lectures, conferences and special educational programs and adherence to departmental and hospital compliance requirements. On occasions an individual attending may be asked to make direct comments concerning a resident's progress, to verify reports made by other attendings.

It should be emphasized that the main goal of the CCC is to help all residents graduate from the residency program as successful, competent practitioners. However, the residency program, as well as the CCC has a responsibility to protect the public by ensuring that surgery residents who complete their training have achieved appropriate levels of competence in the manner defined by the ACGME, ABS and outlined in this manual.

Resident Applicant Interview Dates

September 22nd (Tulane day)

October 20th

November 3rd

November 10th

November 17th

December 1st

December 15th

January 5th (optional)

Program Policies and Expectations



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: General Goals and Objectives

Date: 6/12/17

Goal: The Tulane University Department of Surgery is dedicated to training surgical residents to be competent, humanistic, and scholarly physicians. Residents are expected to provide comprehensive care to adult and pediatric patients presenting with surgical disease in both the inpatient and ambulatory settings. General goals are listed below. The mechanism of accomplishing and evaluating these goals are in italics.

1. 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. At each phase of training, residents are expected to acquire progressive proficiency and competence in the following components of patient care.

- a. Communicate effectively with patients and their families, and demonstrate a caring and respectful behavior when interacting with patients and their families.
- b. Gather essential and accurate information about their patients.
- c. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- d. Develop and execute patient management care plans appropriate for the resident's level (including management of pain).
- e. Counsel and educate patients and their families.
- f. Use information technology to support patient care decisions and patient education.
- g. Perform competently all medical and invasive procedures considered essential for the area of practice.
- h. Demonstrate competence in manual dexterity appropriate for the resident's level.

- i. Provide health care services aimed at preventing health problems and maintaining health.
- j. Work with health care professionals, including those from other disciplines, to provide patient-focused care.

2. Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. At each phase of training, residents are expected to acquire progressive proficiency and competence in the following components of medical knowledge

- a. Demonstrate competence in knowledge and critical evaluation of pertinent scientific information
- b. Demonstrate an investigatory and analytic thinking approach to clinical medicine.
- c. Demonstrate knowledge of the fundamentals of basic science as applied to clinical surgery.
- d. Demonstrate knowledge of the principles of immunology, immunosuppression, and the management of general surgical conditions arising in transplant patients

3. Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. At each phase of training, residents are expected to acquire progressive proficiency and competence in the following components of practice-based learning and self-improvement

- a. Identify strengths, deficiencies and limits in one's knowledge and expertise through self assessment and by incorporating formative evaluation feedback from daily practice.
- b. Set individual learning and improvement goals and work toward those goals by identifying and performing appropriate learning activities.

Systematically analyze practice experience using quality improvement methods, perform practice-based improvement activities and implement changes to improve practice.

- b. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- c. Obtain and use information about their population of patients and the larger population from which their patients are drawn

- d. Use an evidence-based approach to patient care by applying knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on which diagnostic and therapeutic decisions are made.
- f. Use information technology to optimize learning, manage information, access on-line medical information; and support their education
- g. Participate in the education of patients, families, students, residents and other health professionals.
- h. Actively participate in morbidity and mortality conference to analyze and evaluate one's patient care outcomes.

4. Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. At each phase of training, residents are expected to acquire progressive proficiency and competence in the following components of interpersonal and communication skills

- a. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
- b. Communicate effectively with physicians, other health professionals, and health related agencies.
- c. Create and sustain a therapeutic, ethically sound relationship with patients and families, that includes counseling and education
- d. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- e. Work effectively with others as a member or leader of a health care team or professional group
- f. Effectively document practice activities including maintaining comprehensive, timely and legible medical records.
- g. Foster the development of the profession through effective teaching strategies
- h. Act in a consultative role to other physicians and health professionals.

5. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. At each phase of training, residents are expected to acquire progressive proficiency and competence in the following components of professionalism

- a. 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
- b. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- c. Demonstrate sensitivity and responsiveness to patients' gender, age, culture, race, religion, disabilities, and sexual orientation.
- d. Establish respect for patient privacy and autonomy.
- e. Demonstrate accountability to patients, society and the profession.
- f. Demonstrate timely completion of medical records and other administrative requirements such as caselog completion and work hours logs.
- g. Demonstrate a commitment to continuity of patient care.

6. Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. At each phase of training, residents are expected to acquire progressive proficiency and competence in the following components of systems-based practice

- a. Be able to coordinate patient care within the health care system relevant to surgery while incorporating considerations of cost awareness and risk-benefit analysis in patient and population based care.
- b. 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
- c. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
- d. Practice and advocate for cost-effective health care and resource allocation that does not compromise quality of care.

- e. Advocate for quality patient care, optimal patient care systems and assist patients in dealing with system complexities.
- f. 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.
- g. Participate in identifying systems errors and implementing potential systems solutions by understanding and applying the Plan-Do-Check-Act (PDCA) method of systems improvement.
- h. Demonstrate knowledge of risk-benefit analysis
- i. Work in interprofessional teams to enhance patient safety and improve quality of patient care.
- j. Demonstrate and understanding of the role of different specialists and other health care professionals in overall patient care management.

7. Transitions of Care

Residents must demonstrate knowledge and proficiency in the safe and effective transition of care for patients under their stewardship. Residents are expected to

- a. Understand the importance of in-person sign-in and sign-out of patients who will require on-going care via a colleague (i.e., a night-float resident)
- b. Identify the components of closed-loop communication, and successfully demonstrate proficiency of this communication strategy.
- c. Identify the component of the written (or electronic) sign-out form that ensures patient safety.
- d. Recognize the importance of timely completion of documents essential to facilitating successful transitions of care from one arena to the next (i.e., off-service notes, post-operative notes, discharge dictations).



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Rotation Specific Goals and Objectives

Date: 6/12/17

Goal: Each rotation is to maintain a set of educational and technical goals and objectives. The objectives are to be specific for each post-graduate year represented within each rotation.

Policy: The surgery service goals and objectives are to be maintained by the program director. They are to be reviewed annually by the rotation faculty and the Surgery Department Graduate Medical Education Committee.

Goals and objectives are to reflect the expectations and competencies specific to the post-graduate year.

All goals and objectives are handed out to all residents yearly and are available on the department web site for periodic review.

Prior to the beginning of a rotation, the resident will discuss these goals and objectives with the faculty assigned to the rotation.

The resident and faculty, mid-point in the rotation and prior to completing the rotation, will review the service objectives to ensure the resident is achieving the expected objectives.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Resident Didactic Education Curriculum

Date: 6/12/17

Goal: To establish the didactic program for resident education

Policy: Core didactic curriculum will consist of conferences scheduled on Tuesday afternoons and Friday mornings. Except for emergencies, residents and medical students are expected to be freed from clinical duties during core curriculum conference schedule. Residents are to turn pagers and cell phones over to the program coordinator during conferences. In addition, all available faculty are expected to attend morbidity and mortality and grand rounds conference. Assigned faculty are expected to attend core curriculum conference on a rotating basis.

Tuesday afternoon from 4:30 pm – 6:00 pm:

1. Core Curriculum Conference – This conference is attended by residents and an assigned faculty moderator. The schedule is established by the program director in consultation with the residents. Residents read the assigned material based on the Scientific American Surgery Weekly Curriculum before the conference date. Residents are expected to be active participants in the core curriculum conferences. Testing on content is given at the discretion of the faculty moderator and residents may be assigned specific presentations to give during the conference

Friday morning from 7:00 am – 9:00 am:

1. Morbidity and Mortality – This conference is attended by surgical faculty, residents and medical students. This educational conference is designed to teach the pathophysiology and decision-making process regarding complex and interesting surgical cases and surgical cases that result in a complication.

Each resident service reviews a comprehensive list of cases and any complication, which occurred from Friday to Thursday of the preceding week. This allows time for evaluation of potential complications. All complications are briefly discussed. One faculty member will serve as the conference moderator.

The second portion of the conference will be reserved for discussion of a specific interesting case which has been selected by the chairman or PD and has occurred over the preceding year. The resident responsible for presenting the case will be notified at least 1 week ahead of time to allow for ample time for preparation. This resident will present the details of the case from the podium to the conference attendees, explain the pathophysiology and discuss the knowledge base contained in the surgical literature. The faculty moderator for the day will guide the discussion. A PBLI slide will be completed for each case.

All cases presented will be blinded. No patient identifiers are used. The resident discussion includes projectable images of any significant radiographic data and a PowerPoint-style presentation highlighting key features identified within the surgical literature.

2. Grand Rounds – Presentations at this conference are by department faculty, invited lecturers and surgical residents as assigned by the Chair. These presentations generally last 60 minutes including a period of questions and answers. All senior residents and research residents will give grand rounds yearly.
3. Chair/PD conference: This conference is held monthly and attended by all residents and well as the Chair and/or PD. The format of this conference is to allow open dialogue between residents and the Chair and/or PD. The goal of this conference is to allow ongoing issues and problems to be addressed and resolved, and to provide a forum in which residents may provide feedback to the Chair and PD about their experiences within the program.
4. Specialty Conferences – Each specialty area is expected to have its own set of conferences which are maintained by the section chief. Attendance is expected for the residents rotating on these services. These sections include:

Pediatrics (Dr. David Yu))

- Tumor Board (Children’s Hospital)
- Pediatric Surgery Conference (Children’s Hospital)

Abdominal Transplant (Dr. Joseph Buell)

- Liver Selection
- Kidney Selection
- Multidisciplinary Liver Conference
- Journal Club
- Research Conference

Trauma/Emergency Medicine (Dr. Rebecca Schroll)

- Multidisciplinary Trauma Conference
- Trauma Peer Review and ICU QPI

- Trauma/Critical Care Journal Club

Tulane Lakeside

- Multidisciplinary Breast Conference
- Journal Club

Tulane Acute Care and Tulane Elective

- Multidisciplinary Tumor Board



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Resident Scholarly activity

Date: 6/12/17

Goal: To ensure that the Tulane Surgery resident has the skills necessary to precisely formulate a scientific question, access and accurately interpret the medical literature, organize this data to formulate a cogent answer to the question, use presentation skills to communicate and teach their audience their findings.

Policy: **Scholarly Requirements:** All residents are required to participate in a scholarly activity during their training. Scholarly activity is defined as:

1. Formulating a hypothesis or clinical question.
2. Investigation of the medical literature to answer or advance the hypothesis question.
3. Organization of this information into a formal research hypothesis or presentation.
4. Presentation of this information in the presence of a learning group.

Examples of scholarly activity include: published review or original research manuscripts, podium or poster presentation at local, regional or national meetings, articles, or presenting grand rounds. All activities will be reviewed by the program director

Research Requirements: Residents are not required to participate in research, but they are encouraged to do so. It is expected that each resident will develop at least one scholarly work during his or her residency. This can include a paper for publication or an oral, poster or video presentation at a regional or national meeting. The program recognizes that meaningful research, depending upon the project, requires extended time to design, implement and evaluate a project. Residents are not asked to engage in any activity that would compromise their primary objective, which is to learn surgery and develop the skills necessary for success as a surgeon.

For all residents, the program provides the fundamentals of research through the structured didactic curriculum, and evening journal clubs. These objectives include developing a scientific hypothesis, study design and limitations, fundamental statistical analysis, and ethics of research.

If a resident has substantial interest in research, the program makes all efforts to facilitate that resident's research goals. Namely, mentorship is arranged, and advanced research training can be provided (K-30/ GCRC, public health classes). Residents are encouraged to submit completed research for presentation at national meetings and to publish such research in peer reviewed journals



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Review of Resident Case Volume

Date: 6/12/17

Goal: To ensure adequacy of surgical training, a review of surgical case volume by rotation and by resident must be completed.

Policy: At the monthly meeting of the Surgical Education Division (Resident Section), the program director reviews the case volume for the past month. Case volume will be assessed on each rotation and by resident for volume and breadth of experience. If any significant deficiencies are noted, the deficiencies will be brought to the attention of the Department of Surgery Graduate Medical Education Committee. Determination of the cause of the deficiency will be undertaken and, if necessary, changes in the rotational schedule will occur to correct the identified deficiencies.

The responsible faculty for each rotation will be provided information regarding the number of cases performed on their service.

Each resident and their respective faculty advisor will be provided a detailed report regarding the resident's cumulative case log to date, and any areas which the Graduate Medical Education Committee feels are below expected norms.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: POLICY ON SUPERVISION OF RESIDENTS (PGY 2 AND ABOVE)

Date: 6/12/17

Goal: Documentation of supervision for resident clinical rotations.

The purpose of this memorandum is to establish the Tulane University Department of Surgery policy for the supervision of resident performance, including the method of documenting such supervision. It is the policy of the Tulane Department of Surgery that all residents are given the required level of supervision, whether direct, indirect with supervision immediately available, or indirect with supervision available, during all aspects of their training and that this supervision will be documented in the medical record.

Within all participating institutions, a director of the teaching service (local program director) will be appointed by the residency program director. The director of the teaching service may also be the program director. The residency program director is responsible for the quality of the overall affiliated education, training program discipline and for ensuring that the program is in compliance with the policies of the ACGME and RRC. The local program director is responsible for the quality of educational experiences provided within the participating institution and is responsible for ensuring that the resident is aware of and adheres to established practices, procedures, and policies of the institution. The local program director will:

- Periodically assess the local teaching faculty's discharge of supervisory responsibilities from evaluations and interviews with residents, other practitioners and other members of the health care team.
- Work with the program director to structure training programs consistent with the requirements of the RRC and the affiliated medical school.
- Ensure that residents attend required rounds, lectures, seminars, core curriculum and other educational venues and scholarly activities required to fulfill the curriculum goals and objectives of the residency program.

- Provide for all residents entering their first rotation to participate in an orientation to institutional policies, procedures, and the role of residents within each affiliated institution's health care system.
- Provide residents the opportunity to participate on committees where decisions are made that affect resident activities (Quality Assurance, Utilization Review, Ethics, GME Program Committees, and Medical Staff Activities).

Proper supervision of residents is expected in all areas of all affiliated institutions to assure consistently high standards of patient care. It is a cardinal principle that overall responsibility for the treatment of each patient lies with the staff practitioner to whom the patient is assigned and who supervises the resident physician. All inpatients and outpatients will have one staff practitioner as the physician in charge of the patient's medical treatment. The name of this staff practitioner will be clearly designated on each patient's medical record. The staff member will be involved in patient treatment to assure consistently high standards of patient care. This staff practitioner will be responsible for, and must be familiar with, the care provided to the patient. The staff practitioner is expected to fulfill this responsibility, at a minimum, in the following manner:

- Direct the care of the patient and provide the appropriate level of direct supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, the experience and judgment of the resident being supervised and within the scope of the approved clinical privileges of the staff practitioner. Documentation of this supervision will be via progress note, or countersignature of, or reflected within, the resident's progress note daily.
- Meet the patient early in the course of care and document, in a progress note, concurrence with the resident's initial diagnosis and treatment plan. At a minimum, the progress note must state such concurrence and be properly signed and dated.
- Participate in attending rounds. Participation in rounds provides the direct supervision to residents. A variety of face-to-face interactions such as chart rounds, X-ray review sessions, pre-op reviews, or informal patient discussions also fulfill this requirement.
- Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are: medically indicated, fully explained to and understood by the patient to meet informed consent criteria, properly executed, correctly interpreted, and evaluated for appropriateness, effectiveness and required follow-up. Evidence of this assurance should be documented.
- Assure that a high-risk or technically complex treatment modality (such as the withholding/withdrawal of life-sustaining treatment) is: the appropriate therapy, properly prescribed/ordered, properly initiated or executed, and monitored as appropriate. Evidence of this assurance should be documented.

- Direct appropriate modifications of care as indicated in response to significant changes in diagnosis or patient status. Evidence of this assurance should be documented.

Graduated Levels of Responsibility:

The local program director and the program director will be responsible for developing a personal program with each resident which assures continued growth and guidance from teaching staff. As part of their training program, residents will be given progressive responsibility for the care of the patient. A resident may act as a teacher assistant to less experienced residents. Assignment of the level of responsibility must be commensurate with their acquisition of knowledge and development of compassion, judgment and skill, and consistent with safe and effective patient care and with the requirements of accrediting agencies.

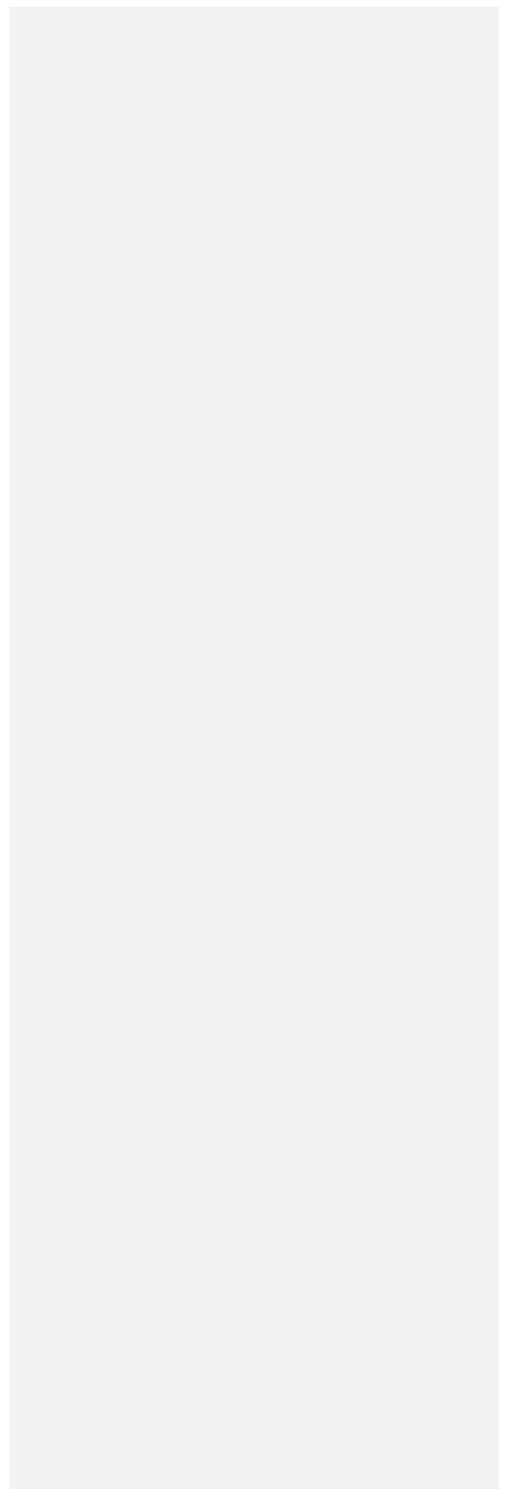
Based on a locally developed process of assessing a resident's knowledge, skill, experience and judgment, residents will be assigned graduated levels of responsibility to perform procedures or conduct activities without a supervisor directly present, and/or act as a teaching assistant to less experienced residents. The determination of a resident's ability to accept responsibility for performing procedures or activities without a supervisor directly present and/or act as a teaching assistant will be based on the staff practitioners' direct observation and knowledge of each residents skill and ability.

Supervision of Residents Performing Invasive Procedures or Surgical Operations:

The inherent risks associated with all types of surgery and invasive procedures require that staff practitioners provide appropriate levels of direct supervision of all residents performing such procedures. Staff practitioners supervising residents will review the indications for the performance of each procedure which should be documented by a written notation in the patient's medical record stating their concurrence with both the performance and with the interpretation of the results and complications, if any.

Residents must have the approval of a staff practitioner prior to surgery or an invasive procedure and so document in the patient's medical record. Staff practitioners will supervise the work-up of patients, scheduling of cases, assignment of case priorities, the preoperative preparation, and the intra-operative and postoperative care of surgical patients and patients undergoing invasive procedures. This supervision must be reflected in progress notes made by staff practitioners at appropriate times during each patient's hospitalization. As residents advance in their education and training, they may be given progressively increasing levels of responsibility. The degree of responsibility will depend upon the individual's general aptitude, demonstrated competence, prior experience with similar procedures, the complexity and degree of the risks involved in the anticipated surgical/invasive procedure. This will be based on the staff practitioners' direct observation and knowledge of each resident's skills and ability. An important aspect of a resident's learning experience is the opportunity of a senior resident to supervise more junior residents. As a general rule, senior residents, when acting in the role of a teaching assistant to less experienced residents, may supervise the performance of surgical/invasive procedures of lesser or more routine complexity. This, however, does not release the staff practitioner's responsibility for the oversight of the patient's care. When a resident is acting as a teaching

assistant, the staff practitioner remains responsible for the quality of care of the patient, providing supervision and meeting medical recorded documentation requirements as defined within this policy.





**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: POLICY ON SUPERVISION OF PGY 1 RESIDENTS

Date: 6/12/17

Goal: To ensure a safe patient care environment while developing skills in the novice trainee.

Policy: All patient care provided by General Surgery residents will be supervised by appropriately qualified faculty attending physicians as detailed in the Department of Surgery Resident Supervision Policy. However, there are unique aspects to the supervision of early trainees that require special supervision.

In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. Therefore, PGY-1 residents will not take home call and there will always be a more senior resident in the hospital immediately available for supervision. As with all residents, a graduated level of responsibility for PGY 1 residents is commensurate with their acquisition of knowledge and development of compassion, judgment and skill, in a manner consistent with safe and effective patient care. It is expected that the entering PGY 1 knowledge and skill will allow for indirect supervision with direct supervision immediately available from a more senior level resident or attending physician who is in the same hospital for the following:

1. evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
3. evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
4. transfer of patients between hospital units or hospitals
5. discharge of patients from the hospital
6. interpretation of laboratory results
7. performance of basic venous access procedures, including establishing intravenous access
8. placement and removal of nasogastric tubes and Foley catheters

9. arterial puncture for blood gases

Because closer supervision is required for more advanced patient management and procedural competencies, PGY 1 residents must have direct supervision (until competency is demonstrated) by a more senior level resident or an attending faculty for the following:

Patient Management skills

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

Procedural skills

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

Once competency has been demonstrated, the PGY 1 resident can perform these skills under indirect supervision with direct supervision from a more senior resident or attending faculty member immediately available. A PGY 1 resident shall be considered competent in the patient management skills after completing ATLS, ACLS, the Fundamentals of Surgery curriculum and direct observation of these skills performed on five patients by a more senior member of the team. A PGY 1 resident shall be considered competent in the procedural skills after completing the departments simulator based PGY 1 skills curriculum and direct observation of these skills performed on five patients by a more senior member of the team. The simulator based curriculum is a proficiency based curriculum modeled in part on the ACS/APDS skills curriculum and consists of basic suture technique, central line insertion, arterial line insertion, airway management to include endotracheal intubation and cricothyroidotomy, tube thoracostomy and paracentesis.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: SUPERVISORY LINES OF RESPONSIBILITY

Date: 6/12/17

Goal: To ensure well established supervisory lines of responsibility and communication regarding patient care.

Policy: All patient care provided by General Surgery residents will be supervised by appropriately qualified faculty attending physicians as detailed in the Department of Surgery Resident Supervision Policy.

The General Surgery residency is organized in a chain of command emphasizing graded authority and increasing responsibility as competency is gained by each resident. Senior residents or fellows serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. The program director and faculty members assign the privilege of this progressive authority and responsibility, conditional independence, and a supervisory role in patient care for each resident. The most senior residents on their primary service assignment and/or in-house call teams will direct junior residents in their activities. Delegation of decision making and portions of patient care is the purview of the attending physician; however, the attending physician remains ultimately responsible for the care of his/her patients. Because of this ultimate responsibility, attending physicians must be notified by the resident for any critical changes in the patients' medical status (including need for transfer to an intensive care setting) or in end-of-life decisions.

Attending physicians for each service are easily identified in the goals and objectives of the service.

The on-call faculty physician for each Tulane University Hospital and Clinic service each day is easily identified using the service call schedules distributed to the residents, through the TUHC Intranet Directory or through the TUHC Telephone Operator (504-988-5236).

Department of Surgery faculty call schedules at all sites are arranged to ensure that attending physicians are always readily available to residents for consultation and support. Each faculty member, or a faculty member taking his/her call, can always be reached by calling the TUHC operator. Faculty members are typically also available through various communication devices (e.g., pager, mobile phone). Faculty members will keep their service residents apprised of all device contact numbers. Faculty members will keep the hospital operator, office support staff, and service residents informed about any transfer of patient care coverage to other faculty members.

Faculty members for rotations at sites other than TUHC are readily reached through the answering services of their respective offices and through the hospital operators at their sites of clinical practice. Faculty members are typically also available through various communication devices (e.g., pager, mobile phone). Faculty members will keep their service residents apprised of all device contact numbers.

The Program Director monitors the systems in place for prompt, reliable communication and interaction of residents with supervisory physicians in all participating institutions of the residency. Resident concerns about adequate supervision and communication will be conveyed to and promptly addressed by the Program Director.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: PGY 2 and above Work Hours

Date: 6/12/17

Goal: To ensure that each resident has adequate ability to participate fully in the educational activities of the residency program, as well as to maintain a balanced life.

Policy: Resident work hours are designed to facilitate the educational process and ensure the residents have adequate ability to participate in the educational goals and objectives, as well as to maintain a balanced life with adequate periods for rest and personal needs. The Department of Surgery at Tulane University School of Medicine adheres to limitations and guidelines set forth by the RRC and ACGME. In specific:

1. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
2. Didactic and clinical education must have priority in the allotment of residents' time and energy.
3. The learning objectives of the program must not be compromised by excessive reliance upon residents to fulfill service obligations.

All residents are expected and required to adhere to these regulations as set forth below.

1. Duty hours consist of all clinical and academic activities related to the residency program. These hours include patient care and administrative duties related to patient care, time spent in-house during call activities, time spent in house during moonlighting activities and scheduled activities such as conferences. Duty hours do **not** include reading and preparation time spent away from the hospital or medical school site.
2. Total duty hours will be limited to 80 hours per week averaged over a four-week period inclusive of all in-house call activities.

3. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours. After 24 consecutive hours of call, residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
4. No new patients may be accepted after 24 hours of continuous duty, with a new patient defined as a patient not previously cared for by the surgery department.
5. Residents will have one 24-hour day in seven free from all educational and clinical responsibilities when averaged over a four-week period, inclusive of call.
6. Each resident will have an adequate time for rest and personal activities during the work week. A 10-hour duty-free period is appropriate between all daily duty periods but must have 8-hour duty free period and must have 14 hours after any 24 period of in-house call, prior to resuming the next day's duties.
7. In-house call may not occur more frequently than every third night averaged over a 4-week period.
8. For those residents on home call:
 - a. The frequency of at-home call is not subject to the every-third-night, or 24+4 limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
 - b. The frequency of at-home call is not subject to the every-third-night, or 24+4 limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
 - c. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
 - d. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

The Program Director and Chairman of Surgery will be actively involved in ensuring that resident work hours guidelines are met. Work hours will be reviewed at the monthly meeting of the Surgical Education Division (Resident Section).

There are no exceptions to the duty hours as listed above.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: PGY 1 Work Hours

Date: 6/12/17

Goal: To ensure that each resident has adequate ability to participate fully in the educational activities of the residency program, as well as to maintain a balanced life.

Policy: Resident work hours are designed to facilitate the educational process and ensure the residents have adequate ability to participate in the educational goals and objectives, as well as to maintain a balanced life with adequate periods for rest and personal needs. The Department of Surgery at Tulane University School of Medicine adheres to limitations and guidelines set forth by the RRC and ACGME. In specific:

1. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
2. Didactic and clinical education must have priority in the allotment of residents' time and energy.
3. The learning objectives of the program must not be compromised by excessive reliance upon residents to fulfill service obligations.

All residents are expected and required to adhere to these regulations as set forth below.

1. Duty hours consist of all clinical and academic activities related to the residency program. These hours include patient care and administrative duties related to patient care, time spent in-house during call activities or moonlighting activities, and scheduled activities such as conferences. Duty hours do **not** include reading and preparation time spent away from the hospital or medical school site.
2. Total duty hours will be limited to 80 hours per week averaged over a four-week period inclusive of all in-house call activities.

3. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours. After 24 consecutive hours of duty, PGY 1 resident must be relieved of all clinical and required academic duties. The resident may remain on-site for an additional 4hrs, if needed for safe effective transition of care.
4. No new patients may be accepted after 24 hours of continuous duty, with a new patient defined as a patient not previously cared for by the surgery department.
5. PGY 1 residents will have one 24-hour day in seven free from all educational and clinical responsibilities when averaged over a four-week period, inclusive of call.
6. Each resident will have an adequate time for rest and personal activities during the work week. A ten hour duty free period is acceptable between daily duty periods with 8 hours being the required minimum.
7. In-house night-float call may not occur more than six consecutive nights.
8. PGY 1 residents may not take at-home call as they cannot be directly supervised in this capacity.
9. PGY 1 residents may not moonlight.

The Program Director and Chairman of Surgery will be actively involved in ensuring that resident work hours guidelines are met by monitoring work hours reports weekly. Monthly work hours will be reviewed at the monthly meeting of the Surgical Education Division (Resident Section).

There are no exceptions to the duty hours as listed above.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Resident Moonlighting

Date: 6/12/17

Goal: To ensure that each resident has sufficient opportunity to participate fully in the educational activities of the residency program.

Policy: It is the philosophy of the Department of Surgery that residency education in general surgery is a full-time endeavor. It is essential to ensure external activities do not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Moonlighting or other employment outside the residency-training program could substantially increase the number of hours a resident is working per week and therefore interfere with the ability of the resident to participate fully in the educational activities and could adversely affect their achievement of the goals and objectives of the residency program. As such moonlighting is strictly limited to intramural moonlighting at the sponsoring institution provided it adheres to the following:

1. Moonlighting is allowed for PGY 2 and above
2. No resident achieving less than the 30% on the most recent ABSITE will be allowed to moonlight.
3. Moonlighting will not be allowed if in-house overnight call is required
4. All hours spent in the hospital will be counted toward work hours for the week.
5. All other work hour restrictions will be adhered to including time off, hours between shifts and maximum continuous hours in the hospital.
6. All moonlighting must be approved by the program director.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Assessment and Promotion of Residents

Date: 6/12/17

Goal: To ensure promotion of residents is based upon the School and Department academic, clinical and professional standards, with provision unsatisfactory performance.

Policy: **Assessment:** In addition to timely rotational evaluations by supervising faculty, a resident's performance is periodically (no less than every six months) assessed in writing by the Clinical Competency Committee and communicated to the resident. This assessment will include the residents' competence in patient care (based in part on review of case volume, breadth and complexity), medical knowledge (based in part on the ABSITE), practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. Faculty, peer, professional staff and self-evaluations will be used. The assessment will be communicated to the resident and available for review by the resident during the office hours of the Residency Program Coordinator.

Promotion: Residents are expected to meet and adhere to academic, clinical and professional standards set forth in the Department of Surgery Residency General Goals and Objectives. Residents are eligible for promotion from one year of training to the next based upon these requirements and satisfactory completion of the learning objectives of the year as determined by the faculty and program director.

Unsatisfactory performance: Residents are expected to meet and adhere to all academic, clinical and professional standards set forth in the Institutional, Departmental, and residency program requirements. Inadequate performance or unprofessional behavior is grounds for disciplinary action, up to, and including, termination. Unprofessional Behavior includes, but is not limited to, acting improperly towards patients, supervisors and/or peers; disrespect for faculty, patients, supervisors and/or peers; dishonest, unethical and/or illegal behavior; failure to meet

clinical responsibilities; and failure to correct deficiencies in academic performance in a responsible and timely fashion. Inadequate performance should be clearly communicated to the resident, preferably in writing, as early as possible.

Unsatisfactory performance will result in remediation or disciplinary action consisting of one of the following:

REMEDICATION AND PROBATION.

Probation and remediation are used to correct academic and/or professional deficits, including, but not limited to, deficits in medical knowledge, time management, organizational abilities, communication skills, and procedural skills.

1. **Remediation** is the process of improving resident performance. Remediation may occur either within, or separate from, probation.
 - a. Where remediation is separate from probation, it is a voluntary exercise on the part of the resident to engage in activities to improve his or her performance. As such, remediation is not reportable, nor may a resident be mandated to participate in stand-alone (i.e., separate from probation) remediation.
2. **Probation** is a formal level of discipline in which the resident may still engage in his or her training program within the confines of a probationary plan. Implicit in “probation” is that failure to successfully complete the probation plan will result in either extension of the probation or termination of the contract, at the clinical competency committee’s discretion. The Office of Graduate Medical Education, in concert with the resident’s program director, oversees all probations as outlined above.
 - a. The decision for probation should be made by the respective program’s Clinical Competency Committee, after this committee has reviewed the resident’s performance evaluations.
 - b. If after reviewing the resident’s performance evaluations, the CCC agrees that probation is appropriate, the resident will be so notified, and he/she will be informed that he or she has the right to address the CCC to contest the decision. The decision for probation is otherwise not grievable.
 - c. The resident will be given a probation agreement that will outline the terms and timeframe of the probation.
 - d. Should the resident refuse the probation agreement, his or her contract with the University will be terminated. He/she will then have an opportunity to grieve this decision as outlined below in the provisions of termination.
 - e. Guidelines for Probation and Remediation. A probation plan will be developed by the program director, in concert with Clinical Competency Committee for the respective program. The probation plan will generally have the following components:
 - i. Documentation of deficiencies. Except in extenuating circumstances, probation should not be evoked for a one-time event, including isolated performances on in-service examinations. A pattern of deficiency should be documented in the resident’s file.

- ii. Formal and explicit presentation of the deficiency. The resident will be presented a written account of the deficiency.
- iii. The probation plan will have a defined time-line, no less than three, but not more than 12 months.
- iv. The probation plan will have an *a priori* end-point(s) that will define the success or failure of the remediation effort. The probation plan's end-points must be achievable within the time-frame outlined in the program.
- v. The focus of the remediation effort will match the deficiency.
 - a. Medical Knowledge
 - b. Time Management & Organization
 - c. Clinical Reasoning
 - d. Communication
 - e. Patient Interaction
 - f. Attitude & Motivation
 - g. Inter-personal and Team Skills
 - h. Procedural Skills
- f. The program director will design, in concert with the CCC, the remediation plan and have the probation plan reviewed by the DIO prior to meeting with the resident.
- g. The probation plan will include planned efforts by the program director or the program faculty to help the resident improve. While the resident is ultimately accountable for improvement, the program and the program director are responsible for helping the resident to improve.
- h. The accounts of the probation plan will be documented, with at least one mid-point evaluation that will be communicated to the resident.
- i. The consequences of failure to successfully complete the remediation program will be clearly outlined.
- j. Upon successful completion of the probation plan, the resident will be removed from this status. Documentation will remain part of the resident's permanent file.
- k. Upon failure to successfully complete the probation plan, the resident will be asked to either repeat training, extend training, be subject to non-renewal, or be terminated. The remediation may be extended for a period not to exceed six months, at the program director's discretion. For termination or non-renewal actions, the resident will be provided a copy of the grievance and fair hearing policy, and will sign acknowledgment of receipt of this document.

NON-RENEWAL, NON-PROMOTION, AND DELAYED GRADUATION

- 1. Non-Renewal is a decision to not renew a resident's participation in a residency program.
 - a. In the absence of extenuating circumstances, such a decision should ideally be made no later than four months prior to the initiation of the resident's next contract start date. Termination and non-renewal after this date remains an option.

- b. If a Resident's contract is not to be renewed, he or she must be given an opportunity to appeal this decision to the Clinical Competency Committee. If upon appeal, the Clinical Competency Committee upholds the decision to extend training, the resident has a right to grieve this decision through the University's Grievance Committee
2. Non-Promotion is a decision to not promote the resident to higher levels of training based upon merit- based competency. The decision to not promote a resident rests with the program's Clinical Competency Committee.
 - a. If the decision does not necessitate extended training time, the decision is not grievable.
 - b. If the decision mandates extended training time, the resident must be given an opportunity to appeal this decision to the Clinical Competency Committee. If upon appeal, the Clinical Competency Committee upholds the decision to extend training, the resident has a right to grieve this decision through the University's Grievance Committee
3. Delayed Graduation
 - a. If the resident is asked to extend total training time (i.e., delay graduation) for performance reasons, he or she must be given an opportunity to appeal this decision to the Clinical Competency Committee. If upon appeal, the Clinical Competency Committee upholds the decision to extend training, the resident has a right to grieve this decision through the University's Grievance Committee
 - b. Preliminary interns cannot be made to extend their preliminary training time. Inadequate performance should result in the decision to not grant credit for the year of training.

SUSPENSION

1. Suspension is a formal level of discipline in which the resident will temporarily no longer engage in his or her training program. The purpose of suspension is to allow time to investigate a resident issue and to fine determine the appropriate pathway to resolve that issue, and/or to ensure the resident receives appropriate assistance to ensure that he or she is fit for duty.
 - a. Suspension to enable time to investigate a complaint and determine the appropriate action will be suspension with pay and benefits.
 - b. Suspension to ensure the resident receives appropriate assistance to ensure that he or she is fit for duty (i.e., the Physicians Health Foundation) will be suspension with benefits but without pay, unless designated by the DIO.
2. Suspensions can only be reversed by the DIO or the Dean.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Satisfactory Completion of Residency

Date: 7/1/17

Goal: To define “one year” and “satisfactory completion”, as the program must routinely state to licensure and other accrediting bodies whether a resident has satisfactorily completed one or more years of residency education.

Policy: Residency Year: In the absence of a definition of one year from the RRC for Surgery and the ACGME, the department has adopted the definition of “one year” utilized by the American Board of Surgery in the Requirements for Certification in Surgery II.C.2 (ABS, Inc., Booklet of Information, 2014-20015).

1. “One Year” of residency in this program shall consist of forty-eight (48) weeks of full-time surgical experience. For documented medical problems or maternity leave the program will accept forty-six (46) weeks of full-time surgical experience as comprising “one year” of residency.
2. To receive credit for each of the first three years of general surgery residency, an individual must accrue a minimum of one hundred forty-two weeks of full-time surgical experience. For documented medical problems, maternity leave or paternity leave the program will accept forty-six (46) weeks of full-time surgical experience as comprising “one year” of residency for one of the first three years. Forty-eight (48) weeks is required for all other years during the first three years.
3. To receive credit for each of the last two years of general surgery residency, an individual must accrue a minimum of ninety-four (94) weeks of full-time surgical experience. For documented medical problems or maternity leave, the program will accept forty-six (46) weeks of full-time surgical experience as comprising “one year” of residency for one of the last two years. Forty-eight (48) weeks is required for the other year.

Satisfactory Completion: For each year prior to the ultimate year, satisfactory completion will be ascribed when the resident meets the definition of one-year (above) and meets the requirements for promotion (see protocol for Assessment and Promotion)

For satisfactory completion of the residency, the resident must

1. completed five years of full-time surgical experience as defined above
2. not be on probation or academic remediation
3. have no deficiencies in case volume in the defined categories or in total volume
4. demonstrate to the authorities of the program sufficient professional ability to practice competently and independently as documented in the Program Director final evaluation, in consultation with the faculty. This evaluation remains as part of the residents' permanent record and will state: ***The program director, in consultation with the program's faculty, has deemed the resident sufficiently competent to enter practice in surgery without direct supervision.***



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Grievance/Fair Hearing Process for Residents

Date: 6/12/17

Goal: This Fair Hearing procedure is used in the adjudication of all actions resulting in termination, or non-renewal. The Fair Hearing procedure is to be followed as below:

POLICY:

1. A resident may request a Grievance-Fair Hearing for termination, non-renewal, or a contested CCC decision to not graduate the resident.
2. Contesting evaluations, letters of recommendation, documentation of performance, and probation are not grounds for a Grievance-Fair Hearing.
3. A Grievance-Fair Hearing must be filed in writing within five business days of the decision being grieved, addressed to the DIO in the Office of the Graduate Medical Education.
4. The purpose of the Grievance-Fair Hearing is to ensure that the house officer's due process rights have been met.
5. A resident may be removed from clinical responsibility pending the Grievance-Fair Hearing, if the DIO determines that patient care may be compromised.
6. Once the request has been received, the DIO will assure that a Grievance-Fair Hearing is an appropriate means for adjudicating the complaint. If the request is not appropriated for a Grievance-Fair Hearing, the resident will be notified.
7. If the DIO deems the Grievance-Fair Hearing request is an appropriate means for adjudicating the complaint, he or she will convene the Grievance-Fair Hearing board as outlined below. Subject to the availability of all parties, the first meeting of the Fair Hearing Board will occur within 30 days of the written request.
8. The Fair Hearing Board will consist of the following five voting members, appointed by

the DIO or his or her designee in cases of conflict of interest or inability to attend. The chair will be a nonvoting member.

- a. Three (3) faculty members from programs not directly associated with the resident who has filed the Grievance-Fair Hearing.
- b. Two (2) house officers from programs not directly associated with that of the resident who has filed the Grievance-Fair Hearing.

FAIR HEARING PROCEDURE.

Unless otherwise specified, the following procedures are to be used in all Grievance/Fair Hearing Procedures. All capitalized terms shall have the meaning as set forth in the Tulane University School of Medicine: Resident and Fellow, Policies and Procedures.

1. The Chair of the Grievance/Fair Hearing Board, along with the committee members, will be identified at least three weeks prior to formally convening the Fair Hearing Board. The resident then has 4 business days to formally submit an objection to one or all of the committee member's participation.
 - a. In making an objection, the resident must establish reasonable evidence that the Board member's participation in the Grievance/Fair Hearing would unduly bias the proceedings.
 - b. The Chair of the Grievance/Fair Hearing Board will make the decision as to the objection.
2. At least 5 business days before the hearing date, both the Resident and the Institution shall submit witness lists and documents to be presented at the Grievance/Fair Hearing Board. These items shall be delivered to the Chair of the Grievance/Fair Hearing Board.
3. If the Resident fails to appear, the hearings will proceed and the Grievance/Fair Hearing Board will render a decision. A resident who fails to appear after proper written notice will be deemed to have waived his/her right to contest the Institution's decision.
4. Neither the Resident nor the Institution shall be represented by counsel at the hearing. The Resident and the Institution may have an advisor present at the Grievance/Fair Hearing Board (which may include counsel) but the advisor may not participate in the proceedings except to advise the Resident or the Institution.
5. All persons shall be asked to affirm that their testimony is truthful. Furnishing false information to the University may result in formal charges.
6. Both the Resident and the Institution shall be offered the opportunity to present their witnesses and to question the other's witnesses.
7. Prospective witnesses shall be excluded from the Grievance/Fair Hearing during the testimony of other witnesses. All parties and witnesses shall be excluded during

deliberations of the Grievance/Fair Hearing Board except at that time at which they are providing testimony.

8. The burden of proof shall be on the Resident, who must establish that the Institution's decision was in error by preponderance of the evidence. Formal rules of evidence shall not be applicable; nor shall harmless or technical procedural errors be grounds for appeal. All evidence reasonable people would accept in making decision about their own affairs is admissible. Irrelevant or immaterial evidence will be excluded, as determined by the Chair of the Grievance/Fair Hearing Board.
9. Final decision of the Grievance/Fair Hearing Board shall be by the majority vote of all members of the Board present and voting.
10. Written findings and recommendations of the Grievance/Fair Hearing Board will be forwarded to the Dean of the Tulane School of Medicine within 10 working days of the Grievance/Fair Hearing with a copy to the Resident and the Institution. At this time, either the Resident or Department Chair has the right to request a meeting with the Dean to review these issues.
11. The Dean will render his or her final decision within ten (10) working days of receipt of the Grievance/Fair Hearing written findings and recommendations or ten (10) working days after meeting with the parties, if these meetings were so requested.
12. All hearings of the Grievance/Fair Hearing Board will be taped for use in deliberation by the Grievance/Fair Hearing Board, although the Grievance/Fair Hearing Board deliberations will not be taped. Any tape recording may only be made by the Chair of the Fair Hearing Board and shall be private and used for Grievance/Fair Hearing deliberations only.
13. The final decision of the Dean of the School of Medicine shall be reported to the DIO, the Graduate Medical Education Committee and the applicable program director.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Adjudication of resident complaints

Date: 6/12/17

Goal: To ensure that each resident has a mechanism to resolve complaints and grievances related to the work environment, the program, the faculty or the application of University or Hospital rules, regulations, policies and procedures.

Policy:

The Department recognizes that problems may arise related to the work environment, the program, the faculty or the application of University or Hospital rules, regulations, policies and procedures. Normally, these matters can be effectively resolved via informal discussion with your advisor, local program director or the residency program director. However, institutional probation, termination, non-renewal or actions taken against residents that could significantly threaten a resident's intended career development is not subject to this adjudication of complaints review process but is adjudicated through the Department of Surgery GME Grievance/fair hearing process found in the department of surgery protocol for a Grievance/fair hearing for residents. If your grievance raises issues of discrimination, harassment, or retaliation, it will be handled in accordance with the University's Harassment Policy, found in the resident handbook.

If residents have issues that are not resolved to their satisfaction and have proven unsuccessful, they are to follow the standard adjudication of resident complaint policy. This policy is shared in writing and discussed with the residents during the first week of the training year. The policy is as follows:

Any complaint that a resident may experience is first brought to the attention of the preceptor who should attempt to resolve the concern after an investigation of the issue. If the grievance is not resolved to the resident's satisfaction with the preceptor, or if there is a problem with the preceptor, the issue is then brought by the resident to the local Program Director. If this step does not result in an adequate resolution, the problem can then be brought to the Residency program director. If still unresolved the issue can be brought to the Department of Surgery Chairman. If this result remains unsatisfactory, the Chairman of the Department will appoint a Departmental Committee comprised of two faculty and two residents to investigate formally the matter and report to the Chairman of the Department. At this level, if there continues to be a need for

greater resolution, the resident can appeal through the Tulane University system in accordance with the University Grievance Policy. That policy is as follows:

1. *Step 1* You have five (5) business days from receipt of a response from your department head in which to request review of a grievance. The grievance must be submitted in writing to the Workforce Management Organization. Upon receipt of the written grievance, the Workforce Management Organization will determine if there are reasonable grounds for a grievance review. You will be notified of the Office's decision within five (5) business days of your submission of a grievance. If the Workforce Management Organization determines that your grievance raises issues of discrimination, harassment or retaliation, it will be handled in accordance with the Harassment Policy, which is detailed in Section II of this Handbook.
2. *Step 2* If the Workforce Management Organization determines there are reasonable grounds for a grievance review, it will appoint a grievance review panel. Both you and your supervisor may request that one member of the panel be replaced. The grievance review will be held within five (5) business days of the panel's appointment. The grievance review procedure is not a legal or judicial process, and is in no way binding on the University. It is a mechanism designed to obtain an impartial evaluation of the problem so that the parties involved can reach a mutually agreeable solution. In order to maintain its informal nature, you may not be represented by an attorney during the grievance review. You may be assisted by another University employee who is not an attorney. You and your department head will be present at the grievance review, and each will have the right to present information and to invite witnesses to appear. A representative of the Workforce Management Organization will be present to serve in an advisory capacity. After the grievance review, the panel will meet in private to review the information presented and make a recommendation. The panel generally will provide its recommendation and other information it deems relevant to the Workforce Management Organization within five (5) business days of the grievance review if circumstances so permit.
3. *Step 3* The Workforce Management Organization will notify you, your department head, and the President of the University of the panel's recommendation within five (5) business days of its receipt of the recommendation.
4. *Step 4* If you and your department head are satisfied with the panel's recommendation, the Workforce Management Organization will work with you to document and implement the resolution. If you or your department head are not satisfied with the panel's recommendation, either of you may request, within five (5) business days after receipt of the panel's recommendation, review of the recommendation by the President of the University. The President will make a determination regarding the grievance within a reasonable time and notify the Workforce Management Organization in writing of this determination. The Workforce Management Organization will notify you and your department head in writing of the President's determination generally within five (5) business days of receipt from the President if circumstances so permit. The President's determination shall be final.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Residency Quality Assurance/Quality Improvement Program

Date: 6/12/17

Goal: To continually assess the program: clinical rotations, didactic curriculum, skills training, research initiatives and evaluation of existing policies and procedures.

- Policy:**
1. Chair/PD Conference – At this monthly conference, the Chair and/or PD will ascertain whether residents are currently meeting the goals and objectives of their rotations and assess the efficacy of the didactic curriculum. At this conference a review of skills training will also be undertaken. The Chair will inquire and note resident participation in clinical and basic science research. Finally, the Chair will discuss with the residents their duty hours and operative experience.
 2. Faculty meetings – At each monthly faculty meeting, an agenda item will be placed to discuss urgent issues pertaining to resident evaluations of rotations, didactic sessions and the training program. The Division of Surgical Education (Resident Section) will be charged with compiling this information and any additional supporting information such as case volume, resident work hours, publications, etc. which can be used by the faculty to determine whether educational goals and objectives are being met. Action plans will be developed during these meetings and placed in the minutes.
 3. Program Evaluation Committee - The Program Evaluation Committee will be responsible for a quarterly comprehensive review of all rotations, resident case volume, clinical and didactic activities. A formal report of these meetings will be provided at the annual Departmental Internal Review for Quality Assurance/Quality Improvement.
 4. Annual Departmental Internal Review – A detailed internal review will be held annually, in May. The format will consist of a program evaluation “retreat”

attended by all available residents as well as the Chair and PD. During the program evaluation retreat to analyze the rotations, educational curriculum and other aspects of the residency program. Strengths, weaknesses and opportunities for improvement with respect to resident education will be identified. Any threats to excellence in resident education will be addressed and detailed plans for improvement will be documented and communicated back to the residents.

5. An anonymous program survey will be sent to all faculty and residents yearly.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Advisory Faculty Requirements

Date: 6/12/17

Goal: To ensure that each resident has access to a faculty member who is able provide comprehensive and frequent summative feedback regarding the resident's progress within the residency program.

Policy:

1. Each resident will be assigned a faculty member as an advisor. Residents will be allowed to request a specific faculty member based upon interests. The Chair and the Program Director have ultimate authority to approve resident faculty advisor assignments.
2. Faculty advisors are expected to meet formally with their assigned residents at least quarterly. The faculty member will be provided with the resident's confidential file prior to their advisory meeting.
3. Faculty members will furnish a written report of their advisory meeting to the Program Director and Department Chair.
4. In addition to meeting with their assigned faculty advisor, each resident will be scheduled to meet with the Program director at least twice yearly to review progress and to assess any individual needs with respect to residency education and performance.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Vacation and Leave Policy

Date: 6/9/17

Goal: To provide the resident with an outline of the allowable time for vacation/academic/scientific meeting attendance during the academic year (July 1 – June 30 annually).

Scheduled Paid Leave (Vacation)

1. Length of Scheduled Paid Leave Benefit (vacation)
 - a. All residents are granted 3 (three) weeklong vacation blocks per academic year.
 - i. Vacations may be taken only in one-week blocks (Saturday – Friday or Monday-Sunday).
 - b. All residents may be granted one assigned 7-day “holiday” vacation between December 22nd and January 5th each academic year.
 - i. Each resident may request their preference for one of the two assigned “holiday” vacation blocks between either December 22nd - December 28th or December 30th - January 5th but first choice will not be guaranteed.
 - c. Residents who prefer not to take a 7-day “holiday” vacation between December 22nd and January 5th may take a fourth 1-week vacation at another point in the same academic year.
2. Guidelines for Scheduled Paid Leave
 - a. Vacation cannot be scheduled for:
 - i. The month of July
 - ii. December 22nd through January 5th, other than assigned
 - iii. The week preceding or the weekend including the January In-Training Service Exam (ABSITE) (January 20th-30th)
 - iv. The month of June (except graduating residents and exiting preliminary residents who may take the last week)

- b. Two residents cannot take vacation at the same time if they are on the same rotation
 - c. Two residents at the same level in the same hospital may not take vacation at the same time.
 - d. If a resident takes a holiday week and 3 other weeks, at least 1 of the 3 other vacation weeks must be taken in the fall semester.
 - e. If a resident elects not to take a “holiday” vacation week and instead takes 4 other vacation weeks, 2 must be taken in the fall semester and 2 must be taken in the spring semester.
3. Requesting Time Off
- a. Scheduled paid leave is allotted on seniority and availability when all guidelines are followed.
 - b. Residents must complete and submit to the Program Coordinator a completed Resident Leave Request Form for each scheduled request. The form is available in the Program coordinators office.
 - c. Scheduled paid leave requests for the fall semester and the holiday block must be submitted by June 25. Scheduled paid leave requests for the spring semester must be submitted by Nov 1.

Unscheduled Paid Leave

- 1. Length of unscheduled paid leave
 - a. All residents may be granted up to seven days per year of unscheduled paid leave for a medical emergency, for immediate family illness/problems or bereavement as defined in the resident handbook.
 - b. Residents requiring time to attend interviews must request unscheduled paid leave.
 - c. Any time used for either of the above situations will be deducted from their allotted schedule leave (vacation) time since residents may not have more than 4 weeks free from clinical duties per year as per ABS requirements.
- 2. Requesting time off
 - a. When these situations occur emergently, the resident should notify the Program Director, the Chief Resident, and the Supervising Physician or Preceptor with whom he/she is scheduled to work as soon as possible. In this case, a completed Resident Leave Request Form must be submitted to the Program Coordinator within 24 hours of return to duty.
 - b. For interviews, or non-emergent issues, a completed Resident Leave Request Form must be submitted to the Program Coordinator before the leave begins.

Maternity/ Paternity Leave

- 1. Length of maternity/paternity leave – see resident handbook
 - a. Maternity/paternity leave will be granted for a period of up to six weeks. All or a portion of the six weeks may be requested.

- b. Maternity/paternity leave is an un-paid leave of absence but benefits will continue for up to six weeks.
 - c. Maternity/paternity leave will be a paid leave of absence for the portion of the leave allotted to remaining vacation or sick leave for that year.
2. Length of Leave Without Extending Residency
- a. The sum of all types of leave days (including scheduled (vacation, conferences), unscheduled (medical, bereavement), maternal/paternal, administrative or suspension) cannot exceed 28 days per resident year as per ABS policy. Leave longer than 28 days will require extension of the residency training except as noted below.
 - b. Once during the first three years of residency and once during the last two years of residency, the sum of all types of leave days can be up to 42 days but only for documented medical problems or maternity leave.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Policy for Department Sponsored Travel for Residents

Date: 6/12/17

Goal: To provide the resident with an outline of the allowable expenses for scientific meeting attendance

Policy: The Department of Surgery desires to foster resident research and as such, if approved, will cover expenses for the lead resident author when the research leads to regional or national presentations. This includes oral or video presentations, presented by the resident.

1. All travel must be approved in advance by the program director and the department chairman.
2. Covered expenses include
 - a. coach airfare arranged through the department business office
 - b. standard room at the conference hotel and conference rate for the day before and day of the presentation
 - c. reimbursement up to the US General Services Agency per diem meal and incidental expenses rate
 - d. conference registration fees
3. All original receipts must be submitted to receive reimbursement.
4. The resident should discuss funding options with the faculty mentor prior to requesting department funds.
5. Time away for presentations is considered as non-clinical time and will count toward the 28 days of non-clinical time allowed by the American Board of Surgery.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Resident Selection and Eligibility

Date: 6/12/17

Goal: To define those individuals eligible for consideration of admission as a surgery resident, and the selection process used.

Policy: The Department of Surgery adheres to the resident selection and eligibility policy of the Graduate Medical Education Department of Tulane Medical School. That policy is:

A. Resident Eligibility. To be eligible for appointment to the Tulane University residency and fellowship programs, applicants must meet one of the following qualifications:

1. Be a graduate in good standing from an allopathic medical school in the U.S. or Canada that is accredited by the Liaison Committee on Medical Education (LCME).
2. Be a graduate in good standing from an osteopathic medical school in the U.S. or Canada that is accredited by the American Osteopathic Association (AOA).
3. Be a graduate in good standing from a medical school outside of the U.S. or Canada who meets the following qualifications:
 - a. Be a US Citizen or
 - b. Be a non-US citizen that does not require Visa sponsorship
 - c. Have clinical experience/rotation in the United States.

B. Resident Selection

1. Tulane University Department of Surgery Residency Program selects from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate are considered in the selection. These characteristics are accessed by the components of the ERAS application, or the equivalent, including the following: the applicant's Dean's letter of recommendation, the applicant's letters of recommendation from faculty, the applicant's medical school transcript and grades, the applicant's NBME or COMPLEX scores, the applicant's scholarly and community service record, and the applicant's evaluation from those who interview him or her on the date of his interview with the program. Tulane University

has as its policy to consider all candidates for graduate medical education regardless of race, sex, creed, nationality, or sexual orientation. Performance in medical school, personal letters of recommendation, official letters of recommendation, achievements, humanistic qualities, and qualities thought important to the desired specialty will be used in the selection process.

2. The Tulane University Department of Surgery residency program participates in the National Residency Matching Program (NRMP) in selecting residents.
3. The program distributes a sample copy of the resident's contract to all applicants during the interview process.
 - a. This contract outlines the terms, conditions, and benefits of appointment to the training program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment.
 - b. Information that is provided must include: financial support; Institutional vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents.

C. Recruiting residents outside of the match

1. The surgery residency participates in an organized match and is bound by the conditions of the agreement with that entity. No applicant who is also a part of the organized match can be accepted into the residency program outside of the terms of that match process.
2. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences, including case-logs, and a summative competency-based performance evaluation of the transferring resident.

E. Extension of Contracts

1. All residents who match to the program will be sent a written contract outlining the terms and conditions of employment as a resident at Tulane. This contract will be mailed to the applicant within two weeks of the match results. Residents employed outside of the match or off cycle will receive a similar contract within two weeks of extending the offer for employment.
2. The contract must comply with the institutional requirements for employment. A listing of the core components of the Tulane University standard GME contract is provided below. With the exception of the start and finish date, the standard institutional GME contract cannot be modified without the express permission of the DIO. The contract shall contain:
 - a. Residents' responsibilities
 - b. Duration of appointment
 - c. Financial support

- d. Conditions for reappointment, including criteria for non-renewal and non-promotion
 - e. Grievance procedures and due process
 - f. Professional liability insurance
 - g. Health and disability insurance
 - h. Vacation, parental, sick, and other leave(s)
 - i. Duty Hours
 - j. Moonlighting
 - k. Counseling services
 - l. Physician impairment policies
 - m. Harassment policies
 - n. Accommodation for disabilities
 - o. Access to information related to eligibility for specialty board examinations
3. Each resident contract requires the signature of the resident, the program director, the departmental chair, and the DIO. Payroll will not authorize salary payment unless the DIO has approved the contract by signature.
4. Contracts for all residents and fellows are extended on a yearly basis. A contract must be initiated each year.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Policy for Timely Completion of National Examinations

Date: 6/12/17

Goal: To ensure all residents are eligible to obtain a Louisiana Medical License.

Policy: The Department of Surgery desires to ensure all residents are eligible to obtain a Louisiana license prior to beginning the PGY 3 year. To accomplish this:

1. The United States Medical Licensing Exam (USMLE) STEP II CK and CS must be passed prior to matriculation into any Tulane training program.
2. The United States Medical Licensing Exam (USMLE) STEP III must be taken within the PGY1 year of residency training. This requirement also applies to residents transferring into Tulane University programs during the PGY-2 year of training; these residents must have taken Step III in order to be eligible for enrollment.
3. Any resident who fails to take STEP III by June 30th of the PGY1 year of training will be placed on immediate probation, for which the remediation will require a non-paid leave of absence (LOA) as outlined within Chapter XIV. Such Leave of Absence will remain in effect until STEP III has been taken and supporting documentation is obtained. The Departmental Chair and/or the Program Director will determine the maximal duration for which the LOA will be permitted; after that point, the resident is then in violation of his or her probation and immediate termination will be enacted.
4. STEP III must be passed by December 31st of the PGY2 year of residency training. Failure to pass STEP III by December 31st may result in a formal letter of non-renewal of contract for the upcoming academic year.
5. All residents must have passed STEP III prior to matriculation into the PGY-3 year of training.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Policy for Timely Completion of Work Hours and Case Logs

Date: 6/12/17

Goal: To ensure all residents show professionalism by completing their work hours monitoring sheets and ACGME online case logs in a timely manner.

Policy: The Department of Surgery desires to ensure all residents are adhering to the required work hour regulations. Additionally, the department wants to do so in a timely manner so if problems develop they can be swiftly addressed to avoid further violations. The department also wants to ensure residents are obtaining adequate operative clinical experience. To monitor this experience, the residents' work hours are reviewed weekly and cases logs are reviewed monthly. To allow both of these goals to occur, residents must show professionalism by completing the work hours monitoring sheets and the case-log daily and so the weekly evaluation by the program director can occur.

1. Work hours will be evaluated on a weekly basis.
2. Work hours will be evaluated on a Monday to Sunday time-frame.
3. Work hours are to be reported by end of business day on the Tuesday following the work week of concern.
4. If a resident is 2 weeks behind in the work hours monitoring sheet, s/he will be dismissed from clinical duties for that Friday and only be allowed to return once the work-hours have been updated. All missed days, including that Friday will be counted toward vacation days.
4. Case-log reports will be evaluated monthly at the monthly Surgical Education Division – Resident section meeting.

If a resident shows no changes in the case numbers in the case log from one month to the next, an inquiry as to the reason will be made. If the lack of change is due to failure to log cases, s/he will be dismissed from clinical duties and only be allowed to return once the case-log has been updated. All missed days, including the day of dismissal will be counted toward vacation days. IF no cases were performed, the concern will be forwarded to the Program Evaluation Committee.



**Tulane University School of Medicine
Department of Surgery
Protocol**

Subject: Policy on Advanced Trauma Life Support Course and Bleeding Control Course Instruction

Date: 6/12/17

Goal: To ensure all residents participate in ATLS and BCON education.

Policy: Advanced Trauma Life Support (ATLS) and Bleeding Control (BCon) are both clinical skill sets in which every graduating general surgery resident should be proficient. In addition, clinical education of others is also a valuable skill set in which all graduating residents should be proficient. To accomplish both of these goals, the Dept of Surgery requires that all residents participate in ATLS and BCon education as detailed below:

ATLS:

1. All residents will take ATLS during their intern year (usually during intern orientation) and become ALTS certified.
2. All residents will take the ATLS instructor course and become instructor certified by the end of their PGY-2 year.
 - a. The Dept of Surgery will pay the fees for both of the above courses.
 - b. Each resident must be monitored teaching one lecture and one skills station before they are officially designated an ATLS instructor.
3. Once designated an ATLS instructor, each resident is required to teach at least one lecture and one skills station during an ATLS course of their choice each year.
4. For each additional ATLS course during which the resident voluntarily teaches at least one lecture and one skill station, he/she will be compensated monetarily by the ATLS program.

BCon:

1. All residents will be provided with BCon (Stop the Bleed) training and become instructor certified.
2. Each resident is required to teach at least one BCon course of their choice per year.