

Tulane Surgery Resident Policy and Procedures Manual

Updated July 1, 2009

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

Subject: Resident Medical Education Committee

Date: 7/13/06

Goal: The Resident Medical Education 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 Resident Medical Education 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 three faculty members appointed by the Chair.

The Resident Medical Education Committee will be responsible for a quarterly comprehensive review of all rotations, resident case volume, clinical and didactic activities and resident performance. To insure privacy protection for their peers, the resident members of the GME committee will be excused during the review of resident performance. A formal report of these meetings will be provided at the semi-annual Departmental Internal Review for Quality Assurance/Quality Improvement.

In addition, the Resident Medical Education 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.

Resident Medical Education Committee Members

Department Chair.....	Douglas Slakey
Program Director.....	James Korndorffer
Clerkship Director.....	Michael Weaver
Residency Coordinator (non-voting).....	Valarie Gousman
Appointed Faculty.....	Edward Newsome
Appointed Faculty.....	Mary Killacky
Appointed Faculty.....	Anil Paramesh
Administrative Chief Resident PGY 5.....	Georgia Wahl
PGY 4 Representative.....	Ravi Tandon
PGY 3 Representative.....	Dave Aviv
PGY 2 Representative.....	Misty Ghere
PGY 1 Representative.....	Eric Simms

Resident Medical Education Committee Meeting Dates 2009-2010

- 1. September 2nd**
- 2. December 2nd**
- 3. March 3rd^h**
- 4. June 3rd**

Core Curriculum Schedule

July 2009 – June 2010

Section	Date	Subsection	Instructor (Resident/ Staff)
Professionalism	7/1/09	Residency Expectations	Wahl Korndorffer/Slakey
Colon and Rectum 7/8/09–7/15/09	7/8/09	Colorectal & Anus (1)	Baucom/ Griffin/Mayfield
	7/15/09	Colorectal & Anus (2)	Chaly/ Griffin/Mayfield
Liver/Spleen	7/22/09	Spleen & Coagulation/ Hemostasis	Wahl/ Killackey
	7/29/09	Liver (1)	Sherafgan/ Slakey
	8/5/09	Liver (2)/Transplant Immunobiology	Sierra/ Paramesh
	8/12/09	Liver/Portal HTN	Thomas/ Paramesh
	8/19/09	Key Words/Didactic Session	Hidalgo/ Killackey
Cardiac/Vascular/Renal 8/26/09 – 9/23/09	8/26/09	Renal Physiology/Fluids/ Electrolytes	Trahan/ Paramesh
	9/2/09	Cardiac & Vascular	Martin/ Pigott
	9/9/09	PVD & Lymphatics	Guste/ Weaver
	9/16/09	Thoracic	Ghere/ McGinness
	9/23/09	Key Words/Didactic Session	Hannan/ Brown
Trauma/Critical Care 9/30/09 – 11/11/09	9/30/09	Nutrition	Gupta/ Jaffe
	10/7/09	Trauma (1)	Simms/ Duchesne
	10/14/09	Trauma (2)/Stress response	Duke/ McGinness
	10/21/09	Shock/Blood Transfusion	Rennie/ Duchesne
	10/28/09	Wound Healing/Burns & Plastic Surgery	Tandon/ Wright
	11/4/09	Neurosurgery & GU	Aviv/ Meade
	11/11/09	Key Words/Didactic Session	Hannan/ Meade
Subspecialty/ Miscellaneous 11/18/09 – 12/16/09	11/18/09	Statistics & Pharmacology	Rennie/ Bellows
	11/25/09	Thanksgiving	None
	12/2/09	Pediatric Surgery	Yu/ Steiner
	12/9/09	Anesthesia & Orthopedics	Aviv/ McGinness

	12/16/09	Key Words/Didactic Session	Baucom/	Steiner
	12/23/09	Cancelled Christmas Holiday		None
	12/30/09	Cancelled New Year's Holiday		None
Review Questions 1/6/10 - 1/27/10	1/6/10	Review Questions (1)	Duke/	Korndorffer
	1/13/10	Review Questions (2)	Rennie/	Bellows
	1/20/10	Review Questions (3)	Dorsey/	Steiner
	1/27/10	Review Questions (4)	Keel/	Korndorffer
	2/3/10	ABSITE Debriefing		Korndorffer
Professionalism 2/10/10-3/10/10	2/10/10	Ethical Coding and Billing	Billing Department	
	2/17/10	Mardi Gras		None
	2/24/10	Job Hunting after Residency		Korndorffer
	3/3/10	Breast	Baucom/	Jones
	3/10/10	General Surgical Oncology	Chaly/	Korndorffer
Oncology 3/17/10 - 4/14/10	3/17/10	Skin & Soft Tissue	Baucom/	Brown
	3/24/10	Head & Neck	Aviv/	Brown
	3/31/10	Keywords/Didactic Session	Sierra/	Kandil
	4/7/10	Gallbladder & Biliary Tract	Hidalgo/ McGinness	
	4/14/10	Pancreas	Ghere/	Paramesh
GI/Endocrine 4/21/10 - 6/9/10	4/21/10	Stomach	Sherafgan/	Jaffe
	4/28/10	Esophagus	Rennie/	Bellows
	5/5/10	Thyroid/Parathyroid	Wahl/	Adinolfi
	5/12/10	Adrenal/Pituitary	Tandon/	Kandil
	5/19/10	Key Words/Didactic Session	Hannan/	Slakey
	5/26/10	Small Bowel	Unruh/	Brown
	6/2/10	Hernia & Appendix	Stephens/	Korndorffer
Colorectal/Liver/Spleen 6/09/10 -	6/9/10	Colorectal & Anus (1)	Baucom/	Griffin/Mayfield
	6/16/10	Colorectal & Anus (2)	Chaly/	Griffin/Mayfield
	6/23/10	Spleen/Hematologic Dz & Hemostasis	Rennie/ Killackey	
	6/30/10	ABSITE Review Questions	Baucom/	Korndorffer

Resident Applicant Interview Dates

Program Policies and Expectations



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

Subject: General Goals and Objectives

Date: 5/13/09

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 (Evaluations that evaluate each sub-component of this competency are in italics).

- a. Communicate effectively with patients and their families, and demonstrate a caring and respectful behavior when interacting with patients and their families. (*Patient-of-Resident Q#1, Nurse-of-Resident Q#1, Student of Resident Q#1, Resident-of-Resident Q#1, Faculty-of-Resident Q#1, Self-Evaluation Q#1*).
- b. Gather essential and accurate information about their patients. (*Resident-of-Resident Q#2, Faculty-of-Resident Q#2, Self-Evaluation Q#2*).
- c. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific

evidence, and clinical judgment. (Resident-of-Resident Q#3, Faculty-of Resident Q#3, Self-Evaluation Q#1).

d. Develop and enact patient management plans. (Resident-of-Resident Q#4, Faculty-of Resident Q#4, Self-Evaluation Q#3).

e. Counsel and educate patients and their families. (Patient-of-Resident Q#8, Resident-of-Resident Q#1, Faculty-of Resident Q#1, Self-Evaluation Q#1).

f. Use information technology to support patient care decisions and patient education. (Student of Resident Q#6, Resident-of-Resident Q#6/9, Faculty-of Resident Q#9, Self-Evaluation Q#3).

g. Perform competently all medical and invasive procedures considered essential for the area of practice. (Resident-of-Resident Q#23, Faculty-of Resident Q#23, Self-Evaluation Q#23).

h. Provide health care services aimed at preventing health problems and maintaining health. (Patient-of-Resident Q#4, Resident-of-Resident Q#5, Faculty-of Resident Q#5, Self-Evaluation Q#5).

i. Work with health care professionals, including those from other disciplines, to provide patient-focused care. (Nurse-of-Resident Q#10, Resident-of-Resident Q#14, Faculty-of Resident Q#14, Self-Evaluation Q#19).

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 (Evaluations that evaluate each sub-component of this competency are in italics).

a. Demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. (Student of Resident Q#2, Resident-of-Resident Q#2/6, Faculty-of Resident Q#6, Self-Evaluation Q#6).

b. Demonstrate an investigatory and analytic thinking approach to clinical medicine. (Student of Resident Q#3, Resident-of-Resident Q#3/7, Faculty-of Resident Q#7, Self-Evaluation Q#7).

c. Know and apply the basic sciences appropriate to their discipline. (Student of Resident Q#2, Resident-of-Resident Q#2/6, Faculty-of Resident Q#6, Self-Evaluation Q#6).

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 (Evaluations that evaluate each sub-component of this competency are in italics).

a. Identify strengths, deficiencies, and limits in one's knowledge and expertise. (Patient-of-Resident Q#3, Nurse-of-Resident Q#3, Student of Resident Q#4, Resident-of-Resident Q#4/8, Faculty-of Resident Q#8, Self-Evaluation Q#8).

b. Set learning and improvement goals. (Student of Resident Q#4, Resident-of-Resident Q#4/11, Faculty-of Resident Q#11, Self-Evaluation Q#11).

c. Identify and perform appropriate learning activities. (Student of Resident Q#7, Resident-of-Resident Q#7/9, Faculty-of Resident Q#9, Self-Evaluation Q#8).

d. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. (Student of Resident Q#5, Resident-of-Resident Q#5/10, Faculty-of Resident Q#10, Self-Evaluation Q#10).

e. Incorporate formative evaluation feedback into daily practice. (Nurse-of-Resident Q#5, Resident-of-Resident Q#11, Faculty-of Resident Q#11, Self-Evaluation Q#11).

f. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems. (Student of Resident Q#6, Resident-of-Resident Q#6/9, Faculty-of Resident Q#6, Self-Evaluation Q#9).

g. Use information technology to optimize learning. (Student of Resident Q#7, Resident-of-Resident Q#7/9, Faculty-of Resident Q#9, Self-Evaluation Q#9).

h. Participate in the education of patients, families, students, residents and other health professionals. (Patient-of-Resident Q#4, Student of Resident Q#8, Resident-of-Resident Q#8/15, Faculty-of Resident Q#15, Self-Evaluation Q#15).

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 (Evaluations that evaluate each sub-component of this competency are in italics).

a. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds. (Patient-of-Resident Q#5 &6, Student of Resident Q#11, Resident-of-Resident Q#1/11, Faculty-of Resident Q#1, Self-Evaluation Q#1).

b. Communicate effectively with physicians, other health professionals, and health related agencies. (Nurse-of-Resident Q#7, Student of Resident Q#10, Resident-of-Resident Q#10/12, Faculty-of Resident Q#12, Self-Evaluation Q#12).

c. Work effectively as a member or leader of a health care team or other professional group. (Nurse-of-Resident Q#5, Student of Resident Q#9, Resident-of-Resident Q#9/15, Faculty-of Resident Q#15, Self-Evaluation Q#14).

d. Act in a consultative role to other physicians and health professionals. (Resident-of-Resident Q#14, Faculty-of Resident Q#14, Self-Evaluation Q#19).

e. Maintain comprehensive, timely, and legible medical records. (Nurse-of-Resident Q#6, Resident-of-Resident Q#13, Faculty-of Resident Q#13, Self-Evaluation Q#13).

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 (Evaluations that evaluate each sub-component of this competency are in italics).

- a. Demonstrate compassion, integrity, and respect for others. (*Nurse-of-Resident Q#8, Student of Resident Q#13, Resident-of-Resident Q#13/16, Faculty-of Resident Q#16, Self-Evaluation Q#16*).
- b. Show responsiveness to patient needs that supersedes self-interest. (*Patient-of-Resident Q#7, Student of Resident Q#14, Resident-of-Resident Q#14/17, Faculty-of Resident Q#17, Self-Evaluation Q#17*).
- c. Establish respect for patient privacy and autonomy. (*Patient-of-Resident Q#8, Student of Resident Q#15, Resident-of-Resident Q#3/15, Faculty-of Resident Q#3, Self-Evaluation Q#1*).
- d. Demonstrate accountability to patients, society and the profession. (*Nurse-of-Resident Q#9, Student of Resident Q#12, Resident-of-Resident Q#12/16, Faculty-of Resident Q#16, Self-Evaluation Q#15*).
- e. Show sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (*Patient-of-Resident Q#9, Student of Resident Q#13, Resident-of-Resident Q#13/18, Faculty-of Resident Q#18, Self-Evaluation Q#18*).

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 (Evaluations that evaluate each sub-component of this competency are in italics).

- a. Work effectively in various health care delivery settings and systems relevant to their clinical specialty. (*Nurse-of-Resident Q#11, Resident-of-Resident Q#19, Faculty-of Resident Q#19, Self-Evaluation Q#19*).
- b. Coordinate patient care within the health care system relevant to their clinical specialty. (*Patient-of-Resident Q#11, Nurse-of-Resident Q#10, Resident-of-Resident Q#22, Faculty-of Resident Q#22, Self-Evaluation Q#22*).

c. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate. (Patient-of-Resident Q#10, Student of Resident Q#16, Resident-of-Resident Q#16/20, Faculty-of Resident Q#20, Self-Evaluation Q#20).

d. Advocate for quality patient care and optimal patient care systems. (Student of Resident Q#17, Resident-of-Resident Q#17/21, Faculty-of Resident Q#21, Self-Evaluation Q#21).

e. Work in inter-professional teams to enhance patient safety and improve patient care quality. (Nurse-of-Resident Q#11, Resident-of-Resident Q#14, Faculty-of Resident Q#14, Self-Evaluation Q#14).

f. Participate in identifying system errors and implementing potential systems solutions. (Resident-of-Resident Q#10, Faculty-of Resident Q#10, Self-Evaluation Q#10).



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

Subject: Rotation Specific Goals and Objectives

Date: 5/20/09

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 semi-annually by the Graduate Medical Education Committee and the Department Chair.

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: Rotation Specific Responsibilities

Date: 5/20/09

Goal: To insure uniformity of patient care, expectations for each rotation are discussed verbally with residents and the beginning of the rotation. Additionally, faculty responsible for each rotation may develop a set of written rotational expectations and responsibilities to clarify in writ

Policy: Acute Care and Elective Services

1. Round as team every morning by 7:00 AM, every resident should know all the patients on the service.
2. Chief resident to make telephone rounds with the attending between 7:00 – 7:30 AM every weekday.
3. Chief resident to call attending on Friday morning to set up round scheduled for the weekend
4. At least one resident should be present in all clinics – Chief resident to assign duty
5. Residents are not to be in clinic unless attending is present
6. Round as a team at least twice a day – call attending if any problems or for results of any diagnostic studies performed during that day
7. Round with attending every day (time may vary for each attending)
8. If rounds take place during another attending's clinic time, only one resident needs to round with the attending at that time
9. Answer all pages
10. Residents interested in operating should call the attending the night before the scheduled OR case as well as see the patient in pre-op, review his/her records and complete any needed documentation. Cases that are seen in clinic by a resident should be done by that resident (if possible).

11. A note will be written by a member of the team on each patient, each day.
12. The chief will write a note on all new patients admitted (or consulted) to the service.
13. The chief will write a note at least every 3 days on all patients and status.
14. Level to level check-out will occur daily



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

Subject: Resident Didactic Education Curriculum

Date: 5/20/09

Goal: To establish the didactic program for resident education

Policy: Core didactic curriculum will consist of conferences scheduled on Wednesday mornings. Except for emergencies, residents and medical students are expected to be freed from clinical duties during core curriculum conference schedule. In addition, all available faculty are expected to attend morbidity and mortality and grand rounds conference.

The Wednesday core curriculum conferences are as follows:

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 turns in a comprehensive list of case indicating the diagnosis, surgery performed, results of pathology and any complication which occurred. The time frame for cases is from noon Monday to noon Monday. This list of cases is turned in to the conference coordinator by 7 am. Wednesday. The list is reviewed by the faculty member assigned as the conference moderator. This faculty member chooses 2-4 interesting cases or cases with complications to

be discussed. The moderator notifies the resident service not later than noon the following Friday.

At the conference, the resident service presents the case from the podium to the attendees. The junior resident on the service presents the case. The senior resident then discusses the case details and the results of a comprehensive literature review, explaining the pathophysiology and the knowledge base contained in the surgical literature. Faculty guide the discussion.

All cases presented will be blinded. No patient identifiers are used. The senior 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 Chairman. These presentations last 30-40- minutes, with a period of questions and answers if one lecture is to be given. On certain dates, two case presentations are given, each lasting approximately 20 minutes. This format is used primarily for resident presentations.
3. Core Curriculum Conference – This conference is attended by medical students, residents and an assigned faculty moderator. The schedule is established by the Chairman in consultation with the residents. Residents read the assigned material before the conference date. The curriculum for this conference is based on the APDS Surgical Curriculum and the ABSITE keywords list. 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.
4. Chairman’s Conference – This conference is attended by residents on alternating Wednesdays. At this conference, residents are expected to provide the Chair with details about their current experiences within the residency program. In addition, the Chair provides the residents feedback as a group regarding performance and other aspects of the residency program.
5. Specialty Conferences – Each specialty area is expected to have its own set of conferences which are maintained by the section chief. These sections are:

Pediatrics (Dr. Rodney Steiner)

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

Plastics (Dr. Edward Newsome)

- Weekly Case Conference
- Morbidity & Mortality Conference
- Hand Conference
- Grand Rounds
- Journal Club

Abdominal Transplant (Dr. Sander Florman)

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

Trauma/Emergency Medicine (Dr. Norman McSwain)

- ICU Discharge Planning Meeting
- Multidisciplinary Trauma Conference
- Surgery Topics Conference
- Basic Science Conference
- Morbidity & Mortality Conference
- Simulator Conference

Tulane Lakeside

- Multidisciplinary Breast Conference
- Journal Club

Tulane Acute Care and Tulane Elective

- Multidisciplinary Tumor Board
- Minimally Invasive Journal Club



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

Subject: Resident Scholarly activity

Date: 5/20/09

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. A scholarly activity is defined as:
1. Formulating a hypothesis or clinical question.

2. Investigation of the medical literature to answer or advance the hypothesis or 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 original research, published review or original research articles, presentation of a case report or a grand rounds comprehensively reviewing a topic. 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. 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 caring for their patients. If a resident has substantial interest in a project, 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 review or rounds.**

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



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

Subject: Review of Resident Case Volume

Date: 7/13/06

Goal: In order 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.

At their quarterly meeting, 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: Resident Supervision

Date: 1/26/07

Goal: Documentation of supervision for resident clinical rotations.

POLICY ON SUPERVISION OF RESIDENTS

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 direct supervision in 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 in order 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 direct 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 directly 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 directly 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 in the course of 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: SUPERVISORY LINES OF RESPONSIBILITY

Date: 5/20/09

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. Junior residents will be directed in their activities by the most senior residents on their primary service assignment and/or in-house call teams. Delegation of decision making and supervisory authority is the purview of the attending physician, and the attending physician remains ultimately responsible for the care of his/her patients.

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: Resident Work Hours

Date: 8/15/06

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, 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 six 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 for rest and personal activities during the work week. A minimum 10-hour period is appropriate between all daily duty periods and after any 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+6 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+6 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: Resident Moonlighting

Date: 8/15/06

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.

Moonlighting and other employment outside the residency training program is therefore strictly prohibited.



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

Subject: Assessment and Promotion of Residents

Date: 8/15/06

Goal: To ensure promotion of residents is based upon the School and Department academic, clinical and professional standards, with provision for Academic remediation, probation or termination/nonrenewal

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 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 Institutional and Program Requirements noted below:

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Surgical residents must: a) demonstrate manual dexterity appropriate for their training level; b) be able to develop and execute patient care plans appropriate for the resident's level.
2. *Medical Knowledge* about of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Surgical residents are expected to: critically evaluate and demonstrate knowledge of pertinent scientific information.
3. *Practice-based learning and improvement* that involves the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals: (1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (2) set learning and improvement goals; (3) identify and perform appropriate learning activities; (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (5) incorporate formative evaluation feedback into daily practice; (6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (7) use information technology to optimize learning; and, (8) participate in the education of patients, families, students, residents and other health professionals. (9) participate in mortality and morbidity conferences that evaluate and analyze patient care outcomes, and (10) utilize an evidence-based approach to patient care

4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals. Surgical residents are expected to: (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (2) communicate effectively with physicians, other health professionals, and health related agencies; (3) work effectively as a member or leader of a health care team or other professional group; (4) act in a consultative role to other physicians and health professionals; and, (5) maintain comprehensive, timely, and legible medical records, if applicable. (6) counsel and educate patients and families; and (7) effectively document practice activities

5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. Surgical residents are expected to demonstrate: (1) compassion, integrity, and respect for others; (2) responsiveness to patient needs that supersedes self-interest; (3) respect for patient privacy and autonomy; (4) accountability to patients, society and the profession;(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (6) high standards of ethical behavior, and (7) a commitment to continuity of patient care

6. *Systems-based practice*, as manifested by actions that 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. Surgical residents are expected to: (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (2) coordinate patient care within the health care system relevant to their clinical specialty; (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;(4) advocate for quality patient care and optimal patient care systems; (5) work in interprofessional teams to enhance patient safety and improve patient care quality; (6) participate in identifying system errors and implementing potential systems solutions. (7) practice high quality, cost effective patient care; (8) demonstrate knowledge of risk-benefit analysis; and,(9) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

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 particular year as determined by the faculty and program director.

Inadequate performance should be clearly communicated, in writing, to the resident as early as possible.

If part of these requirements are not met, and the program director and faculty deem it appropriate, the resident may be placed on Academic remediation, probation, suspension, or the resident may be terminated from the program or not renewed in the program:

1. Academic Remediation

Academic Remediation is used to correct academic deficits, including, but not limited to, deficits in medical knowledge, time management, organizational abilities, communication skills, and procedural skills.

An academic remediation program will be developed by the program director, in concert with members of the faculty from the residency program. The remediation program will have the following components:

- a. Documentation of deficiencies. Except in extenuating circumstances, formal remediation should not be evoked for a one-time event. A pattern of deficiency should be documented in the resident's file.
- b. Formal and explicit presentation of the deficiency. The will be presented a written account of the deficiency.
- c. The remediation program will have a defined time-line, no less than 3, but not more than 12 months.
- d. The remediation program will have an a priori end-point(s) that will define the success or failure of the remediation effort. The remediation program's end-points must be achievable within the time-frame outlined in the program.
- e. The focus of the remediation effort will match the deficiency.
 - i. Medical Knowledge
 - ii. Time Management & Organization
 - iii. Clinical Reasoning
 - iv. Communication
 - v. Patient Interaction
 - vi. Attitude & Motivation
 - vii. Inter-personal and Team Skills
 - viii. Procedural Skills
- f. The program director will design the remediation and have the remediation plan reviewed by the DIO prior to confronting the resident.
- g. The remediation program will include 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 remediation program will be documented, with at least one min-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 Academic Remediation, the resident will be removed from this status. Documentation will remain part of the resident's permanent file, but will only be disclosed upon written authorization of the house officer or through legal process.

k. Upon failure to successfully complete the remediation, the resident will be asked to either repeat training, extend training, non-renewal or termination. The remediation may be extended for a period not to exceed six (6) months, at the program director's discretion. For all of these actions, the resident will be provided a copy of the grievance and fair hearing policy, and will sign acknowledgment of receipt of this document. See Grievance and Fair Hearing Policy.

2. Probation

a. Probation is a formal level of discipline in which the resident may still engage in training within the confines of the probationary plan. There are two types of probation: academic and professional.

i. Academic probation refers to probation in concert with Academic Remediation to correct academic deficits that include, but are not limited to, deficits in medical knowledge, time management/ organizational abilities, communication skills, patient interaction skills, attitude and motivation, interpersonal/team skills, and procedural skills. See **Academic Remediation**.

ii. professional probation:

(a) Professional probation may be used to monitor the on-going after-careplan

(b) Professional probation may also be used to ensure that egregious

unprofessional conduct does not occur.

b. The Office of Graduate Medical Education, in concert with the resident's program director, oversees all probations.

c. Failure to comply with the requirements of a probational agreement will result in immediate termination from the University. In such an instance, the resident will be provided a copy of the Grievance and Fair Hearing Policy, and be asked to sign an acknowledgement of receipt.

d. Probationary actions will not be reported to entities outside of Tulane

University unless the probation is unsuccessfully met.

3. Suspension-

- a. Suspension is a formal level of academic or professional discipline in which the resident may temporarily no longer engage in his or her training program.
- b. Residents who are suspended will receive pay and benefits unless designated by the DIO.
- c. Institutional suspensions can only be reversed by the DIO or the Dean.
- d. Because suspected impairment may put patient care at risk, a resident may not be cleared of a suspension until a favorable fitness for duty evaluation has been established.
- e. At the time of suspension, the resident will be provided a copy of the Grievance and Fair Hearing Policy, and be asked to sign an acknowledgement of receipt.

4. Termination or Nonrenewal of Appointment

Depending on the seriousness of ascertained deficiencies, a resident may be terminated from the program or the resident's agreement of appointment may not be renewed. Such actions may also be taken when it is determined that sufficient progress in curing deficiencies was not achieved as a result of participation in the Academic Remediation program.. In instances where a resident's agreement is not going to be renewed, the department will provide the resident(s) with a written notice of intent not to renew a resident's agreement no later than four months prior to the end of the resident's current agreement. However, if the primary reason(s) for the nonrenewal occurs within the four months prior to the end of the agreement, the department will provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement. Residents may implement the institution's Fair Hearing policy if they have received a written notice of intent to terminate or not to renew their agreements.



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

Subject: Satisfactory Completion of Residency

Date: 2/9/07

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, 2006-2007).

- 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) In order to receive credit for each of the first three years of general surgery residency, an individual must accrue 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.
- 3) In order to receive credit for each of the last two years of general surgery residency, an individual must accrue ninety-four (94) weeks of full-time surgical experience. For documented medical problems or maternity leave 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: Fair Hearing Process for Residents

Date: 8/15/06

Goal: To ensure residents' due process rights are met in adjudication of actions resulting in probation, termination/non-renewal or otherwise threatening the career of the resident.

Policy: The Grievance-Fair Hearing procedure is to be followed as below:

1. A resident may request a Grievance-Fair Hearing for any of the following administrative decisions: suspension, probation, termination, or non-renewal.
2. Contesting evaluations, letters of recommendation, documentation of performance, Academic Remediation are not grounds for a Grievance-Fair Hearing. While a decision to suspend can be grieved, a suspension cannot be grieved if the resident has agreed to participate in professional remediation. Because a suspicion of physician impairment may put patient care at risk, all residents who are undergoing Professional Remediation will be suspended until a fitness for duty evaluation has cleared the concern for being impaired.
3. A Grievance-Fair Hearing must be filed in writing within five business days of the decision being grieved, addressed to 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.
9. Neither the house officer nor the institution shall be represented by legal counsel at the proceeding. However, each may produce witnesses and documentation on their behalf.
10. At the conclusion of the Grievance-Fair Hearing, written findings and recommendations will be forwarded within ten (10) working days to the Dean of the School of Medicine who will make the final decision. At this time, the house officer or the department chair has the right to request a meeting with the Dean to review these issues. The Dean will render his final decision within ten (10) working days of receipt of the Fair Hearing written findings and recommendations
11. All proceedings and decisions of the Fair Hearing Board and the Dean of the School of Medicine shall be reported to the Graduate Medical Education Committee and the applicable program director in a confidential manner.

GRIEVANCE AND FAIR HEARING PROCEDURE. Unless otherwise specified, the following procedures are to be used in all 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 first meeting of the Fair Hearing Board will occur within 30 days of the Resident's written request for a Fair Hearing-Grievance, subject to the availability of all parties.
2. The Chair of the 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.

3. 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 Fair Hearing-Grievance. These items shall be delivered to the Chair of the Fair Hearing Board.
4. 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. If the Resident fails to appear, hearings will proceed in absentia.
5. 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 Fair Hearing-Grievance (which may include counsel) but the advisor may not participate in the proceedings except to advise the Resident or the Institution.
6. All persons shall be asked to affirm that their testimony is truthful. Furnishing false information to the University may result in formal charges.
7. Both the Resident and the Institution shall be offered the opportunity to present their witnesses and to question the other's witnesses.
8. Prospective witnesses shall be excluded from the Fair Hearing-Grievance during the testimony of other witnesses. All parties and witnesses shall be excluded during deliberations of the Fair Hearing Board.
9. 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.
10. Final decision of the Fair Hearing Board shall be by the majority vote of all members of the Board present and voting.
11. Written findings and recommendations of the Fair Hearing Board will be forwarded to the Dean of the Tulane School of Medicine within 10 working days of the Fair Hearing-Grievance. At this time, either the Resident or Department Chair has the right to request a meeting with the Dean to review these issues.
12. The Dean will render his final decision within ten (10) working days of receipt of the Fair Hearing written findings and recommendations or ten (10) working days after meeting with the parties.
13. All hearings of the Fair Hearing Board will be taped for use in deliberation by the Fair Hearing Board although the 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 Fair Hearing deliberations only.



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

Subject: **Adjudication of resident complaints**

Date: **5/20/09**

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 grievance review process but is adjudicated through the fair hearing process found in the department of surgery protocol for a fair hearing for residents and the policy for academic remediation and fair hearing found in the resident handbook. 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 grievance 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 grievance 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 Office of Human Resources. Upon receipt of the written grievance, the Office of Human Resources 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 Office of Human Resources determines that your grievance raises issues of discrimination, harassment or retaliation, it will be handled in accordance with the Harassment Policy

2. Step 2

If the Office of Human Resources 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 Office of Human Resources 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 Office of Human Resources within five (5) business days of the grievance review if circumstances so permit.

3. Step 3

The Office of Human Resources 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 Office of Human Resources 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 Office of Human Resources in writing of this determination. The Office of Human Resources will notify you and your department head in writing of the within five (5) business days of receipt so permit. The President's determination generally from the President if circumstances shall be final.



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

Subject: Residency Quality Assurance/Quality Improvement Program

Date: 4/3/07

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

- Policy:**
1. Residents/Chair Conference – At this monthly conference, the Chair 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. Resident Medical Education Committee - The Resident Medical Education 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 meeting with all faculty and residents. The Program Director will print out all faculty and rotation evaluation forms. Prior to the meeting, the Division of Surgical Education (Resident Section) will review faculty evaluations for content and provide summary data for both faculty and rotations. All information provided at the meeting will be anonymous as to the reviewer. During the Program evaluation a SWOT analysis of each rotation will be completed. 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. At each review, a summary of the previous review will be made at the beginning of the session. This will enable all faculty and residents to interpret progress within the surgery education program.
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: **7/13/06**

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: 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.

Faculty advisors will 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.

Faculty members will furnish a dictated report of their advisory meeting to the Program Director and Department Chair.

In addition to meeting with their assigned faculty advisor, each resident will be scheduled to meet with the Department Chair and Program director at least twice yearly in order 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: 5/20/09

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).

Policy: Scheduled Paid Leave (Vacation)

1. Length of Scheduled Paid Leave Benefit (vacation)
 - a. All residents are granted two (2) weeklong vacation blocks per academic year. Vacations may be taken only in one-week blocks (Monday - Sunday).
 - b. All residents are granted an assigned 7 day vacation between December 20th and January 5th each academic year.

2. Guidelines for Scheduled Paid Leave
 - a. Vacation cannot be scheduled for:
 - i. The month of July
 - ii. December 20th through January 5th, other than assigned
 - iii. The week preceding the January In-Training Service Exams (ABSITE)
 - iv. The last two weeks in June (except graduating residents)
 - b. Two residents cannot take vacation at the same time if they are on the same rotation.
 - c. A resident and an intern on the same service may not overlap vacation
 - d. Senior Residents have priority over junior residents, regarding requests.

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 must be submitted by July 30. After that time vacations will be assigned.

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 family illness or problems or bereavement as defined in the resident handbook.
 - b. Residents may use their seven days of allowable unscheduled paid leave for attending interviews.
- 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 leave will be leave with pay for a period of up to six weeks.

This time

represents vacation and sick leave. All or a portion of the six weeks may be requested.

- b. Paternity leave of up to one month will be granted to any father during the first month

after delivery or adoption of a child. Such leave should also be requested in as much

advance as possible. Paternity leave will be paid and should be made up of vacation and/or sick leave.

Length of Leave Without Extending Residency

1. The sum of all types of leave days (including scheduled (vacation), unscheduled (medical, bereavement), maternal/paternal, administrative or suspension) cannot exceed 28 days per resident year. Leave longer than 28 days will require extension of the residency training except as noted below.
2. 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: 5/28/08

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 will cover expenses for the lead resident author when the research leads to regional or national presentations. This includes oral, video or poster presentations.

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
 - 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



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

Subject: Resident Selection and Eligibility

Date: 2/9/09

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 a 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 of medical schools outside of the U.S. or Canada who meets **both** of the following qualifications:
 - a. Have received a currently valid J-1 Visa sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG), or be a US Citizen; **and**
 - b. Have a full and unrestricted license or a Graduate Education Temporary Permit (GETP) to practice medicine in the state of Louisiana, as issued by the Louisiana State Medical Board.
4. Be a graduate in good standing from a medical school outside the U.S. who has completed a Fifth Pathway program provided by an LCME-accredited medical school.

B. Resident Selection

1. Tulane University Graduate Medical Education Programs select 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. The School of Medicine 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 School of Medicine participates in the National Residency Matching Program (**NRMP**) in selecting residents for the following residency programs: Anesthesiology, Dermatology, General Surgery, Internal Medicine, Internal Medicine/Pediatrics, Internal Medicine/Psychiatry, Internal Medicine/Preventive Medicine, Neurology, Obstetrics/Gynecology, Orthopaedics, Otolaryngology, Pathology, Pediatrics, Pediatrics/Psychiatry, Psychiatry, Radiology, and Child and Adolescent Psychiatry.
3. Tulane University School of Medicine participates in the National Residency Matching Program (**NRMP**) in selecting residents for the following fellowships: Allergy/Immunology, Cardiology, Endocrinology Hematology/Oncology, Infectious Diseases, Nephrology, Pulmonary Critical Care Medicine, Pediatric Cardiology.
4. Specialty programs selecting residents from organized national matching programs other than NRMP:
 - a. Specialty/Subspecialty National Program: Neurosurgery NSMP, Ophthalmology OMP
 - b. Urology American Urology Assoc.

5. All programs must ensure that a sample copy of the resident's contract is available upon request to all applicants. All programs must make a sample contract available on their website.

C. Recruiting residents and fellows outside of the match

1. Program's that participate in an organized match are 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 a residency program at Tulane outside of the terms of that match process.
2. Program directors that wish to add additional residents to their program during the time of the year when the match is not in effect (i.e., off-cycle) must send a formal request to the DIO, including the information contained in II: Policy on Program Expansion
3. The DIO will review the proposal and present his or her recommendation to the GME Committee. If the GME Committee approves the increase, the request will be forwarded to the executive faculty and the Dean for final approval.

D. Recruitment of residents and fellows between training programs at Tulane.

1. When a position in a training program is, or becomes, vacant, the program may advertise the vacancy and its intent to fill the position after receiving approval from the DIO.
2. A resident who is interested, but who is currently under contract in another training program, may express interest as a candidate for the open position by inquiring about the open position.
3. The resident applicant must disclose to the recruiting program director any contractual obligation that currently exists to the original program. The resident must also disclose to his or her current program director the intention to pursue the open position,
4. The program director and faculty from the recruiting program must refrain from actively initiating, enticing or negotiating with the candidate until the resident's current program director has given approval for this communication,
5. A letter of intent to release the resident from his or her contractual obligation and a letter of recommendation outlining his or her performance with respect to each of the core competencies must be obtained from the current program director before a contract can be offered to the resident by the recruiting program.
6. The start date for the resident in the new program must be approved by the resident's current program director.
7. The DIO will serve as the mediator in any situation in which the two program directors cannot reach an amicable resolution to the resident wishing to switch programs..
8. Failure to abide by the above rules may result in a reduction in the program's match list for the following year.

E. Extension of Contracts

1. All residents who match to a GME position at Tulane 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 (See I.C-D) 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. A sample contract can be found in Appendix 3. With the exception of the start and finish date, the standard institutional GME contract cannot be modified without the express permission of the DIO.

- 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. Criteria for leaves of absence
 - i. Duty Hours
 - j. Moonlighting
 - k. Counseling services
 - l. Physician impairment policies
 - m. Harrassment policies
 - n. Accommodation for disabilities
 - o. Access to information related to eligibility for specialty board examinations
3. Each resident contract will require the signature of the resident, the respective program director, the departmental chair, and the DIO. Payroll will not authorize salary payment unless the DIO has approved the contract by signature.