



COLLEGE OF MEDICINE
DEPARTMENT OF SURGERY
POLICY MANUAL
2006 - 2007

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INTRODUCTION

This policy manual provides the basic guidelines necessary for you to function effectively during your post-graduate training program in the Department of Surgery at the University of South Florida, Health Sciences Center. You are responsible for reading and complying with the policies of the Department.

Policy, as outlined here, is directed to residents in the General Surgery Program. ***Specialty residents in training, within the Department of Surgery, may be subject to additional regulations in their respective Divisions.***

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DEPARTMENT OF SURGERY **HOUSE OFFICER RESPONSIBILITIES**

House officer responsibilities, while progressing through the General Surgery program, will include patient care and teaching. The house officer will be expected to participate in the teaching of medical students at the University of South Florida, Health Sciences Center, as well as nurses and paramedical personnel with whom s/he comes in contact.

Patient care is administered at the Tampa General Hospital, the James A. Haley Veterans' Hospital, the Veterans' Administration Medical Center Bay Pines, H. Lee Moffitt Cancer Center and All Children's Hospital. Progressive and increased responsibility for patient care is given to the house officer as s/he advances through the program under the direction of senior house staff and faculty.

The Division of General Surgery within the Department of Surgery at the University of South Florida, Health Sciences Center, has the primary responsibility for teaching the residents general principles and techniques of surgery.

Within the Department of Surgery there are residencies in Plastic Surgery and Vascular Surgery as well as fellowships in Hand Surgery, Surgical Oncology, Colorectal Surgery, Bariatric Surgery, Burn Surgery, Transplant and advanced GI surgery/Laparoscopy and Critical Care. The General Surgery residents work closely with Departmental faculty within the other Divisions and subspecialties including Vascular surgery, Surgical Oncology, Department of Interdisciplinary Oncology, Transplant surgery, Pediatric Surgery, Plastic Surgery, Thoracic/Cardiovascular Surgery, Otolaryngology, Neurosurgery, and Orthopedic Surgery.

The first two years are an opportunity to administer pre- and post-operative care and to develop basic surgical techniques. In addition to general surgery experience, the first and second year residents rotate through Plastic Surgery, Surgical Intensive Care, Surgical Oncology, Thoracic/Cardiovascular Surgery, Transplant, Trauma, Burns, and Vascular Surgery.

The third and fourth years include rotations in Pediatric Surgery, Surgical Oncology, Thoracic/Cardiovascular Surgery, Transplant Surgery, Trauma, Otolaryngology, and Vascular Surgery, as well as General Surgery experience. The fifth year allows the resident primary responsibility for the care of patients. As the resident progresses through the training program s/he becomes increasingly responsible for pre-, intra and post-operative decision making.

The goals of the residency program at the University of South Florida are to produce a well-rounded competent general surgeon, fully trained in the principles and techniques required of a general surgeon. Certification by the American Board of Surgery is expected.

The Department of Surgery Chairman's Office is always available to assist you with your questions and problems. Please feel free to contact Dr. Cynthia Karsonovich or Wendy McCrorey for direction.

DEPARTMENT OF SURGERY FACULTY

GENERAL SURGERY

Alexander S. Rosemurgy, II, M.D., Director

Michael H. Albrink, M.D.
Sarah M. Cowgill, M.D.
John Cromwell, M.D.
Rodney M. Durham, M.D., Ph.D.
Peter J. Fabri, M.D.
Lewis M. Flint, M.D.
Scott F. Gallagher, M.D.
Steven B. Goldin, M.D., Ph.D.
John T. Goodgame, M.D.
Richard Harmel, M.D. (Pediatric Surgery-ACH)
Andre Hebra, MD (Pediatric Surgery-ACH)
Colleen Jaffray, MD
Cynthia Karsonovich, M.D.
Gail Kay, M.D. (Pediatric Surgery-ACH)
Jose Lopez, M.D.
Jorge E. Marcet, M.D.
A. Scott McGuirt, M.D.
Christopher Murphy, M.D.
Michel M. Murr, M.D.
Charles N. Paidas, M.D. (Pediatric Surgery)
G. Michael Perez, M.D.
Steven S. Rakita, M.D.
David H. Shapiro, M.D.
Terry E. Wright, M.D.
Emmanuel E. Zervos, M.D.

ORTHOPEDIC SURGERY

Robert J. Belsole, M.D., Director

Joshua M. Bernard, D.P.M.
Paul Beyer, D.P.M.
Karen S. Duane, M.D.
Blaine Markee, M.D.
Heidi Multhopp-Stephens, M.D.

PLASTIC SURGERY

David Smith M.D., Director

C. Wayne Cruse, M.D.
Richard Klein, M.D.
Wyatt G. Payne, M.D.
Gerard Mosiello, M.D., D.D.S.
Martin C. Robson, M.D.
Paul Smith, MD

SURGICAL ONCOLOGY

Vernon K. Sondak, M.D., Director

W. Bradford Carter, M.D.
Charles E. Cox, M.D.
Sophie Dessureault, M.D.
Susan C. Hoover, M.D.
Richard C. Karl, M.D.
Scott T. Kelley, M.D.
Christine C. Laronga, M.D.
G. Douglas Letson, M.D.
Mokenge Malafa, M.D.
David Shibata, M.D.
Christopher Windham, M.D.
Timothy J. Yeatman, M.D.

THORACIC/CARDIOVASCULAR SURGERY

Arthur Larson, MD
Dimitri S. Novitzky, M.D.
James Obney, M.D.
Reginald Peniston, M.D.
K. Eric Sommers, M.D.

VASCULAR SURGERY

Dennis F. Bandyk, M.D., Director

Paul A. Armstrong, D.O.
Martin R. Back, M.D.
Brad L. Johnson, M.D.
Murray Shames, MD

ADMINISTRATIVE FACULTY

Richard C. Karl, M.D., Chairman
Charles N. Paidas, M.D., Program Director
Joseph Smith, Chief Administrator
Cynthia Karsonovich, M.D., Associate Program Director
Steven B. Goldin, M.D. Ph.D., Surgery Clerkship Director
Lewis M. Flint, M.D., Surgical Education Consultant

DEPARTMENT OF SURGERY
HOUSE STAFF
2006-2007

PGY- 5 (Chiefs)

Aguirre, Alfonso
Barrios Martin
Rasheid, Sowsan
Norcross, Laurie
Shafii, Alexis

PGY-5 Plastic Surgery

Ghurani, Rami
Lee, Kenneth

PGY-4

Hodgett, Steven
Keeling, Brent
Mizrahi, Ben
Osborne, Dana
Schuetz, Christian
Watson, Leann

PGY4 (Research)

Hackmann, Amy
Larson, Shawn
Sanchez, Julian
Vohra, Nasreen

PGY-4 Plastic Surgery

Aponte, Rick
Durkin, Alan
Salama, Moises

PGY-3

Kaafarani, Haytham
Mullins, Richard
Panetta, Nicholas
Pearson, Heidi
Rideout, Drew
Sontchi, Richard

PGY-2

Aston, Jason
Bogle, Kent (GS-P)
Bradner, Michael
Golkar, Farhaad
Hernandez, Jonathan
Krieger, Beth
Lopez, Jorge (GS-P)
Sanchez, Jaime

PGY-2 Plastic Surgery

Pappas, Effie
Tavana, Lance
Temmen, Traci

PGY-1

Davis, Donald
Hartney, Mark (GS-P)
Santiago, Luis
Shafii, Susan
Tummel, Evan
Vazquez, Daniel (GS-P)
Wilson, Stephen
Wilson, Misti

PGY-1 Prelim

Lau, Tsz (NS)
Le, Tien (NS)
Lee, Carlos (Oto)
Meredith, James (Oto)
Rodriguez, Alejandro (Urol)
Wiegand, Luke (Urol)

PGY-1 Plastic Surgery

Harrington, Michael
Khan, Farah
Prince, Melanie

OTO (*Otolaryngology*) NS (*Neurosurgery*) URO (*Urology*) GS-P (*Preliminary*)

DEPARTMENT OF SURGERY SUB-SPECIALTY RESIDENTS AND FELLOWS
2006-2007

BARIATRIC SURGERY FELLOWS

Kuruba, Rajesh
Martinez, Ferdinand

BURN SURGERY FELLOW

Aya-Ay, Melanie

CRITICAL CARE RESIDENT

Kapoor, Samir

GASTROINTESTINAL SURGERY FELLOWS

Ross, Sharona – Advanced GI and Minimally Invasive Surgery
Khera, Samira – Colorectal Surgery

SURGICAL ONCOLOGY FELLOWS

PGY-7

Lewis, James
McLoughlin, James
Nair, Rajesh

PGY-6

Melis, Marcovalerio
Meredith, Kenneth
Moller, Mecker
Sarnaik, Amod

BREAST SURGERY FELLOW

Kiluk, John

TRANSPLANT FELLOW

Pruchnic, Timothy

VASCULAR SURGERY RESIDENTS

PGY-7

Brumberg, Robert

PGY-6

Chauvapun, Joe

TAMPA GENERAL HOSPITAL
2006-2007

ALEXANDER S. ROSEMURGY, II, M.D.
CHIEF, GENERAL SURGERY SECTION
Tampa General Hospital
(813) 844-7393

Office of Clinical Affairs/TGH House Staff Coordinator
Elaine Adams - 844-7412

GENERAL SURGERY

DEFINITION OF SERVICES

TGH-BLUE (PGY-2)

Bariatric and endocrine surgery. This service covers Drs. Murr and Gallagher.

TGH-GREEN (PGY5, PGY-1)

Colorectal surgery. This service is staffed by Drs. Marcet and Cromwell.

TGH-GOLD A (PGY-5, PGY-3, PGY-1 x 2) and **GOLD B** (PGY-5, PGY-4, PGY-1)

Elective General Surgery, Advanced laparoscopy, pancreaticobiliary, esophageal surgery. This service will include admissions and consults to Drs. Rosemurgy, Albrink, Goldin and Zervos.

TGH- Pediatric Surgery (PGY-3)

Pediatric surgery at TGH under the direction of Dr. Paidas.

TGH-TRAUMA (PGY-5, PGY-4 x 2, PGY-2 x 3, PGY-1 x 2).

The responsibilities of this service will include all admissions via the emergency room. The attending on the TGH ER General Surgery call schedule will admit patients presenting to the ER on his/her call day, to this service. This service will also care for the Hillsborough County Clinic patients and in-house consults for Drs. Durham, Flint and Shapiro.

TGH-Transplant (Transplant Fellow, PGY-3, PGY-1)

This service will cover all transplant cases at TGH. It will also cover Drs. Alsina, Bowers, Bruce, Leone and Mayes.

TAMPA GENERAL HOSPITAL
GENERAL SURGERY

DEFINITION OF SERVICES (continued)

TGH-BURN SURGERY (PGY-1, Fellow)

The first year resident on the Burn Surgery rotation is responsible for the supervision of the Burn Unit patients admitted to Drs. Cruse, David Smith, and Paul Smith.

TGH VASCULAR (PGY-3, PGY-1, PGY-6-Fellow)

This service will manage vascular patients. Attendings on this service are Drs. Bandyk, Back, Johnson and Shames.

TGH ENT (PGY-4)

Residents on this service will participate in the workup, care and surgery of patients with head and neck disease. They will attend clinic and cover patients with Dr. Douglas Klotch. This resident will also take senior resident in-house call with the vascular service.

JAMES A. HALEY VETERANS' HOSPITAL
2006-2007

REGINALD PENISTON, M.D.
CHIEF, SURGICAL SERVICE

Room D260

Phone 972-2000 x6513

VAH House Staff Coordinator – Nannette Decker
Phone 972-2000 x 1727

GENERAL SURGERY

DEFINITION OF SERVICES

VA1 (General Surgery) (PGY-5, PGY-3, PGY-1)

Residents on this service participate in all aspects of general surgery in addition to surgical endoscopy. The attending physicians on this service are Drs. Karsonovich, Lopez, Fabri, Murphy, Perez and Rakita.

VAII (Vascular Surgery) (PGY-5, PGY-1)

Patient population consists of vascular surgery patients. The attending physicians on this service are Drs. Back, Bandyk, Johnson, Shames and Armstrong.

VA-SICU/TPN (Surgical Intensive Care Unit) (PGY-2)

This service is a part of general surgery which emphasizes pre-op and post-op management of critically ill surgical patients as well as specialized nutrition support. Skills learned include use of Swan-Ganz catheters, management of ventilators, use of hemodynamic monitoring and inotropic medications. This service is under the direction of Dr. Fabri and Dr. John Brown.

VAC (Chest Service) (PGY-2)

This service consists of patients with cardiac and pulmonary, diseases at the VA Hospital. The size of this service and the intensity with the veterans patients will allow the residents to become proficient in brochoscopy, mediastinoscopy, implantation of pacemakers, plus the pre-, intra-, and post-operative handling of cardiac and, pulmonary disease with a moderately large volume of patients. The attending physicians are Drs. Larson, Novitzky, Peniston and Sommers.

VA NIGHT FLOAT (PGY-2, PGY-1)

Residents on this service will function to provide 'call coverage' for the VAI, VAIL, VAChest, and the surgical subspecialty services (Plastic surgery, Orthopedics, Gynecology, Neurosurgery, Urology) on Monday through Thursday evenings from 6:00 pm to 6:00 am. and all day Sunday. Additionally, the PGY-2 will perform endoscopies with the VAI surgery service on Wednesdays.

2006-2007

TERRY E. WRIGHT, M.D.
CHIEF, SURGICAL SERVICE

Room 2D158
(727) 398-9386

GENERAL SURGERY

DEFINITION OF SERVICES

BPVA (PGY-3 or 4)

The Surgery rotation at the VA Medical Center Bay Pines includes general surgery, thoracic, gynecology, and vascular surgery. Graded responsibility is provided commensurate with experience. Attendings include Drs. Goodgame, Jaffray, McGuirt and Wright.

ALL CHILDREN'S HOSPITAL
2006-2007

RICHARD HARMEL, M.D.
CHAIRMAN, DEPARTMENT OF SURGERY

SUITE 210

PHONE: (727) 892-4170

GENERAL SURGERY

The PGY-2 resident rotating at All Children's Hospital will be a fully integrated member of the house staff at All Children's Hospital where s/he will participate with Dr. Richard Harmel, Dr. Gail Kay and Dr. Andre Hebra in the management of pediatric surgical cases.

The resident functions under the guidance of the attendings and performs a large number of operations on this rotation.

H. LEE MOFFITT CANCER CENTER
AND RESEARCH INSTITUTE
2006-2007

VERNON K. SONDAK, M.D.
DIRECTOR, DIVISION OF SURGICAL ONCOLOGY

(813) 972-8482

Surgical Oncology House Staff Coordinator - Jackie Campbell (813) 745-3131

SURGICAL ONCOLOGY

(PGY-6, PGY-4, PGY-3, PGY-2 x 2, PGY-1)

The H. Lee Moffitt Cancer Center and Research Institute has been established for, and dedicated to, specific care of cancer patients. It is the intent and desire of those who work at this institution to provide the optimum of care for the cancer patient. Upon arrival at the H. Lee Moffitt Cancer Center you will undergo an orientation program specifically designed to give you information regarding the specialized care of cancer patients. This orientation will also aid you in your role as a surgical resident in the care and management of these patients.

During your tenure at the H. Lee Moffitt Cancer Center your meals will be provided for you on call nights. Adequate call room facilities are available for your use. Surgical scrub attire should be worn only in the operating room. Only during extreme circumstances will they be worn outside the operating room.

Individual residents will be assigned to and primarily responsible for covering the GI, Breast, Melanoma or Thoracic surgery services.

Attendings: Drs. Karl, Carter, Cox, Dessureault, Hoover, Kelley, Laronga, Malafa, Marcet, Shibata, Sommers, Sondak, and Yeatman.

DEPARTMENT OF SURGERY

PROFESSIONAL RELATIONS

“What a Good Physician Owes to Other People”

“Dignity for Everyone”

“Communications to Enhance Care”

PATIENT CARE

- The team (staff physician, chief resident, house officer, nurse, and student) is responsible for each patient's care. Quality care for the individual patient is the ultimate goal of each physician team member.
- The junior house officer has the PRIMARY responsibility for patient care. S/he should evaluate the patient, write the necessary orders, perform the primary patient care procedures, and act as the primary physician with respect to the patient and his family. S/he dictates the discharge summary on each patient.
- The senior house officer is not simply a stand-by consultant, but an active participant in the patient's care. S/he conducts rounds and examines the patient everyday with the junior house officer. S/he does not dictate therapy, but does advise of alternate possible explanations, direction of evaluation, or treatments. S/he also writes an admission note. S/he selects applicable articles from the surgical literature to enhance the education of her/his team and augment patient care. All consultations will be directed to the senior house officer, and s/he will see consultations and make appropriate disposition.
- The staff physician is ultimately responsible for every aspect of patient care. S/he is also actively engaged in patient care and rounds on all patients. S/he is responsible for providing her/his guidance and experience in all facets of the patient's care. S/he will round at designated times Monday through Friday and be available on call for other problems. Each patient will be staffed, as soon as possible, after admission.

HOUSE STAFF RELATIONS WITH THE STUDENT (CLINICAL CLERK):

All house officers will be expected to participate in the education of medical students. This includes:

- Teaching them the requisite patient care procedures.
- Instructing them in the development of logical approaches to clinical problems.
- Encouraging their reading in General Surgery texts and providing them with selected review articles on topics concerning their patients.
- Instructing and assisting the students in development of good patient care and treatment. Ensuring that the students attend all necessary conferences.
- Reviewing each of their “work-ups” and providing constructive criticism.
- Treating the medical students in a professional and courteous manner.

SURGICAL EDUCATION

Overall Educational Goals for USF Department of Surgery

The goal of the University of South Florida surgical residency program is to prepare each resident to function as a qualified practitioner of surgery at the high level of performance expected of a board-certified specialist in general surgery.

PGY 1

1. Care of surgical patient on the ward; including preoperative evaluation, writing preoperative and postoperative orders, postoperative care. Assessment: faculty evaluations, ABSITE
2. Basic pathophysiology of surgical disease. Assessment: ABSITE
3. ACLS and ATLS certification Assessment: Course test
4. Basic procedures: start IV, placement of central lines, swan ganz catheters, chest tubes
Assessment: Supervision/log book
5. Surgery: basic techniques, sterile technique, surgeon in simple procedures, excision subcutaneous lesions, breast biopsies, hernia repair. First assist on larger procedures. Assessment: Observation in OR, Faculty evaluation, animal labs.
6. Communicate as a professional with patients, hospital staff, students, fellow residents and attending staff. Assessment: 360 degree evaluation via web based evaluation program including review of core competencies
7. Begin developing adult learning skills. Assessment: Faculty and advisor evaluations

PGY 2

1. Care of more complex or severely ill patients including critical care, trauma and burns. Assessment: faculty evaluations
2. Expand basic surgical knowledge and learn to apply it during evaluation and care of patients with more complex surgical problems. Gain understanding of surgical specialties while caring for multiply injured patients. Assessment: faculty evaluations, ABSITE
3. More advanced procedures: swan ganz, bronchoscopy, and tracheostomies. Assessment: Supervision/log book
4. Surgery: be able to perform more advanced procedures under supervision and first assist on more complex surgical procedures. Focused exposure to breast surgery. Assessment: Observation in OR, Faculty evaluation.
5. Communicate more effectively with patient care team, begin to assume leadership position within the team, show foresight and planning in regards to patient care, concise and effective presentation. Assessment: 360 degree evaluation via web based evaluation program including review of core competencies
6. Further improvement of adult learning skills

PGY 3

- 1 "Leader/supervisor" on a smaller surgical team with close attending supervision. Assessment: faculty evaluations
2. "Mid-level/sub leader" on larger surgical teams with supervision and input from more senior residents and attendings. Coordinate patient care to include appropriate evaluation and treatment by other health care professionals and consultants Focused exposure to pediatric and cardiothoracic surgery. Assessment: faculty evaluations
3. Mastery of basic surgical pathophysiology and patient care (ward and ICU), basic understanding of surgical alternatives. Assessment: faculty evaluations, ABSITE

4. Procedure: teach and supervise basic procedures including line placement, chest tubes
5. Surgery: teach and supervise junior residents in the performance of basic surgeries including excision of subcutaneous masses, breast biopsies, hernia repairs. Perform as surgeon on more complex surgical procedures. Focused exposure to cardiothoracic and vascular surgery. Assessment: Observation in OR, Faculty evaluation, feedback from junior residents
6. Develop teaching and supervision skills. Assessment: Faculty evaluation, feedback from junior residents and students
7. Improve communication with patient care team and function more effectively as team leader. Communicate effectively with other health care professionals. Begin to address issues of problem solving and dispute resolution. Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management. Assessment: 360 degree evaluation via web based evaluation program including review of core competencies
8. Improve mastery of adult learning skills

PGY 4

1. Function in the role of senior resident with its associated increase in responsibility in an affiliated hospital. Assessment: faculty and 360 degree evaluations
2. Assume leadership of larger surgical teams and supervise care of surgical patients at various levels of acuity with input from surgical attendings, consultants and other health care professionals. Assessment: faculty evaluation
3. Master common surgical procedures. Assessment: Observation in OR, Faculty evaluation
4. Surgery: teach and supervise some more advanced surgeries. Assessment: Observation in OR, Faculty evaluation, feedback from junior residents
5. Mastery of general surgical knowledge. Assessment: faculty evaluations, ABSITE
6. Advanced understanding of subspecialties including surgical oncology, transplant, and head and neck surgery. Assessment: faculty evaluations, ABSITE
7. Further develop skills in problem solving and dispute resolution. Assessment: 360 degree evaluation via web based evaluation program including review of core competencies
8. Continue to improve the mastery of adult learning skills

PGY-5

1. Provide clinical and administrative leadership of residents and students assigned to the surgical services of the affiliated hospitals. Assessment: faculty and 360 degree evaluations
2. Begin to function as a responsible surgeon under appropriate supervision. Assessment: faculty evaluations
3. Master surgical skills. . Assessment: Observation in OR, Faculty evaluation, ABSITE
4. Provide oversight of all aspects of pre, peri and postoperative care. Coordinate evaluation, input, and care from consultants and other health care professionals. Assessment: faculty evaluations
5. Achieve the full competence (knowledge, skills, attitudes) of a board eligible general surgeon

ACGME Six Competencies

General Competencies

Residents must become competent in the following six areas at the level expected of a surgical practitioner. Training programs must define the specific knowledge, skills, and attitudes required and provide the educational experience for residents to demonstrate:

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

2) Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Surgical residents are expected to:
a) critically evaluate and demonstrate knowledge of pertinent scientific information.

3) Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Surgical residents are expected to:
a) critique personal practice outcomes.
b) demonstrate a recognition of the importance of lifelong learning in surgical practice.

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

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

6) Systems-Based Practice as manifested by actions that demonstrate an awareness of and response to the larger context and system of health care and effectively call on system resources to provide optimal care. Surgical residents are expected to:
practice high quality, cost effective patient care.
demonstrate a knowledge of risk-benefit analysis.
demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

SERVICE SPECIFIC EDUCATIONAL GUIDELINES

Trauma

PGY 1

1. ATLS certification
2. Insert a variety of tubes: endotracheal, thoracostomy, intravenous, intra-arterial
3. Define the categories of shock based upon type, and explain the etiology and pathophysiology of each type of shock: cardiogenic, hypovolemic, septic, tamponade, tension pneumothorax
4. Care for trauma patients on the ward and formulate their rehabilitation plans
5. Communicate effectively with consultants, ancillary staff, patients and family

PGY 2/3

1. Direct the evaluation of an acutely-injured patient to include resuscitation and decision for diagnostic procedures such as CT scan and operation.
2. Evaluate diagnose and with the appropriate consultants direct and oversee management of urologic, orthopedic and neurosurgical injuries.
3. Perform emergency diagnostic and therapeutic procedures such as: peritoneal lavage, chest tube insertion, and pericardiocentesis
4. Outline the indications for such basic surgical procedures as: laparotomy, thoracotomy, hemorrhage control, debridement of injured tissue, support musculoskeletal injuries
5. Establish the emergency airways including cricothyroidotomy
6. Non operative management the following situations: multiple trauma, multiple organ system failure, hypovolemic shock, renal failure, ARDS and liver failure.
7. Place and manage invasive monitoring catheters, interpret the data obtained, and manipulate the hemodynamic variables toward calculated goals.
8. Initiate and maintaining appropriate ventilatory support
9. Perform bronchoscopy
10. Perform nutritional assessment and provide adequate caloric support

PGY 4/5

1. Perform triage of several sets of multiply-traumatized patients (single victims) requiring in-hospital resuscitation or operative intervention
2. Perform resuscitative thoracotomies as necessary
3. Treat traumatized patients and perform needed operative repair.
4. Demonstrate the ability to perform as senior trauma leader in coordinating the patient's care, delegating duties to junior team members, and conferring with subspecialty consultants as needed
5. Function as the multi-specialty team leader by coordinating timing and sequencing of operative interventions of the chest, abdomen, head, urologic and orthopedic considerations
6. Manage penetrating wounds through understanding the injury potential of wounding mechanisms
7. Perform all operative and management procedures for trauma to the chest, abdomen, extremities, and head with direct supervision
8. Direct all surgical management of patients in the ICU, including taking direct responsibility for admission and discharge.

General Surgery (Services: TGH Gold A, TGH Gold B, TGH Blue, TGH Green, James A. Haley VA-1 and Bay Pines VA)

PGY 1

1. Specify characteristics of the history, physical examination findings, and mechanism of visceral and somatic pain for the following processes: acute appendicitis, perforated ulcer, diffuse peritonitis, bowel obstruction
2. Illustrate use of the following diagnostic studies in the work-up of the above process: blood chemistries (white blood count, hematocrit), urinalysis, plain x-rays, ultrasound CT scan
3. Describe the anatomy, clinical presentation, and complications of non-operative management for these hernias: direct, indirect, inguinal, and femoral, ventral, umbilical and differentiate between incarceration and strangulation
4. Perform, record, and report complete patient evaluation and assessment
5. Evaluate and diagnose the acute abdomen
6. Assist with hernia repairs in the groin or umbilical regions, demonstrating a basic understanding of the anatomy and surgical repair
7. Interpret the following in coordination with attending radiologists and staff: Acute abdominal series (identify free air, small bowel obstruction, ileus, colonic pseudo-obstruction, volvulus; the presence of ascites, atelectasis vs. pneumonia), Upper GI series, Barium enema (identify neoplasms, signs of ischemia), Abdominal ultrasound and CT scans
8. Evaluate and institute management of abdominal wound problems, including infection, evisceration, dehiscence
9. Coordinate pre- and post-operative care for the patient with the acute abdomen
10. Perform less complicated surgical procedures such as: gastrostomy, appendectomy, hemorrhoidectomy, incision and drainage of perirectal abscess
11. Accept responsibility for (under the guidance of the chief resident and attending surgeon) the post-operative management of: nasogastric tubes, intra-abdominal drains, abdominal incisions, Foley catheters, IV catheters and fluid
12. Evaluate and manage nutritional needs (enteral and parenteral) of surgical patients until normal GI function returns
13. Outline the pathophysiology, evaluation, and management of the following: symptomatic gallstones, acute cholecystitis, gallstone pancreatitis, cholangitis, acalculous, cholecystitis and gallstone ileus
14. Understand the pathophysiology and management of common endocrine disease such as hyperparathyroidism, thyroid masses, and adrenal gland tumors

PGY2/3

1. Open and close abdominal incisions of all varieties
2. Serve as assistant to the primary surgeon during operations of the esophagus, stomach, small intestine, colon, and anorectum
3. Provide follow-up care to the surgical patient in the outpatient clinic or surgical office
4. Perform initial consultation for inpatients with problems of the GI tract; develop differential diagnosis and initiate treatment plan
5. Perform, under appropriate supervision, GI operations, including: small bowel resection with anastomosis, lysis of adhesions, repair of enterotomies, colon resection, drainage of intra-abdominal abscess

6. Develop diagnostic and therapeutic endoscopy skills such as: diagnostic esophagogastroduodenoscopy, percutaneous endoscopic gastrostomy, diagnostic colonoscopy, flexible sigmoidoscopy, rigid proctosigmoidoscopy
7. Coordinate intervention of multiple specialties that may be involved in management of complex GI problems such as: variceal hemorrhage, biliary obstruction, inflammatory bowel disease, localized and advanced malignancies
8. Manage nonoperative care of patients with pancreatitis and learn indications for operative management of pancreatitis, timing of surgery in patients with gallstone pancreatitis, Ranson's criteria for assessing pancreatitis and its correlation with prognosis
9. Basic Laparoscopic Skills: discuss techniques for gaining access to the abdomen, including Veress needle, open (Hassan cannula), first assist during laparoscopic cholecystectomy
10. Assist in operations on the thyroid, parathyroid and adrenal glands, both open and laparoscopic

PGY4/5

1. Serve as an effective surgical team leader
2. Perform laparotomy for acute abdomen, demonstrating a systematic approach for determination of the etiology of the process and appropriate measures for its management (e.g., acute appendicitis, small bowel obstruction, perforated peptic ulcer)
3. Demonstrate knowledge and outline appropriate work-up for disorders of the esophagus, stomach, small intestine, colon, and anorectum, and serve as surgeon during operative interventions of these GI disorders
4. Coach a junior resident through the repair of simple hernia (indirect inguinal or umbilical) and basic laparotomy
5. Explain the pathophysiology of carcinoma of the pancreas to include: typical history and presentation, diagnostic evaluation (CT, ERCP, PTC, MRCP, laparoscopy, laparotomy), indications for operative versus nonoperative biliary drainage and stenting, surgical resection
6. Management of esophageal varices: Sengstaken-Blakemore tube, sclerotherapy, transjugular intrahepatic portosystemic shunts (TIPS), surgical shunts
7. Coordinate overall care of patients with hepatobiliary disease including: initial evaluation, appropriate diagnostic studies, indicated consultations, operative management
8. Summarize intra-abdominal laparoscopic procedures currently being performed, including: cholecystectomy, hernia repairs, anti-reflux procedures, adrenalectomy, splenectomy
9. Manage patients with primary and revisional bariatric procedures and common complications including leaks, DVT/PE, strictures, bleeding and respiratory failure
10. Understand the role of interdisciplinary team management of bariatric patients and interact with specialists from different disciplines
11. Formulate and communicate diagnostic and treatment plans with team members and patients alike

Minimally Invasive Surgery (TGH Gold A & B /Blue/Green, JAHVA and Bay Pines VA Surgery Services)

Understand Laparoscopic Surgery

1. General concepts – ports, pneumo- peritoneum, scopes, magnification; general limitations, general indicators, general techniques, general risks
2. Understand commonly undertaken minimally invasive surgery techniques especially pertinent to the Gold Service. Understand the diseases/disorders being treated: achalasia, gastroesophageal reflux, bariatric surgery, cholecystitis. To a lesser extent: splenectomy (ITP), adrenalectomy (adenoma), colectomy (polyps) and hepatic cysts.
3. Understand preoperative concerns unique to minimally invasive (laparoscopic) surgery: cardiac, pulmonary, previous operations
4. Understand postoperative concerns, especially unique to laparoscopic surgery: pulmonary, cardiac, pain, potential complications, especially related to, pneumo-peritoneum insufflation, and specific operations

PGY 1/2

Focus educational efforts on above, plus better understanding of general concepts of laparoscopy and disorders/diseases being treated

PGY 3, 4, 5

Above, plus emphasis on operative techniques

METHODS THROUGH WHICH GOALS AND OBJECTIVES WILL BE MET:

1. Clinics – residents at all levels attend clinic and see patients and participate in evaluation, preoperative work-up, postoperative follow-up, counseling, and care
2. Rounds – All residents round on patients with attendings on a regular basis, though often informally and at unscheduled times. Additionally, at 5:00 PM Monday each week, all residents, medical students, and attendings round together on all patients. Thorough descriptions and discussions of pathophysiology occur. Discussions of care, operations, and complications, if any, are undertaken. Rounds last, generally 2½ hours.
3. Conferences – GI/Surgery/X-ray Conference once per week at 4:00 PM Tuesday, all surgeons meet with members of the Division of Digestive Diseases and Nutrition, Internal Medicine, and members of the Department of Radiology. X-rays and patient care are reviewed with emphasis on diagnosis and treatments, especially nonoperative care. Tumor Board once monthly at 7:00 AM 2nd Thursday, attendings, residents, and medical students on Gold Surgery meet with interventional radiologists, other surgeons from other services, and medical oncologists. This conference focuses on nonoperative diagnosis and care of a host of disorders/diseases, especially involving the liver and biliary tree. General Surgery Journal Club, once per quarter, 6:30 PM Thursday, residents, faculty, fellows, research staff, midlevel providers, and medical students review and critically analyze 4 current peer-reviewed research articles. Service-specific conferences also available contribute to the residents' and fellows' education, including: Gold Service Teaching Time Mondays 5:00 PM, Obesity Team Thursdays 8:00 AM, Colorectal Journal Club 3rd Thursdays 6:30 PM, Research Conference Fridays 7:00 AM, Colorectal Conference Fridays 7:00 AM, and Trauma Conference Fridays 7:30 AM (except 5th Fridays).
4. Additionally, all members of the Blue Surgery Service must attend a clinical/research interdisciplinary conference: Thursday 8-11am.
5. JAH VA-1 Service: All resident will attend weekly preoperative conference to review following weeks cases on Fridays at 11am. They will attend multidisciplinary tumor board on 1st and 3rd Tuesdays of the month at 3:30 pm.

VA Night Float

PGY1

1. Communicate effectively with primary care team; give thorough, accurate and appropriate sign outs and transfer of patient care at the beginning and end of shifts.
2. Call for 'help and guidance' from upper levels when unable to evaluate and treat patients or their problems effectively on your own.
3. Perform appropriate admission history and physical exams.
4. Perform appropriate preoperative workup including obtaining informed consent.
5. Recognize when patients are 'critically ill' and require transfer to ICU.
6. Evaluate 'ABC's', appropriateness of airway and identify patients who require endotracheal intubation.
7. Evaluate and treat hemodynamically unstable patient and work through differential diagnosis including hypovolemia, sepsis, myocardial infarction, pulmonary embolus, deep venous thrombosis.
8. Evaluate, work up and treat the oliguric/anuric patient.
9. Evaluate, work up and initiate treatment of the patient with a postoperative fever.
10. Evaluate and work up patient with altered mental status.
11. Insert a variety of tubes: intravenous, nasogastric, foley.
12. Communicate effectively with consultants, ancillary staff, patients and family

PGY2

1. Communicate effectively with primary care team; give thorough, accurate and appropriate sign outs and transfer of patient care at the beginning and end of shifts.
2. Call for 'help and guidance' from upper levels and primary team when unable to evaluate and treat patients or their problems effectively on your own.
3. Function as night float 'team leader'. Communicate plan to junior members of night float team. Provide oversight and supervision of night float intern.
4. Recognize when patients are 'critically ill' and require transfer to ICU
5. Manage ICU patients effectively and appropriately.
6. Insert and appropriately interpret and use data from arterial lines, central lines and swan ganz catheters.
7. Identify patients in need of mechanical ventilation and manage ventilator appropriately.

Pediatric Surgery (TGH)

PGY1/2

OBJECTIVES

GOALS

Patient care

- Become proficient in the perioperative care of children and general supportive care of the newborn (ie.thermoregulation, fluids)
- Recognize common complications following operative procedures related to children
- Learn to assess the multiply injured child
- Learn basic nutritional support including the IV and oral routes.
- Become proficient and teach common bedside procedures like chest tube thoracostomy and IV insertion
- Attend outpatient clinic to understand decisions and patient selection for surgery

Medical Knowledge

- Develop an understanding of the natural history of common diseases of childhood, including those of thorax and abdomen.
- Understand the anatomy and physiology of fetus and how it affects perinatal surgical decision making.
- Understand the basics and indications for operative procedures, and be able to assist and perform such procedures (abdominal wall hernias, pyloromyotomy, laparoscopic cholecystectomy)

Practice-based learning and improvement

- Serve as instructor and supervisor of medical students
- Maintain daily resident work hour log and abide by ACGME rules of work hours
- Maintain log of operative and invasive procedures

Interpersonal and communication skills

- Develop and maintain skills required to work effectively as a team with patients, nursing staff, fellow residents and attendings
- Have ethically sound relationships with children and their families
- Be an advocate for children
- Develop effective listening, writing and presentation skills

Professionalism

- Shares responsibilities and accountability of patient care with other team members
- Recognizes, diffuses, and mediates conflicts
- Contributes and supports team decisions and goals
- Maintain excellence in respect, compassion, integrity, and ethical principles

System-based practice

- Understand and demonstrate cost effective health care for children
- Follow the critical care pathways of postoperative care after common pediatric surgical procedures

PGY3/4

OBJECTIVES

GOALS

1. Patient care

- Become proficient in the management of the critically ill or injured child and formulate a patient management plan.
- Develop skills necessary for perioperative care of children following thoracic and abdominal procedures.

- Recognize and treat common complications following pediatric surgical procedures.
- Learn techniques for management of the critically ill newborn and premature infant.
- Attend outpatient clinic to understand decisions and patient selection for pediatric surgery, especially the workup of childhood tumors.

2. Medical Knowledge

- Strengthen the understanding and natural history of common diseases of childhood.
- Understand the anatomy and physiology of the fetal and childhood pathologies.
- Understand the indications, and assist and perform the more complex pediatric surgical procedures such as newborn bowel obstruction, premature hernias, esophageal atresia and solid tumors.
- Be able to effectively work up and consult on common childhood disorders including tumors, GI diseases and hematological crisis.
- Be familiar with the use of a multidisciplinary approach to common childhood diseases.

3. Practice-based learning and improvement

- Serve as instructor and supervisor of medical students and junior housestaff
- Maintain daily resident work hour log and abide by ACGME rules of work hours
- Maintain log of operative and invasive procedures

4. Interpersonal and communication skills

- Develop and maintain skills required for to work effectively as a team leader with patients, nursing staff, fellow residents and attendings
- Have ethically sound relationships with patients
- Develop effective listening, writing and presentation skills
- Oversees the junior housesatff.
- Learns to functions as a team leader for the fellow.

5. Professionalism

- Shares responsibilities and accountability of patient care with other team members, and assumes leadership in the absence of the Pediatric Surgical Chief Resident
- Recognizes, diffuses, and mediates conflicts
- Contributes and supports team decisions and goals
- Maintain excellence in respect, compassion, integrity, and ethical principles

6. System-based practice

- Understand and demonstrate cost effective health care
- Follow the critical care pathways of postoperative care after pediatric surgical procedures

Pediatric Surgery (All Children's Hospital)

PGY2

1. Describe appropriate fluid, electrolyte and nutritional (enteral and parenteral) management of the full-term neonate.
2. Describe the embryology of neonatal organ systems and their common congenital anomalies, including:
 - a. Craniocervical: dermoid cysts, branchial cleft cysts and fistulas
 - b. Foregut: esophageal atresia/tracheoesophageal fistula, duodenal atresia
 - c. Respiratory: cystic adenomatoid malformation, congenital diaphragmatic hernia
 - d. Cardiac: common cyanotic and acyanotic cardiac malformations
 - e. Midgut: intestinal atresia, malrotation, meconium ileus
 - f. Hindgut: rectosigmoid Hirschsprung's disease, imperforate anus, meconium plug
 - g Body wall defects: gastroschisis, omphalocele, umbilical and inguinal hernias
 - h. Renal: ureteral obstruction, vesicoureteral reflux
 - i. Lower GU tract: urethral valves, hypospadias

3. Explain the pathophysiology of necrotizing enterocolitis.
4. Describe the arterial and venous anatomy of the neonate.
5. Assist or perform under supervision: placement of central venous access, tube thoracostomy, incision and drainage of cysts and abscesses, hernia reduction/repair.
6. Describe the pathophysiology and evaluation of respiratory distress, bilious emesis, cyanosis, abdominal distention, gastroesophageal reflux, bloody diarrhea, jaundice, and body wall defects.
7. Describe the immediate care, operative correction, and postoperative management of life-threatening anomalies: congenital diaphragmatic hernia, midgut volvulus, necrotizing enterocolitis, gastroschisis, prune-belly syndrome.

Surgical Oncology (H Lee Moffitt Cancer Center)

Cancer care is rapidly evolving. Modern cancer management now requires multidisciplinary strategies at all levels. The surgical resident of the new millennium must become facile with cancer management that frequently involves the disciplines of surgery, radiotherapy, chemotherapy, biological therapy, and immunotherapy. In addition, it is becoming clear that a strong background in molecular biology may be necessary to exploit the burgeoning body of genetic and epigenetic discoveries related to cancer biology. The surgery resident of the future will need to develop strong interpersonal communication skills and a team approach to cancer management to facilitate these important interactions

Clinical Objectives:

A. The resident is expected to develop an understanding of the *natural history* and the *multidisciplinary approach* to the management of each of the following primary disease foci: Breast cancer, melanoma, disorders of the spleen (benign and malignant), gastrointestinal cancer; [esophageal cancer, gastric cancer, hepatobiliary primary (hepatocellular and Klatskin tumors) and secondary malignancies, pancreatic cancer, colorectal cancer, small bowel cancer (including carcinoid tumors) and anal cancer], lung cancer (primary and metastatic) and soft tissue sarcomas.

B. Preoperative evaluation:

History and physical examination pertinent to disease focus

Appropriate use of preoperative testing to include ultrasound, nuclear medicine scans (i.e., Octreoscan, Red cell tagged scan, bone scans, lymphoscintigraphy) CT scans, PET scans, MRI scans, ECRP, EUS, EGD, colonoscopy, MRCP, angiography, CT or US guided biopsies (FNAs or cores) Appropriate preoperative preparation to include use of bowel preps, cardiac echo, exercise and chemical stress tests, use of coronary artery stenting.

C. Common operative procedures (not a complete list): Ivory Lewis Esophagectomy, Orringer Esophagectomy, Whipple, distal pancreatectomy, hepatectomies, formal and partial, biliary resections, colectomies, LAR, APA, coloanal procedures, ileoanal procedures, pouches, colostomies, ileostomies, pelvic exenteration, hemipelvectomy (internal and external), Soft tissue sarcoma resection, wide local excisions, transanal excisions, plastic surgical reconstruction with tissue flaps, implants, and expanders, splenectomy, gastrectomy (partial distal, proximal, total, D1, D2, D3, BI, BII, roux-en-y reconstructions), mastectomy, lumpectomy, sentinel lymph node biopsy, axillary

dissection, limb perfusion, pulmonary resections and staging procedures, oncologic thoracic procedures such as pericardial window, pleurodesis.

D. Principles of Surgical Oncology: the resident should understand the concept of proximal, distal and radial margin assessment for each disease focus and the pathologic procedures used to monitor these margins

E. Multidisciplinary Cancer Management Objectives: Understand indications and application of adjuvant chemotherapy, Understand indications and application of adjuvant radiotherapy, Understand indications and applications of neo-adjuvant chemoradiotherapy, Understand identities and basic mechanisms of action, and associated toxicities of commonly used chemotherapeutics, Develop an appreciation for the value of multidisciplinary interactions between surgeons, pathologists, radiologists, medical oncologists, radiotherapists, and gastroenterologists. **MECHANISM:** Weekly multidisciplinary tumor conferences

Breast Surgery (H Lee Moffitt Cancer Center)

Breast Cancer:

1. Describe the epidemiology and biostatistics and changing incidence of breast cancer.
2. Describe the effect of hormone replacement therapy on the development of breast cancer. Understand the basic concepts of lead time bias in screening and of length time bias on prevention trials.
3. Describe the NSABP prevention trial and its impact on the use of Tamoxifen as a prevention agent.
4. Describe the benefit versus risks of taking Tamoxifen. Be able to describe the risks of Tamoxifen on the development of uterine cancer, the incidence of stroke and the risk of thrombophlebitis and pulmonary embolism.
5. Describe the benefits and relative risks of raloxifene (Evista) and toremifene (Fareston) as they relate to the above noted risks of uterine cancer and thromboembolic episodes.
6. Describe which patients are candidates for BRCA 1-2 genetic screening and be prepared to discuss the problems associated with the screening, insurability, and potential for follow-up, prevention methods, and possible prophylactic mastectomy.
7. Describe the use of natural remedies such as flaxseed, soy products, (Genestine) for use in patients with breast cancer or high-risk populations. Describe the use of Estramet testing for management of patients with HRT with and without breast cancer.
8. Describe the key factors of a breast exam and be able to teach the patient the key findings as they relate to texture consistency and size of palpable lumps in the breast as well as proper timing of the breast exam relative to the menstrual cycle.
9. Describe the physical signs and symptoms of breast cancer including the mammographic signs of breast cancer.
10. Describe the mammographic findings that necessitate breast biopsy and the preferred biopsy technique depending on the size location and nature of the lesion.
11. Describe the differences pathologically and the treatment for: Phylloides tumor vs. Cystosarcoma Phylloides, Fibroadenoma vs. Lactating Adenoma vs. Juvenile Adenoma
12. Describe the significance of nipple discharge as it relates to a breast cancer diagnosis. Be able to differentiate between benign, physiologic bloody nipple discharge, physiologic milky nipple discharge and abnormal milky nipple discharge and fibrocystic nipple discharge and the work-up of each.

13. Describe the surgical indications and contraindications for lumpectomy and mastectomy in the following: DCIS, T1, T2 and T3 invasive breast cancer
14. Describe the recommended chemotherapy as primary adjuvant therapy: Stage I, Stage IIA, Stage IIB, Stage IIIA, and Stage IIIB breast cancer
15. Describe when and how to operate on Stage III breast cancer.
16. Describe when and how to operate on Stage IV breast cancer.
17. What are the following prognostic indicators and the significance of each of breast cancer: Lymph Node status [a) H&E Positive b) Cytokeratin Positive c) extra capsular extension], S-Phase, DNA Ploidy, Estrogen/Progesterone Receptors, Her 2 Nu
18. Describe when radiation is indicated and not indicated: a) following lumpectomy b) following mastectomy.
19. Describe the method and standard dosage, time required, number of treatments and a description of the treatment plan for radiation therapy along with the potential complications. Describe how to manage DCIS a) less than 1cm b) >4cm c) EIC.
20. Describe what is the incidence of lymphedema following axillary lymph node dissection and following sentinel node biopsy without axillary lymph node biopsy.
21. Describe the incidence of positive nodes in the following breast lesions: DCIS, T1A, T1B, T1C, T2, T3
22. Describe the psychosocial impact of breast cancer: Severity of Disease, Life Change, and Time to Psychological Recovery.
23. Describe the long term effects of the surgical diagnostic interview (telling the patient that they have cancer for the first time) What two things does the patient remember?
24. Describe the three keys to decision making for a woman contemplating Lumpectomy vs. Mastectomy.
25. Describe the literature that would indicate whether a patient should be given an open ended decision making capacity with facts or a specific recommendation.
26. Understand the current research protocols for the treatment and staging of breast cancer being done at the Moffitt cancer center: Seed Vs Wire Localization study MCC# 14112, Dual Isotope scanning Seed Localization Trial, Z0010 American College of Surgeons Oncology Group Trial (Micromets), Z0011 American College of Surgeons Oncology Group Trial (Node Dissection), Stage III protocol (Dr. Minton and Dr. Jove STAT 3 evaluation), STAR Prevention Trial (Postmenopausal Tamoxifen vs. Raloxifen).

Breast biopsy:

1. Describe the epidemiology and statistics surrounding the current and future increase in incidence of breast biopsy procedures.
2. Describe the technical method, indications for, relative cost of and limitations or contraindications for the following types of breast biopsy: Fine needle aspiration breast biopsy (FNA), Core needle biopsy (palpable, ultrasound, or stereotactically guided), Vacuum assisted core needle biopsy (MIBB, Biopsies), Advanced breast biopsy instrumentation (ABBI stereotactic large core biopsy), Surcore biopsy (ultrasound directed large core biopsy), Needle localized breast biopsy (mammographically or ultrasound guided), Radioactive seed localized breast biopsy (RASLO) (mammographically or ultrasound guided), Open breast biopsy (palpable mass).
3. Describe in detail the closure of an open breast biopsy incision to avoid dehiscence and subsequent wound infection.
4. Describe the preferred method of the author for wound dressing of breast incisions and the relative merits of the technique.
5. Describe where and how to make the incision for an open or needle localized biopsy in various locations of the breast.

6. Describe the techniques to achieve hemostasis of a breast biopsy incision and the relative merits and problems associated with each.
7. Describe the signs symptoms, clinical course and treatment of a breast wound hematoma , and a seroma.
8. Describe in what circumstance one would consider packing a breast incision.
9. There are three benign pathologic entities that require a specific approach for biopsy and treatment: Fibroadenoma, Keratin Plugging, Intraductal Papilloma
10. Discuss the pathophysiology of each and their therapeutic management.
11. Name three entities that result in bloody nipple discharge one physiologic and two pathologic. Describe the pathophysiology, biopsy method, treatment and prognosis of each.

Lymphatic mapping for Breast Cancer:

1. Discuss the epidemiology and biostatistics of breast cancer and the projected need for future treatment strategies that will provide more efficient and cost effective means of treating breast cancer.
2. Describe the basic technique of breast cancer lymphatic mapping: Dose, route of administration, location and timing of the radio colloid (Tc^{99m} sulfur colloid) and Lymphazurin (Blue dye) injections.
3. Is there statistical improvement of breast lymphatic mapping with the use of manual massage of the breast after injection with a) radio colloid b) Lymphazurin?
4. Describe Dr. Cox's anatomic pearls for locating the majority of sentinel nodes in breast cancer lymphatic mapping. Also, describe how to scan for and find the nodes not in their usual location.
5. Describe the advantages and disadvantages of Lymphazurin mapping for breast cancer.
6. What is the primary route of excretion of Lymphazurin and how do you need to advise the patient.
7. Describe the pharmacological interactions of Lymphazurin with: a) Lidocaine b) Tc^{99m} Sulfur Colloid .
8. Describe the advantages and disadvantages of Tc^{99m} Sulfur Colloid mapping for breast cancer.
9. Describe the method for locating and complications for the removal of an internal mammary node and the incidence of solitary metastases to the internal mammary chain.
10. Qualify the relative importance of finding an internal mammary node located by pre or intra operative scanning for the total population of breast cancer patients and for the individual breast cancer patient.
11. Describe which breast cancer patients may benefit from the preoperative assessment of a lymphoscintogram.
12. Describe the general principles of radioisotope scanning: Compton effect, Shine through, KeV of an isotope and the importance of calibration and windowing as they apply to mapping, Half life and KeV of the isotopes a) Tc^{99m} b) Palladium c) I^{125}
13. Be able to discuss the current controversies in mapping : Route of injection a) intra parenchymal b) intradermal radio colloid with intraparenchymal Lymphazurin c) peri-areolar sub dermal injection of either or both agents
Method of preparation of the Tc^{99m} Sulfur colloid a) 0.22 micron filtered b) Unfiltered
Mapping in DCIS, c) Mapping in advanced (Stage III) breast cancer
14. Describe the differences between breast cancer mapping and melanoma mapping.
15. Describe the necessity for adequate training and monitoring of outcomes as they relate to false negative rates and overall success of mapping a sentinel node.
16. Describe the minimum number of monitored breast cancer cases (sentinel node biopsy followed by complete axillary dissection) by the individual surgeon and the institution that

should be performed prior to proceeding with sentinel node biopsy without complete node dissection in patients with negative sentinel nodes. (Learning Curves)

17. Describe the minimum number of cases required to achieve 90% success in mapping and 95% success in breast cancer lymphatic mapping.

18. Describe the causes for failure of breast cancer lymphatic mapping.

19. Describe the impact of diagnostic biopsy method (FNA, core, excisional) on the successful outcome of breast cancer lymphatic mapping.

20. Describe the level of scrutiny that the pathologist should apply to the sentinel lymph node to determine that it is negative and why is it of importance to evaluate the lymph node with immunohistochemical methods.

21. Describe the importance of micro metastases in a sentinel node regarding: False negative rates and Prognostic impact for long term survival.

22. Describe the implication of micro metastases seen by cytokeratin analysis alone regarding: Completion axillary node dissection in: a) invasive breast carcinoma b) DCIS
Long term prognosis for a patient with a) invasive breast carcinoma b) DCIS
Need for adjuvant chemo or hormonal therapy in a) invasive breast carcinoma b) DCIS

23. Describe the role of lymphatic mapping in prophylactic mastectomy. What are the differences in how the mapping is performed?

24. Describe the value of Sentinel Node Biopsy to the patient in combination with or without an axillary node dissection.

25. Describe the indications and contraindications for sentinel node mapping in breast cancer.

Vascular Surgery (Tampa General Hospital and James A Haley VA)

PGY 1/3

Knowledge Objectives

1. Describe human arterial and venous anatomy; lower limb (arterial and venous), upper limb (arterial and venous), extracranial carotid, intracranial arterial, mesenteric and renal

2. Describe basic “normal” arterial (carotid, visceral, peripheral) and venous (saphenous, deep venous system) hemodynamics, and the abnormalities associated with: “critical” stenosis, intermittent claudication of the lower limb, subclavian steal syndrome, chronic mesenteric angina, renovascular hypertension, acute deep venous thrombosis, chronic venous insufficiency, arteriovenous (AV) fistula

3. Discuss the anatomy, pathology, and pathophysiology of the arterial wall; intima, media, adventitia

4. Discuss the clinical manifestations of the following vascular disorders: atherosclerosis obliterans of the lower limb, aneurysmal arterial disease, thromboembolic disease, arterial and venous

5. Describe invasive and noninvasive techniques for measurement of limb blood pressure and their use in the evaluation of vascular disease, including the arterial pressure criteria of a “hemodynamically significant” stenosis, ankle systolic pressure, ankle-brachial systolic pressure index (ABI), digit systolic pressure and pulse volume recordings, Doppler waveform analysis, exercise treadmill testing

6. Describe the relationship of the following disorders/risk factors to atherosclerotic arterial occlusive/aneurysmal disease: diabetes mellitus, hypertension, renal failure, congestive heart failure, hyperlipidemia, smoking

7. Describe the clinical manifestation and intervention for: ruptured abdominal aortic aneurysm, embolus to the brachial artery, acute lower limb deep venous thrombosis, acute superior mesenteric artery thrombosis, acute lower limb graft thrombosis

- 8.** Differentiate between the following diagnostic techniques for assessment of vascular disease: angiography, computed axial tomographic (CAT) scanning, magnetic resonance imaging (MRI) and MR angiography, duplex scanning (ultrasonography)
- 9.** Explain the concept of “silent” vascular disease and cite examples when it represents a major threat to the patient.
- 10.** Summarize the etiology, pathophysiology, and therapeutic options of specific venous disorders: varicose veins involving the great saphenous system, post-phlebitic (chronic venous insufficiency) syndrome, pulmonary embolus, superficial thrombophlebitis of the great saphenous vein, iliofemoral venous thrombosis
- 11.** Summarize the etiology, pathophysiology, and therapeutic options of specific lymphatic disorders: lymphedema praecox, lymphedema tarda, postoperative lymphedema
- 12.** Summarize the etiology, pathophysiology, and therapeutic options of specific arterial disorders: aortoiliac occlusive disease, abdominal aortic aneurysm, arterial embolic disease, extracranial carotid stenosis, thoracic outlet syndrome, visceral ischemic syndromes, trauma, arteriovenous malformations
- 13.** Describe the type of the non-invasive vascular laboratory testing used to evaluate: arterial occlusive disease, venous disease, arterial aneurysmal disease, digit ischemia, vascular trauma, thoracic outlet syndrome, extracranial carotid stenosis
- 14.** Describe the bedside technique of Doppler ultrasound arterial and venous testing.
- 15.** Outline the patient care principles for lower limb ischemia.
- 16.** Describe the natural history of the following vascular disorders: carotid bifurcation atherosclerotic stenosis, abdominal aortic aneurysm, superficial femoral artery stenosis/occlusion – intermittent claudication, iliofemoral deep venous thrombosis, calf vein thrombosis
- 17.** Summarize principles for the preoperative assessment and postoperative care of patients undergoing: carotid endarterectomy, lower limb arterial bypass, abdominal aortic aneurysm repair, thromboembolectomy of extremity arteries, placement of hemoaccess for hemo-dialysis in the upper limb, varicose vein excision, placement of an inferior vena cava filter, direct thrombin injection and surgical repair of femoral artery false aneurysm, blunt popliteal artery trauma, catheter-directed thrombolysis for acute graft thrombosis, femoropopliteal PTFE graft infection, STSG of venous ulcer.
- 18.** Discuss the principles of and contraindications for anticoagulation and thrombolytic therapy.
- 19.** Describe the evaluation and treatment of the sequelae of vascular intervention including: groin lymphocele/fistula, lower limb swelling, stroke after carotid endarterectomy, infrainguinal vein graft stenosis, graft-enteric erosion/fistula, arterial steal syndrome following AV bridge graft placement for dialysis.
- 20.** Discuss the technique of: pulmonary catheter placement, perma-cath insertion for hemodialysis, digit amputation, below-knee amputation, I&D of diabetic foot infection, varicose vein excision (microphlebectomy), high ligation of the greater saphenous vein, stent-assisted angioplasty, arterial suturing, vena cava filter insertion.
- 21.** Describe measures to reduce the progression of vascular disease.
- 22.** Determine a plan for assessment of operative risk in these categories: coronary artery disease, congestive heart failure, chronic obstructive lung disease (COPD), renal insufficiency, level of anesthetic risk.
- 23.** Demonstrate ability to prepare patients for definitive operative and endovascular interventions, rehabilitation, and discharge planning.
- 24.** Discuss the diagnosis and management of non-atherosclerotic vascular diseases: systemic vasculitis, giant cell arteritis, Takayasu’s disease, radiation induced arterial disease, arterial infection, adventitial cystic disease, popliteal entrapment syndrome,

Buerger's disease, coarctation of the abdominal aorta, persistent sciatic artery aberrant subclavian artery, arteriopathies, Marfan's syndrome, Ehlers-Danlos syndrome, arterial magna syndrome, Behçet's disease, homocystinuria.

Performance Objectives

1. Clinical evaluation and physical examination of patients with arterial, venous, or lymphatic disorders.
2. Demonstrate proficiency in basic vascular surgical techniques, including: suturing an anastomosis, balloon catheter thrombectomy, handling of autogenous vein and prosthetic graft material, closure of vascular incisions (in situ bypass, femoral incisions, carotid surgery)
3. Participate in surgery for varicose vein disease, including: radiofrequency saphenous venous closure, saphenous vein high-ligation and stripping, stab phlebectomy, management of venous ulcers, management of superficial thrombophlebitis
4. Participate in amputations with specific attention to: selection of level required for healing, indications for primary amputation, surgical techniques of digit, metatarsal, and midfoot amputations; surgical techniques of below- and above-knee amputation
5. Demonstrate proficiency in construction catheter, autogenous arteriovenous fistula, and prosthetic bridge grafts for hemo-dialysis.
6. Assist and perform thromboendarterectomy and thrombectomy procedures.
7. Evaluate indications for and management of patients undergoing sympathectomy procedures for reflex sympathetic dystrophy and hyperhidrosis.
8. Perform the preoperative assessment and postoperative care of patients undergoing major vascular surgical procedures.

PGY-4/5

The core curriculum for the Chief Resident in General Surgery is similar to that for Vascular Resident in training. The core curriculum of Vascular Surgery is detailed at the website of the Association of Program Directors in Vascular Surgery (www.vasc Surg.org/doc/1465.html).

The curriculum of Vascular Surgery is divided into three areas:
Basic Science, Vascular Diagnostic Laboratory, Clinical Curriculum
Educational Objectives (25 Topics)

The senior/chief resident on Vascular Surgery are expected to review the clinical curriculum and educational objectives to achieve an understanding of the evaluation and management of patients with vascular disorders.

Knowledge Objectives

1. Identify and describe vascular anatomy and regional anatomy related to arterial/venous vascular disorders for: extracranial carotid occlusive, aneurysmal disease, aortoiliac occlusive, aneurysmal disease, lower/upper limb occlusive disease, visceral/renal occlusive and aneurysmal disease.
2. Discuss the broad range of vascular illness, including congenital vascular disease and diseases of the venous and lymphatic systems
3. Outline the indications for intervention for intermittent claudication, abdominal aortic aneurysm, extracranial carotid stenosis, renal artery stenosis, and visceral artery occlusive disease.
4. Describe the pathogenesis and complications of renovascular hypertension, aneurysmal disease, atherosclerosis obliterans of the lower limb.

5. Illustrate the operative exposure of the major vessels, including: aortic arch, proximal subclavian artery, carotid artery, suprarenal aorta, infrarenal aorta, femoral artery, popliteal artery (above-, below-knee), tibial arteries (anterior, posterior, peroneal)
6. Discuss the operative principles/approaches to: bypass grafting (types of grafts and suture material), emergency vascular surgery, reoperative vascular surgery, principles/technique of endarterectomy, anastomotic construction
7. Summarize the etiology, microbiology, and treatment of diabetic foot infection.
8. Analyze the options for treatment of patients with chronic venous insufficiency and venous ulceration.
9. Categorize the prevention and management of operative and postoperative complications, including: graft infections, ischemic bowel, graft thrombosis, atheroembolic ("trash" leg syndrome), white clot syndrome
10. Summarize the open surgical and endovascular techniques available for managing the following vascular disorders: abdominal aortic aneurysms, internal carotid stenosis, subclavian steal syndrome, femoral popliteal occlusion, tibial artery occlusion
11. Review critical factors for decision making in vascular surgery: risk:reward ratio, morbidity and mortality probability, preoperative and postoperative assessment, intraoperative assessment, noninvasive vascular testing, role of CT scans, MRI, MRA, angioplasty.

Performance Objectives:

1. Demonstrate the appropriate incisions and exposure of: abdominal aorta and its branches, portal venous system, peripheral arterial system, extracranial carotid system, arteriovenous fistula.
2. Obtain vascular control of major vessels, including: ruptured abdominal aortic aneurysm, inferior vena cava, popliteal artery, internal carotid artery, subclavian artery, vertebral artery.
3. Perform selected "open" procedures or parts of the following procedures under supervision: aortic aneurysm repair, carotid endarterectomy, aortoiliac occlusive disease, femoral popliteal occlusive disease, peripheral vascular trauma, inferior vena cava filter placement, arteriovenous bridge graft for hemodialysis

Cardiothoracic Surgery (James A Haley VA)

PGY 2

1. Discuss the following conditions, then choose and justify the appropriate diagnostic and therapeutic modalities: pneumothorax, hydrothorax, hemothorax, hemopneumothorax, pulmonary infiltrates or masses, abnormal cardiac silhouettes, pleural effusions, mediastinal masses, infectious processes, neoplastic processes.
2. Discuss and justify the indications for the following procedures: needle aspiration, thoracotomy, chest tube placement, bilateral thoracotomy, mediastinoscopy, thoracoscopy, median sternotomy.

- 3.** Explain the mechanics and applications of pulmonary function studies in evaluating patients for thoracic surgery.
- 4.** Illustrate the various types of incisions used in thoracic surgery for: lung resections, esophagectomy, mediastinal procedures, tracheal/bronchial procedures
- 5.** Describe the diagnosis and discuss therapy of such surgical complications as: fistulas: bronchopleural, pleuracutaneous, tracheoesophageal (TE), arteriovenous (AV) and thoracic duct, esophageal leak/stenosis/obstruction, loculated hemothorax, postoperative bleeding, empyema, air leaks.
- 6.** Describe and demonstrate a working knowledge of the heart and great vessels, including: cardiac chambers (atria and ventricles), cardiac valves (mitral, aortic, tricuspid, pulmonic), coronary arteries, intrinsic neural conduction system, extrinsic neural innervation (sympathetic and parasympathetic), great vessels (cavae, aorta, innominate artery, carotid arteries, and subclavian arteries).
- 7.** Describe and demonstrate working knowledge of cardiac physiology, including: electrophysiology (action potential, depolarization, repolarization, mechanisms of rhythm control), determinants of cardiac output (heart rate and stroke volume), interactions and control mechanisms (preload, afterload, contractility, Frank-Starling Law, peripheral resistance), determinants of myocardial oxygen consumption, normal pressures, waveforms, and oxygen saturation in cardiac chambers.
- 8.** Discuss techniques, mechanisms of action, and potential complications for mechanical and pharmacologic support of the circulation, including: inotropic agents (dopamine, dobutamine, epinephrine, norepinephrine, amrinone, isoproterenol), pre- /after- load agents (Nipride, nitroglycerine, Neo-synephrine), intra-aortic balloon pump, ventricular assist device, cardiac pacing.
- 9.** Describe and assess the operative indications, risk, and expected outcomes associated with several cardiac surgical procedures, including: coronary artery bypass, valvular replacement/repair (aortic, mitral, tricuspid), operations of the ascending aorta, aortic arch and descending thoracic aorta, pericardial drainage procedure.
- 10.** Discuss the complications of cardiac surgery and methods used to reduce their incidence. Complications: death, myocardial infarction, stroke, bleeding, arrhythmias, low cardiac output syndrome, cardiac tamponade, pneumothorax, sternal and extremity wound infections, respiratory, and renal failure.
- 11.** Review the management of postoperative cardiac surgery patients in the intensive care unit.

Transplant Surgery (Lifeline and Tampa General Hospital)

PGY3/1

1. Demonstrate an understanding of general immunological principles and their application to surgical practice.
2. Demonstrate an understanding of the principles of care for patients with abnormal immune function who are undergoing general surgery procedures.
3. Describe the mechanism of action, dosing schedule, and side effects of the following immunosuppressive drugs; state the rationale for their use and timing in transplantation and in other medical applications: prednisone, cyclosporine, azathioprine, tacrolimus (FK506), mycophenolate mofetil (RS6144), monoclonal antibody (Moab) use for induction, anti-lymphocyte globulin, anti-T3 monoclonal antibody, anti IL-2R Moab
4. Understand effects of immunologic rejection.
5. Monitor drug levels and side effects in immunosuppressants.
6. Analyze and outline the indications for kidney, pancreas, heart, and lung transplant; relate the relative frequency of these operations as well as rates of patient and graft survival
7. Demonstrate competency in the understanding and care for patients who have End Stage Organ Disease.

Burn/Plastic Surgery (Tampa General Hospital)

PGY1

1. Review the criteria for adequate evaluation of a burned patient, including historical aspects of the type of burn and subjective physical findings.
2. Discuss an initial treatment plan for stabilization and fluid resuscitation of a burned patient based on the above evaluation.
3. Describe the clinical factors necessitating immediate intervention to preserve life, limb, and function.
4. Outline the principles of burn shock, immunologic alteration, and bacteriologic pathology of burned skin.
5. Explain the special circumstances created by electrical, chemical, and inhalation burn injury, and apply their relation to management.
6. Assess the appearance of the burn wound in relation to its depth, bacteriologic condition, healing potential, and requirement for intervention.
7. Discuss the physics and pathology of the electrical burn and its relation to associated organ injury, including: current, neurological injury, entrance and exit wounds, vascular problems, deep tissue involvement.
8. Describe the indications, techniques for harvest, application, immobilization, and care of split- and full- thickness skin grafts.
9. Explain the principles of wound contracture, and report desirable and harmful effects of contracture on: initial management of the burn victim, closure of the burn wound rehabilitation of the burn patient
10. Describe and explain the following terms: compartment syndromes, burn eschar, fasciotomy and escharotomy incisions and techniques.
11. Summarize the activities of a specialized burn team or unit in the overall management of the burn patient to include the following: physical therapy, recreational therapy/child life activities, occupational therapy, burn nursing, psychological counseling.
12. Provide emergency burn patient evaluation and monitoring. Determine the level of care and need for transfer to a burn facility.

13. Implement fluid resuscitation protocols for children and adults.
14. Select and apply appropriate dressings and antibacterials.
15. Manage systemic effects of the burn wound in the critically injured surgical patient, considering: sepsis, gastrointestinal (GI) effects, immunologic problems cardio-respiratory effects.
16. Understanding maxillofacial bony and soft tissue anatomy and patterns of injuries.
17. Performing a thorough and complete craniomaxillofacial evaluation.
18. Understanding basic principles of repair and fixation for common craniomaxillofacial injuries.

Plastic Surgery JAHVAH and Moffitt (PGY-1)

Providing an early experience to plastic surgery. Extensive exposure to skin cancer care; wound care, and hand surgery are provided. Some exposure to breast reconstruction and microvascular surgery are also provided. Outpatient clinics in plastic surgery and hand surgery are provided and ample. Procedure experience includes participation in minor surgical procedures, skin tumor biopsy and excision, skin grafting and flap reconstruction.

Plastic Surgery Objectives:

1. Diagnose and treat common skin infections and infections occurring in surgical wounds.
2. Recognize indications for, and perform biopsy of, pre-malignant, malignant or pigmented skin lesions using appropriate techniques.
3. Perform diagnostic workup and clinical staging of patients with skin cancer (including melanoma) using history and physical examination, routine laboratory tests, and appropriate imaging procedures; outline an appropriate surgical plan for these patients.
4. Renders follow-up care and appropriate long-term outpatient surveillance for patients with skin cancer, including melanoma.

Otolaryngology and Head and Neck Surgery (Tampa General Hospital)

PGY4

1. Demonstrate knowledge of the anatomy, physiology, and pathophysiology of the ear, nose, and throat pertinent to the practice of general surgery.
2. Demonstrate the ability to manage ear, nose, and throat problems associated with the practice of general surgery.
3. Identify the anatomy and explain the physiology of the ear, nose, oral cavity, and throat.
4. Summarize the essential components of a focused history and physical examination for common otolaryngologic problems.
5. Discuss the significance of the cornerstones of the physical examination, including: visual inspection, palpation, auscultation, percussion.
6. Evaluate patients with facial trauma and develop a treatment plan for the management of: fractures, hemotympanum, lacerations, epistaxis.
7. Describe the indications for tracheostomy in adults and children.
8. Describe the indications for simple endoscopy and its diagnostic contributions such nasopharyngoscopy, esophagoscopy, direct laryngoscopy.
9. Summarize the characteristics of the common neoplasms of the ear, nose, and throat, and describe appropriate surgical intervention.
10. Outline the diagnostic approaches to otolaryngologic neoplasia, including: direct visualization, indirect visualization, fine-needle biopsy, radiography.

- 11.** Describe diagnostic and therapeutic procedures utilized in treating the following: abscess, oral ulcer, neck mass, salivary gland mass.
- 12.** Explain the tumor, nodes, and metastases (TNM) classification system for tumors of the head and neck.
- 13.** Identify and delineate Zones I, II, and III of penetrating injuries to the neck and their associated management.
- 14.** Discuss indications for radical and modified radical neck dissection.
- 15.** Outline the advantages and disadvantages of irradiation, chemotherapy, and resection of neoplastic lesions of the: tongue, retromolar trigone, floor of mouth, alveolar ridge, buccal mucosa, palate.
- 16.** Formulate a plan for the management of an unknown primary tumor of the head and neck.

RESIDENT SUPERVISION

SCOPE OF PRACTICE GENERAL SURGERY RESIDENCY TRAINING PROGRAM

GENERAL STATEMENT

General Surgery residents can function in two capacities: indirectly supervised, and directly supervised. This scope of practice addresses indirect supervision. General Surgery residents can evaluate outpatients, write prescriptions, write orders and progress notes, and otherwise complete medical records. Residents cannot perform invasive procedures (chest tube, arterial line, central line, and endotracheal intubation) without direct supervision until they have completed an ACLS course. General Surgery residents cannot function without direct or indirect supervision by an attending physician who has privileges for patient care and to perform the indicated procedures.

PGY-1

Can bring patients into operating room for induction of anesthesia; can insert IV lines, and Foley catheters; can write admission orders, pre and post-op orders and notes; can dictate admission history and physical, write progress notes, orders, and prescriptions; can dictate discharge summaries; can write orders for restraints. Under supervision, may provide in-hospital care, assist in surgery, and perform certain operations. May place arterial lines, central lines, chest tubes, Swan-Ganz catheters under the direct supervision of a senior (\geq PGY-3) resident. Eventually these procedures may be done under indirect supervision once a minimum number have been directly supervised.

PGY-2

Can participate in SICU activities and can function in the SICU under the indirect supervision of the SICU attending in both the intensive care unit and non-intensive care unit. This will allow placement of arterial lines, central lines, chest tubes, Swan-Ganz catheters, endotracheal and other superficial procedures. Under supervision, may assist in surgery and perform certain operations at the discretion of the attending surgeon. Under indirect supervision, can write orders for restraints. Can perform bronchoscopy under indirect supervision once a minimum number have been directly supervised.

PGY-3

Can function as senior resident on selected services under the direction of a chief resident and attending physician. Can initiate surgical procedures. Under indirect supervision, can administer conscious sedation and write orders for restraints. Can function as senior resident on call and as senior resident in the SICU. Can participate in clinics under indirect supervision. Can evaluate trauma patients in the ER and supervise their resuscitation (ATLS certified).

PGY-4, 5 & 6 (CHIEF RESIDENT)

Can function as senior resident and supervise routine ward activities and SICU activities. Can participate in clinics under indirect supervision and supervise the conduct of outpatient clinics. Can evaluate outpatients for emergency surgical procedures. Can initiate surgical procedures after discussion with an appropriate attending physician who has privileges to perform the anticipated procedure and anticipating the arrival of the attending surgeon. Under indirect supervision, can administer conscious sedation and write orders for restraints. Can oversee medical record completion.

Evaluation of Patients in the Emergency Room

PGY-1 residents must be directly supervised by a senior (\geq PGY-2) resident. PGY-2 residents may evaluate patients in the ER under the indirect supervision of a senior (\geq PGY-3) resident. PGY-4&5 residents may evaluate patients in the ER under the indirect supervision of the attending surgeon. If requested by the attending in the ER, the senior resident must consult with the attending surgeon on call prior to discharging a patient from the emergency room. The attending surgeon must also be informed about all patients admitted to his service from the ER.

Change in Patient Status

Attending physicians must be informed when a patient on his/her service has a clinically important change in status; this includes but is not limited to instability in vital signs, transfer to the intensive care unit, intubation, need for an invasive procedure/monitoring or death.

OTHER PROFESSIONAL STAFF

NURSING STAFF

- The nursing staff is an integral part of the health-care team. Personal and professional courtesy should be extended to the nursing staff at all times. They should make ward rounds with the teams when possible and they should be advised of changes in plans, special requests, or anticipated problems.
- House officers are responsible for a significant contribution to the education of the nursing staff. Such education is vital in assisting them to take better care of your patients. Explanation and thoughtfulness will yield manifold results.
- Simple “pick-up-after-yourself” and care in performance of procedures will allow the nursing staff time with your patients.

PHARMACY STAFF

- The pharmacist is another vital member of the health-care team. S/he is responsible for all medications dispensed in the hospital.
- S/he is also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicity, administration forms, and combinations.
- It is the pharmacist’s legal and professional responsibility to ensure that the intent of your orders are fulfilled. When the pharmacist questions an order, S/he is doing so to ensure that the patient receives the appropriate medication.

CHIEF RESIDENT DUTIES

The Chief Resident is directly responsible to the Program Director/Assistant Program Director in the Department of Surgery. His/her responsibilities also include the items listed below:

- Assign coverage of operative cases to members of team (residents, students, physician extenders).
- Ensure that residents on their team work no greater than 80 hrs/week (averaged over 4 weeks).
- Ensure all residents have at least an average of one day off in seven.
- Construct the daily O.R. schedule by 8:00 a.m., 48 hours prior to surgery.
- Make daily rounds at a time that allows morning rounds to be completed in time to make scheduled conferences and operations.
- Notify staff any deterioration in patient status and of any emergency surgery.
- Ensure that the residents staff all patients with the proper attendings.
- See that all residents read and follow the regulations in the Department of Surgery Policy Manual.
- Notify the Program Director of the Department when there are major Departmental problems.
- Responsible for all junior residents' actions and their relationships with patients.
- See all hospital consultations and make the appropriate disposition prior to staffing with attendings.
- Supervise all major operating of junior residents.
- Be readily available at all times for consultation and patient care.
- Ensure regular attendance of all house staff and students attend all surgical department educational activities on Monday mornings, (Resident Curriculum Lectures, Surgical Grand Rounds, and Morbidity/Mortality Conferences) in addition to individual hospital conferences (GI, Trauma, Preoperative, Tumor board, Vascular etc).
- Responsibility for the supervision and education of medical students.
- Daily overall running of the team.

SURGERY CHIEF RESIDENT DUTIES
TAMPA GENERAL HOSPITAL

1) Medical Record Completion:

History and physical exam must be completed within the first 24 hours of admission and prior to surgery.

All orders must be signed and dated with time; verbal or telephone orders must be signed by the physician giving the order within 24 hours.

Operative reports must be dictated and written in the record before leaving the operating room.

Symbols and abbreviations used only when approved by Medical Staff.

Records may not be removed from the nurses stations and may never leave the hospital's jurisdiction, except by court order to the Medical Records Department. Records are not to be photocopied.

If items are not completed after 30 days following a discharge, the record is considered delinquent, and the attending physician will be subject to admission privilege suspension.

2) Transfer of Patients:

All requests for acceptance of the patient must be directed to the Transfer Center, 844-7979. Accurate documentation is required when the patient is transferred from one service to another, so there is no doubt as to the responsibility of the patient.

3) Early Discharge Planning:

Begin within 24-48 hours of admission. There must be appropriate communication between the physician and Utilization Management, Nursing, Social Services, and Home Health Care. Write orders for discharge the afternoon prior to discharge, or early in the morning, whenever possible. Patients should be discharged by 11:00 am.

4) Completion of Death Certificates:

Death certificates must be signed within 72 hours of the patient's death. Call the Death Records Office, extension 7467, for information.

SURGERY CHIEF RESIDENT DUTIES
TAMPA GENERAL HOSPITAL (Continued)

5) Additional Chief Resident responsibilities extend to:

- 1)** Disaster drill and true disasters. When a Code is announced, the Chief Resident will respond to the Command Center and assist in getting surgical house staff response, as necessary.
- 2)** Attendance is required at the Chief resident Meetings at the Tampa General Hospital, which are held the third Monday of every month. Patient information from this meeting should be shared with all surgery residents.
- 3)** Investigation, counseling, and appropriate action should be taken when misunderstandings or problems occur between a resident and other physicians, nurses, hospital personnel, or family members. Serious matters require consultation with the Chief of General Surgery and the Medical Director of the Tampa General Hospital.

PATIENT CHARTS

- 1) It is the responsibility of the Surgical house staff to keep all dictation and chart work current. Major delinquencies are not acceptable. The operative note must be done at the completion of the procedure the day of surgery, before leaving the operating room for accuracy and for legal reasons.
- 2) The complete history and physical is to be dictated or written by the junior house officer within 4 hours of admission (in addition to the medical student). A co-signed student's note is not acceptable.
- 3) A senior house officer's note must be on every chart and shall contain a pertinent illness and physical examination.
- 4) Please be sure that each chart includes discharge instructions.
- 5) The discharge summary should be dictated on the basis of the problem list. It is to be dictated by the junior house officer assigned to the patient prior to the patient's departure. A note must be entered into the chart. No patient can be discharged from the hospital until the face sheet has been completed.
- 6) The discharge note includes a brief summary, the diagnosis, the discharge instructing and following. If the Department of Surgery is notified that you have an excessive amount of delinquent charts, you will be suspended from the operating room.
- 7) Each medical student's orders must be countersigned immediately by the house officer. The medical student will write orders only under the direct supervision of his/her house officer. The nursing staff has been instructed not to carry out orders written by medical students until they are appropriately countersigned by a M.D.
- 8) The following is an outline of what a pre-op note should include:

PRE-OP NOTE: A brief statement of history and physical exam.

- A. All pertinent current laboratory data.
- B. A chest x-ray and EKG.
- C. Indications for surgery.
- D. The operative plan.
- E. Post-operative care plan.
- F. Any expected post-operative problems.
- G. A statement concerning the discussion of the patient with staff and/or faculty.
- H. The availability of blood.

PATIENT CHARTS (Continued)

- 9) All charts must include an accurate handwritten brief operative. This note should be written in the operating room at the conclusion of the procedure. This is important because dictated operative notes do not get placed in their charts for several days after the procedure.
- 10) All charts must contain a brief, written post-operative note signature. This note should be written the evening of surgery 4-8 hours after procedure to include the following:
- A. Surgeon(s) names (attending, residents and students).
 - B. Procedure and findings.
 - C. Anesthesia (medication used and name of anesthesiologist).
 - D. Fluids and blood given during surgery.
 - E. Estimated blood loss.
 - F. Complications.
 - G. Drains.
 - H. A statement regarding the patient's condition and prognosis written when the patient reaches the recovery room.
 - I. A diagram or sketch when appropriate.
- 11) P.M. NOTE (Post-op check). This note is written by the primary surgeon at the end of the day on which the surgery was performed. It should briefly describe the patient's progress and condition since leaving the operating room.
- 12) **Progress notes** should be made whenever appropriate. There is no set rule as to their frequency. An extremely ill patient may require hourly notes. All progress notes must include date, time entered, and signature. Each patient should have a minimum of one physician note per day.
- 13) **Operative notes** will be dictated immediately following operation. They should contain sufficient information concerning the pathology found as well as techniques used. Failure to dictate operative notes prior to midnight the day of surgery will result in the suspension of operative privileges for one week.
- 14) All written orders must include the date and time written.
- 15) Signatures must be legible.

DUTY HOURS

Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

On call schedules are prepared by the chief residents and accessed by residents and staff at <http://www.amion.com/>. The password is USFGS.

1. Supervision of Residents

- a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultations.
- c. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
- d. The attending physician has both an ethical and a legal responsibility for the overall care of the individual patient and for the supervision of the resident involved in the care of that patient. Although senior residents require less direction than junior residents, even the most senior must be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained must be established. Judgements on this delegation of responsibility must be made by the attending surgeon who is ultimately responsible for the patient's care; such judgements shall be based on the attending surgeon's direct observation and knowledge of each resident's skills and ability.
- e. A fellow may not supervise chief residents.

2. Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibility, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. Adequate time for rest and personal activities must be provided between all daily duty periods. This should consist of a 10-hour time period provided between all daily duty periods, and after in-house call.

3. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.
 - a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
 - b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patient, or conduct outpatient continuity clinics.
 - c. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the surgery service or department has not previously provided care. The resident should evaluate the patient before surgery.
 - d. At-home call (pager call) is defined as call taken from outside the assigned institution.
 1. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 3. The program director and the faculty must monitor the demands of the at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

NIGHT CALL

- 1) VA and Moffitt night call schedules will be coordinated through the directors of individual surgery services and overseen by the chairman and program director.
- 2) Night call schedules for TGH services will be created and published by each service's faculty sponsor/coordinator and overseen by the service chief.
- 3) All changes in the call schedule at any hospital must be authorized by the Department of Surgery Program/Assistant Program Director and the Senior resident.
- 4) At Tampa General Hospital, all call rooms are located on the fourth floor next to Labor and Delivery and over the Emergency Room. Rooms are assigned by the Department. A lounge, exercise room, computer lab, kitchen, and study rooms are provided for house staff. The code for entering the call rooms can be obtained from the Office of Clinical Affairs or the Chief Residents. For further information, Ms. Elaine Adams can be contacted at 844-7412.

Entrances to the hospital are locked from 8:30 p.m. to 6:00 a.m. daily. House staff can obtain access to the hospital by entering through the Emergency Care Center with the ECC code which can be obtained from the Office of Clinical Affairs.

- 5) At the James A. Haley Veterans' Hospital, the call rooms are on the seventh floor.
- 6) Senior Residents must be readily available at all times for consultation and patient care at night and throughout the year.
- 7) When you are in the sleeping quarters, notify the operators of the telephone number at which you may be reached.

OUTSIDE EMPLOYMENT

House officers may not accept outside employment or engage in other outside activity which may interfere with the full and faithful performance of clinical responsibilities unless such activities are individually and specifically approved by the Program Director/Assistant Program Director. Violation of this policy may lead to disciplinary action up to and including termination of training.

Outside employment malpractice insurance coverage is **not** provided by the Health Sciences Trust Fund and is the responsibility of the house officer.

HOLIDAYS

Residents at **Tampa General Hospital** will observe the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Residents at the **James A. Haley Veterans' Hospital and Bay Pines VA Medical Center** will observe the following holidays:

- New Year's Day
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veterans' Day
- Thanksgiving Day
- Christmas Day

Residents at the **H. Lee Moffitt Cancer Center and Research Institute** will observe the following holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

HOLIDAY HOURS ARE THE SAME AS SUNDAYS.

PAGING

Surgical house staff are provided pagers at all hospitals. The pagers provide the primary means of communication. They should be "on" during duty hours.

House officers will be assigned pagers by the Office of Clinical Affairs. House officers will maintain the same pager for the duration of the residency training at the University of South Florida. At the end of the residency, pagers should be returned to the Office of Clinical Affairs. **Damaged or lost pagers will be the responsibility of the resident.**

Pagers will be assigned to the fellows by the Department of Surgery.

Cautions:

Speak slowly and clearly. Wait for the end of the signal tone to start your message. Be discreet. Conversations are monitored by the switchboard. They are also a radio broadcast which can be heard by anyone with a short-wave set.

It is convenient to keep a list of pager numbers which you frequently need to contact.

A Special Note:

If you are covering the Emergency Room or are on call for emergencies (at any hospital), never leave your pager unattended or turned off. Should you need to go to the operating room or otherwise be unable to respond IMMEDIATELY to a page, leave your pager with another member of the surgical house staff who is free to "cover" for you.

All hospitals have back-up loudspeaker paging systems which may be utilized in the event of radio failure.

Not answering pages during assigned duty hours will be considered grounds for dismissal from the residency.

ABSITE (INSERVICE EXAM)

The ABSITE for 2007 will be held Saturday, January 27, 2007, from 7:30 am to 1:00 p.m. The location will be announced.

RESIDENT LOAN DEFERMENT

Loan Deferment forms should be submitted to the Surgery Residency Coordinator in the Office of Surgical Education. The Department will certify the house officer's current academic year of training and the anticipated graduation date.

APPOINTMENTS AND SALARIES

- 1) Appointments for the post-graduate year positions will be made through the National Resident Matching Program.
- 2) Appointments for first, second, and third post-graduate year positions will include those who plan to enter specialty training after the prerequisite years of General Surgery.
- 3) When appointed to a five year post-graduate position, any resident planning to continue in the five year General Surgery program may expect to complete his/her training, provided that s/he continues to perform house officer duties at a level comparable to peers. In other words, there is no "pyramid" system in the University of South Florida, Health Sciences Center, Department of Surgery program. There is, of course, no guarantee that all residents will reach the senior year automatically. However, residents are evaluated every 3-4 months. Contracts are renewed annually only if the resident's performance and progress is satisfactory. **Residents' progress in the program will be evaluated by faculty, the Chairman and the Program Director every 3-4 months. Contracts will only be renewed and residents only be advanced in the program after successful completion of the evaluation process.** Satisfactory completion of the training program shall be determined by the Program Director/Assistant Program Director within the requirements of the accrediting agency. There is no guarantee of salary or benefits beyond the contracted training period.
- 4) All contracts are renewed on an annual basis for salary change purposes. The salary schedule is as follows:

PGY-1	\$41,100
PGY-2	\$42,650
PGY-3	\$44,750
PGY-4	\$46,550
PGY-5	\$48,100
PGY-6	\$49,700
PGY-7	\$50,700
- 5) Residents engaged in employment outside the Department must notify the Program Director/Assistant Program Director of the time spent and the type of work being done.
- 6) The funding for resident salaries is provided by the hospitals where the residents are rotating. The funds are deposited into a grant account called the Common Pay Source. The University of South Florida administers the Common Pay Source, and residents are paid by the State of Florida.
- 7) Paychecks are issued bi-weekly. Residents are required to sign up for electronic payroll direct deposit, within 30 days, as a condition of employment, as mandated by the State of Florida.

LEAVE POLICY

VACATIONS:

- 1) Vacations will be assigned by the Assistant Program Director in the Department of Surgery.
- 2) Each house officer at the PGY-1 level is entitled to 10 weekdays of vacation. PGY-2,3,4, and 5 levels are allowed 15 weekdays per year. **Vacation leave days MAY NOT be carried over from one appointment year to the next, and no payment for unused leave will be made upon terminating the training program.** In general, vacation leave is to be taken in increments of a full seven days (Monday-Sunday). The weekend before your vacation is **NOT** automatically included and travel plans should be made beginning on Monday unless otherwise approved by the Chairman, Program Director or Assistant Program Director of Surgery.
- 3) There will be no compensation for unused leave. A written leave request form must be submitted to the Assistant Program Director. Once vacations are assigned, they will **NOT** be changed without prior approval of the Chairman.

The deadline for submission of vacation requests is **July 15, 2006**. Requested vacations are not guaranteed. Once vacations are assigned, they **WILL NOT** be changed. After July 15, vacations will be assigned.

- 3) A maximum of two (2) weeks vacation may be taken while assigned to any one hospital in PGY-2 through 5 levels. House officers at the PGY-1 level must take only one week at any one hospital. Residents at the VA must make arrangements through the VA Surgical Office at least two months before the planned vacation.
- 5) Absolutely no vacations will be approved during the following periods:
 - a. The month of July.
 - b. The month of June.
 - c. Christmas/New Year's Week (December 24-January 1)
 - d. Last week in January (ABSITE).
 - e. (ACS Clinical Congress Meeting).
- 6) House officers should "spread" their vacation time evenly over the year. PGY-1 level residents must take at least one week of vacation during the first six months of the year. House officers at the PGY-2, 3, 4, and 5 levels should plan to take at least one week of vacation during each 1/3 (four months) of the year.

SICK LEAVE:

Residents will each be allocated nine (9) working days of sick leave at the beginning of each appointment year. In addition, each resident contributes one (1) working day of sick leave to the Sick Leave Pool. Sick leave pool credits may be used by individuals who are required to discontinue work because of medical needs. Such use may be allowed only after exhaustion of accrued sick leave and all but five (5) weekdays of annual vacation leave, up to the maximum of 90 days per individual, with the pre-approval of the Program Director and the GME office. The use of the Sick Leave Pool is not available for uncomplicated maternity.

The non-pool sick leave days cannot be carried forward in the case of parental leave where accumulated sick leave days may be carried forward with the pre-approval of the Program Director and the GME office.

Sick leave is to be used in increments of not less than a full day for any health impairment that disables an employee from full and proper performance of duties (including illness caused or contributed by pregnancy when certified by a licensed physician). Sick leave may be used in half-day increments as needed for personal appointments with a physician, dentist, or other recognized health care practitioner.

In case of death in the immediate family, sick leave may be used in reasonable amounts at determined by the house officer's immediate supervisor. Immediate family includes spouse, parents, grandparents, brothers, sisters, children, or grandchildren of both house officer and spouse. A resident suffering a personal disability necessitating use of sick leave without prior approval must notify the supervisor as soon as possible.

Unused sick leave will not be paid upon termination of training program for any cause.

UNEXCUSED ABSENCE:

If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. Unexcused time will be taken as leave from the resident's leave entitlement. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending upon the severity and frequency of the infraction. Arrangements for "payback" to other residents who may be assigned to cover night call or assigned hours will be made at the discretion of the Program Director.

FAMILY AND MEDICAL LEAVE:

Please refer to the University of South Florida College of Medicine House Officer Policies and Procedures Manual.

MILITARY AND CHILD CARE LEAVE

Please refer to the University of South Florida College of Medicine House Officer Policies and Procedures Manual.

ADMINISTRATIVE/EDUCATIONAL LEAVE

Compensated leave is allowed at the discretion of the responsible program for administrative or educational purposes.

RESIDENT ASSISTANCE PROGRAM

The Resident Assistant Program (RAP) is a confidential evaluation, brief counseling and referral service designed to assist the resident and family members in finding help with a wide variety of problems. The RAP is intended to help the resident complete the Program in the healthiest condition possible, whether that health issue is mental, physical, or spiritual. This service is voluntary, completely confidential and provided as a benefit of the residency program. To access the program a resident calls 813/870-3344 (24 hours a day, seven days a week), a number reserved specifically for the Resident Assistance Program. The first three visits by the resident and/or his/her family members to the RAP are free of charge. The program is staffed by highly qualified professionals to help with any area of concern related to emotional difficulties, marital problems, alcohol or drug abuse, family matters, grief and loss or legal and financial concerns. The service is established through non-University providers to assure privacy and freedom from interaction with colleagues or supervisors.

HEALTH AND DISABILITY BENEFITS

Please refer to the USF College of Medicine Policies and Procedures Manual for information.

PROFESSIONAL LIABILITY

As a member of the University of South Florida Health Science Center you are provided professional liability protection by the **University of South Florida Health Sciences Center Insurance Trust Fund**, a self-insurance program created by the Florida Board of Regents for the benefit of the University of South Florida Health Sciences center, its students, faculty, and other employees. Proof of protection can be obtained by contacting the Office of Surgical Education or the **USF Trust Fund Office at (813) 974-8008**.

ACCIDENTAL EXPOSURE

All individuals receiving accidental injury with possible exposure to disease (e.g. needle sticks) are to seek immediate and appropriate care at the institution at which the injury occurred. Please refer to the USF College of Medicine Policies and Procedures Manual for information.

EVALUATIONS

FACULTY EVALUATION OF RESIDENTS:

- 1) Residents will be evaluated by the faculty they work with at the end of each rotation. Service evaluations are internet based and include aspects of the 6 competencies (patient care, medical knowledge, practice based learning, interpersonal and communication skills, professionalism, and system based practice). The exact process of the evaluation involves an email notification of the faculty that includes a link to the secure evaluation web site. The residents have access to a hard copy of their evaluations in their personnel file. The personnel file is accessible to the resident through the Office of Surgical Education.
- 2) The faculty meets as a group 3-4 times a year for a comprehensive review of all the residents' evaluations and a discussion of their performance. The residents are informed of the results of the comprehensive evaluation every 3-6 months. This information is relayed in writing to their home address as well as in a meeting with their faculty advisor and the program director.
- 3) Faculty evaluations and written examination will be used by the Faculty Program Director/Assistant Program Director of the Department in determining the progress of the resident through the training program.
- 4) The Chairman, or his designated alternate, will administer any necessary remediation or counseling. When indicated, individuals will be placed on probation or suspended.

RESIDENT EVALUATION OF FACULTY:

Residents turn in written, anonymous evaluations of the program, rotations and faculty 2-3 times per year. The results of these evaluations are reviewed by the chairman and program director. Appropriate feedback is given to the individual faculty members as well as the surgical division chiefs. This information is used to alter the educational content of the program and its rotations as well as for making decisions in regards to resident allocation to certain services (the higher the educational content and the lower the non-educational work load of a particular rotation the more likely residents will be assigned to that particular rotation).

CAUSE FOR DISMISSAL

- 1) Failure to be present during duty hours or when on call.

- 2) Intoxication or imbibing of alcohol or illicit drugs while on duty or on call.
- 3) Conviction of a felony or violation of federal, state, or local narcotics law.
- 4) Falsification of medical records.
- 5) Repeated violation of Department rules after counseling.
- 6) Patient neglect resulting in injury or harm to the patient.
- 7) Performance of invasive procedures without appropriate authorization, except in definite life-threatening situations.
- 8) Failure to maintain academic standards and educational requirements of the Department.
- 9) Falsification of data on your application.
- 10) Performing operating room procedures without proper attending supervision.
- 11) Failure to give emergency help to all patients at all times throughout the hospital, regardless of whether or not that patient is on the service.
- 12) Recommendation by faculty evaluation process.
- 13) Repeated failure to answer pages during assigned duty hours.

GRIEVANCE POLICY

The Department of Surgery follows the grievance policy published by the USF College of Medicine GME office. This policy is available for review in the USF Resident Handbook and the USF College of Medicine web page (www.usf.edu/housestaff).

Policy Statement

As part of the University's policy of Grievance, the fundamental character of the academic enterprise should set the context of administrative decision making. Thus, the values of the academic environment -- values that encourage free expression, self direction, independence of thought and action, individual responsibility, collegiality, and the highest standards of ethical behavior -- should guide the determination of methods of investigation and documentation that will be utilized in the resolution of situations involving non-criminal malfeasance, misfeasance, or other misconduct of University employees in the performance of duties (See University Policy #0-017 – Non-Criminal Investigation Procedures).

In addition, the University of South Florida recognizes the right of its employees and students to voice their concern on campus issues or personal issues of concern to them without fear of any negative, retaliatory, or reprisal action as a result of having lodged a grievance, appeal, or claim (See University Policy #0-013 – Reprisals). Performance of the resident may result in disciplinary actions leading to the discontinuation of the individual in the Residency Program. The circumstances of the discipline and subsequent right of the resident to initiate the Grievance Procedure are outlined below.

Procedure

Responsible Party

Action

A resident's appointment in the residency program may be conditioned, suspended or terminated in the following circumstances:

Program Director

Upon or following review of the resident's progress through the evaluation process outlined in Section IV.A.3 of the Resident Handbook.

Following receipt of reliable information that the resident's clinical judgment or proficiency in clinical skills necessary to the practice of medicine is deficient or impaired. Under such circumstances, the College of Medicine Dean or designee, or the Program Chairman may suspend the resident immediately from patient care responsibilities.

Resident

Shall be afforded written notification of any decision affecting unconditional continuation in the Program. Written notice will include:

1. The grounds upon which the action is based;
2. Advises the resident of his/her right to request a hearing;
3. Informs the resident that he/she has 14 days after receipt to request a hearing;
4. Informs the resident to whom a written request for hearing is to be directed; and
5. States that failure to request a hearing constitutes waiver of all rights to an appeal.

May appeal the decision by filing a letter of dispute with the Chairman of the Program for non-renewal of contract, suspension, termination, imposition of limits on responsibilities or imposition of disciplinary action.

The Chairman of the respective department will attempt to address the appeal and resolve the dispute if possible.

Associate Dean

If the Chairman is unable to resolve the dispute to the resident's satisfaction, the resident may file the letter of dispute with the Associate Dean, Graduate Medical Education, who will review the situation and seek resolution.

If unresolved, the Associate Dean of Graduate Medical Education shall refer the matter to the Dean for consideration by a Performance Dispute Resolution Committee. At that time, the Chairman shall forward documents relating to the Department's position to the Dean for subsequent consideration by the Professional Dispute Resolution Committee.

Dean

Shall designate a three- (3) person Professional Dispute Resolution Committee consisting of one USF College of Medicine Faculty member selected by the Department Chair, one Housestaff or USF College of Medicine Faculty Member selected by the resident, and a third Member selected by the first two members. The third member cannot be a member of the involved Clinical Department or a Chairperson of any Department.

The Dean will provide all material relevant to the Dispute Resolution Committee, including a statement of the Department's position and the resident's letter of dispute. The Dispute Resolution Committee will permit the resident to submit whatever material the resident believes to have bearing on the dispute for the Committee's consideration. The Committee will arrange to meet with the resident to afford him/her an opportunity to make an oral presentation. The Committee will then review all material relevant to the dispute, interview appropriate individuals, and issue written findings and a recommendation to the Dean. The Dean shall render the final decision for the College of Medicine and the University of South Florida. Timeline:

Recognizing that it is in everyone's best interest to resolve disputes expeditiously, it is difficult to meet or enforce strict time lines. Every effort will be made to expedite each step in the appeal process, but emphasis will be placed on fairness rather than speed.

Hearing Conduct:

1. The resident will be given written notice of the time and place of the hearing before the Committee.
2. The resident may bring an attorney, or other advisor, who can assist the resident, however, the attorney/advisor will not be allowed to represent the resident or participate in the deliberation of the Committee.
3. Although evidence may be presented, the hearing is not a legal proceeding, does not follow the rules of law or of evidence, and is not subject to laws relating to the conduct of legal proceedings.
4. Since the Committee is advisory to the Dean and is not serving as the institutional official, the committee report is not subject to appeal, cross-examination, or negotiation.

HARASSMENT:

The University's College of Medicine maintains specific guidelines regarding all forms of harassment, which are consonant with the rules and policies of the University, as well as laws and rules of the State of Florida. Sexual harassment and all other forms of harassment are inconsistent with the role of a professional and are not tolerated by the University. Individuals with knowledge of harassment are encouraged to promptly report such activity to the Office of the Dean or the Associate Dean of Graduate Medical Education of the University's College of Medicine.

DRESS CODE

All male house officers shall wear dress shirts and ties during duty hours. Turtleneck sweaters are NOT acceptable in place of a shirt and tie. The white full length clinical coat is to be worn in all patient contact areas, by both male and female house officers.

Appropriate shoes shall be worn by both male and female house officers while on duty. Flip flops and sandals are not acceptable during regular duty hours.

Each male and female house officer is expected to be neatly and appropriately groomed and attired while on duty.

University of South Florida identification badges are to be worn at all times. ID badges may also be issued at Tampa General Hospital, James A. Haley VA Hospital and Moffitt.

Scrub suits are provided at each hospital for wear in the operating room suite. Scrub suits are not to be worn outside the OR area except in emergencies.

**AMERICAN BOARD OF SURGERY - CANDIDATES FOR BOARD CERTIFICATION IN
GENERAL SURGERY**

BOARD CERTIFICATION:

Senior residents applying for board certification should coordinate applications through the Residency Coordinator in the Office of Surgical Education. Candidates planning to take the American Board of Surgery examination will be required to have a total of 500 cases as surgeon with a minimum of 150 cases during the chief year. Cases as teaching assistant do

not count as cases as surgeon. An individual is expected to have met the case requirement as surgeon before functioning as a teaching assistant. Case logs should be kept up to date as they are now transmitted directly to the American Board of Surgery in mid-May.

The Board has “defined categories” within which specific numbers of cases must be performed. A list can be obtained from the Office of Surgical Education.

IN-SERVICE EXAMINATION:

Each resident is required to participate in the American Board of Surgery In-Service Training Examination (ABSITE) each academic year. The purpose of this examination is to allow the individual house officer to compare his own academic progress with his peers on a nationwide basis. Residents are expected to score above the 25th percentile for the appropriate year in training. The In-Service Training Examination is customarily given on the last Saturday in January (date will be announced). The In-Service Training Examination plays a significant role in resident evaluation by the Department of Surgery. The examination will be used as an important method of determining the house officer’s progress in the program. Emphasis is also placed on the In-Service Training Examination results when applying for fellowship.

LOG OF OPERATIONS

The log of operations is essential for our residency accreditation and will prove to be invaluable in preparing your American Board of Surgery (ABS) application.

Beginning July 1, 2002, each resident is responsible for keeping a record of all their own cases. All residents will be required to record their operative data utilizing the ACGME Resident Data Collection System, which is an Internet-based data collection system utilizing CPT codes. Data may be entered from any PC connected to the World Wide Web. Residents will be passwords and oriented to the system. Case logs should be kept up to date as they are now transmitted directly to the American Board of Surgery in mid-May.

The RRC requires a minimum number of cases (as chief resident, junior resident, and teaching assistant) in the following categories:

It should be noted that the ABS does count first assist, however the RRC does not.

Skin and Soft Tissue/Breast	25
Head and Neck	24
Alimentary Tract	72
Abdomen	65
Liver	4
Pancreas	3
Vascular	44
Endocrine	8
Thoracic	15
Pediatric	20
Plastic	5
Trauma Surgery	10
Trauma non-operative (critical care)	20
Endoscopy	29
Basic Laparoscopic Procedures	34

Candidates planning to take the American Board of Surgery examination will be required to have a total of 500 cases as surgeon with a minimum of 150 cases during the chief year.

Timely and accurate records of the resident's and the Department's operative experience are important, not only for each resident's American Board of Surgery application at completion of residency, but also for the Program's accreditation.

ABS application will not be signed or supported by the Chairman unless the resident's ACGME logs are updated and complete.

ACLS CERTIFICATION

House staff is required to hold current ACLS certification during their term in a USF affiliated institution. House officers not holding certification by January 1 will be required by the University to take vacation leave to complete certification by March 1.

House Officers will be held responsible financially for new courses if attendance was based upon a lack of follow-through from a previous course.

RESEARCH

House officers are encouraged to engage in a basic and clinical research. Basic research protocols must be approved by the Chairman of the Department of Surgery and the Research Committee. Residents wishing to be involved with basic science research need to inform the Department no later than one year prior to the date they anticipate to begin research. All residents are expected to obtain independent non-departmental funding for salary support during their time in the lab. Possible sources of funding include the mentor's grant or the resident's own grant such as those available from the American College of Surgeons and other organizations.

Residents will only be allowed to leave the clinical rotations and enter research if service needs/resident numbers are adequate. In the event that more residents are interested in pursuing research than spots/funding are available, interested residents should submit a proposal (at least one year prior to entering the lab) and absolutely no later than the November prior to the beginning of the academic year. Residents will be selected to enter the lab after their proposals are evaluated by the Chairman and the Research and Educational Committee.

During the course of his/her residency, each house officer will be extended the opportunity to participate in one or more research projects.

MEETINGS

House officers may be sent to regular or national meetings at the discretion of the Chairman and the Division Directors.

It is the prerogative of the Chairman, Program Director and Division Directors to establish resident travel guidelines. Residents **must** submit a leave request and this must be approved by the Chairman prior to attending the meeting. Attendance to meetings is not guaranteed and in the case of conflicts, scheduled vacations and service coverage/commitments take priority. Residents planning approved travel will arrange housing and travel through the Surgery Residency Coordinator to assure reasonable hotel rates and will be reimbursed for their airfare, meals, registration fees, etc. (following established reimbursement guidelines).

CONFERENCES

House staff is required to attend all scheduled conferences at their assigned hospital.

In order to maximize educational time in the new era of work hours restrictions the conference and lecture schedule has been altered so that all educational activity (M & M, Grand Rounds, Resident Lectures) takes place on Monday, 7:30am-12noon. Residents are excused from all clinical duties during this time, roll is taken and attendance is mandatory. These conferences constitute a major portion of the Department's teaching program. The attendance of the house staff at these conferences is interpreted as an index of their participation in the educational process of the Department. House staff is responsible for the attendance of their students at conferences.

Regular attendance is expected of all house staff and students at all Department of Surgery conferences to include: Grand Rounds, Specialty Conference, GI Conference, Trauma Conference, and Morbidity/Mortality Conference, Resident Curriculum Lectures and Teaching Conferences. Attendance will be monitored and will also be used in the overall evaluation process with regards to resident promotions.

MONDAY MORNING SCHEDULE

7:30-8:30 am – Morbidity & Mortality Conference

8:45-9:45 am – Surgical Grand Rounds

10:00 am- 12noon – Resident Lectures (Basic and Clinical Science)

All Monday morning conferences take place in MDL 1005.

MORBIDITY AND MORTALITY CONFERENCE

This weekly conference will cover complications and mortality occurring at the Tampa General Hospital, the James A. Haley Veterans' Hospital, H. Lee Moffitt Cancer Center, Bay Pines VA Medical Center, and All Children's Hospital. In addition, unusual cases will be presented for more detailed discussion by the senior resident on each service.

Senior residents are also responsible for entering their service cases in the M&M log by 12:00 noon on Thursday and are responsible for presentation of all cases listed in the weekly log for the designated week. X-rays or autopsy findings should be available for review when appropriate.

COMMITTEES

The Tampa General Hospital and James A. Haley Veterans' Hospitals have assigned house officers to various standing committees of the hospital. They will allow the selected house officer(s) the opportunity of actively participating in hospital affairs and provide a beneficial educational experience for him/her in the mechanics of hospital administration committees.

DEPARTMENT OF SURGERY
ADVANCED GI AND MINIMALLY INVASIVE SURGERY FELLOWSHIP

ALEXANDER S. ROSEMURGY, II, M.D.
(813) 844-7393

The Advanced GI and Minimally Invasive Surgery Fellowship provides the highest level of training in advanced GI and minimally Invasive surgical techniques, preparing the fellow for future clinical practice, research and teaching. The goals of this one year program are to:

- Train the fellow in the application of new techniques in advanced GI and minimally invasive surgery.
- Prepare the fellow to train others in the application of new technology.
- Include the fellow in the development of new applications of technology and provide guidance and resources for the development of independent investigations that evaluate treatment modalities in advanced GI and minimally invasive surgery.

The program includes clinical, academic, and research components. The minimally invasive experience includes training in advanced techniques including: antireflux surgery, surgery for dysphagia, common duct exploration, hernia repair, bowel resection, gastroesophageal surgery, bariatric surgery and solid organ removal. Experience is gained in flexible endoscopy including diagnostic, therapeutic, and advanced upper and lower endoscopy of the GI tract and rectal ultrasound.

DEPARTMENT OF SURGERY
RESIDENCY IN SURGICAL CRITICAL CARE

RODNEY DURHAM, M.D.
(813) 844-4395

This one year residency in Surgical Critical Care, based at Tampa General Hospital, was accredited for July 1, 2004. It is under the direction of the Trauma Team comprised of Dr. Durham, Lewis Flint, M.D., and David Shapiro, M.D. The goal of this residency is to provide the resident with advanced instruction in the management of critically ill patients. It is intended that the majority of residents will have finished an accredited general surgery program, however, occasionally residents within our general surgery program who have completed three clinical years and who have been guaranteed a position to complete their general surgical training may be accepted into the critical care residency program.

DEPARTMENT OF SURGERY
FELLOWSHIP IN SURGICAL ONCOLOGY

VERNON K. SONDAK, M.D.
(813) 745-3131

The Fellowship Program in Surgical Oncology at the University of South Florida and the H. Lee Moffitt Cancer Center and Research Institute received a five year re-accreditation from the Society of Surgical Oncology in 1999. The program is approved for two fellows per year for a two year period. Applicants must be eligible for a Florida Medical License. Fellows are expected to participate in translational research, to teach other fellows, residents and students, to publish actively, to conduct Grand Rounds, and to develop a research interest which can be pursued full time during the research period of the fellowship. Several basic science programs are available for fellow interaction and participation. It is hoped that the majority of fellows will pursue a career in academic surgical oncology.

The two year surgical oncology fellowship consists of 18 months of clinical activity and at least six months of basic research experience. A third year of research is available for suitable applicants interested in an academic career. Rotations on the Medical Oncology, Radiation Oncology, Surgical Pathology, and Clinical Trials/Statistics services are provided at the beginning of the training program. Rotations on the Sarcoma, Colorectal Cancer, Head and Neck, Breast, Gynecology, Cutaneous Malignancy, Thoracic, and Gastrointestinal Services afford the fellow an opportunity to participate in the interdisciplinary conferences and care teams of each group. The fellowship is heavily focused on operative experience.

DEPARTMENT OF SURGERY
VASCULAR SURGERY HOUSE STAFF

MURRAY SHAMES, M.D.
DIRECTOR, VASCULAR SURGERY RESIDENCY PROGRAM

(813) 259-0956

The Vascular Surgery Residency at the University of South Florida, Health Sciences Center provides a broad range of experience in the clinical management of patients with arterial, venous, and lymphatic disorders of the peripheral vascular system. In-depth clinical experience in both surgical and non-surgical problems is provided along with training in interpretation of arteriography and performance and interpretation of noninvasive vascular diagnostic studies. Appropriate clinical exposure is provided for all levels of general surgical house staff as well.

Vascular Surgery residents at the University of South Florida are assigned to the Tampa General Hospital and James A. Haley Veterans' Hospital.