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1. INTRODUCTION - LOMA LINDA UNIVERSITY HEALTH GENERAL SURGERY RESIDENCY

Welcome to the General Surgery Residency Program at Loma Linda University Health and affiliated hospitals. It has taken much work and focused attention for your arrival at this point in your career - CONGRATULATIONS! Your choice of a residency has been pivotal, for it will affect your future professional satisfaction and your contribution to medicine, as well as your personal and family life. The residency years may be stressful and time consuming, but this intensity will be rewarded by accomplishment and the acquisition of technical skills and knowledge that can be used to help patients in a profound way.

Our goal as surgery attending staff is to teach the knowledge and practice of surgery while reflecting true Christian empathy and compassion. Each of you has different long-term goals: some to serve as community surgeons, some as surgical missionaries, and some as academic surgical researchers and teachers. There is ample opportunity, and we have developed a residency program that will satisfy the development of any of these goals. As Christian teachers, we want our graduates to be known for their outstanding capability and knowledge, their compassion and trustworthiness. Our goal is for you to be leaders in surgery.

2. MISSION STATEMENT

a. To educate medical students and residents in the art and science of surgery.

b. To recruit, support and retain faculty with high academic standards, who are committed to surgical education and are excellent role models to younger generations of surgeons.

c. To maintain and foster a research environment that contributes to medical knowledge and stimulates innovative thinking in our residents and faculty.

d. To foster an educational environment in which the mission of Loma Linda University, “To make man whole,” is emphasized not only in the care of the patient but also by helping our residents to become excellent surgeons while they continue to cultivate their cultural, social and spiritual life.

3. GENERAL EDUCATIONAL OBJECTIVES

a. To acquire a comprehensive knowledge base, clinical decision-making ability, and technical skills in the principal components of general surgery. These goals are fostered in an environment of progressively-graded responsibility in patient care and in the operating room.

b. To acquire a broad experience in the additional components of general surgery, including acquisition of the appropriate knowledge base, the development of specific technical skills, and an understanding of the principles of decision-making particular to the specialty.
c. To acquire the ability to quickly and effectively assess, stabilize, and manage (operatively or non-operatively, as appropriate) the patient with severe multiple injuries, regardless of the organ systems involved.

d. To demonstrate the intellectual curiosity and commitment required to participate fully in the didactic curriculum of the residency program and to develop personal, life-long habits of self-study and continuing education.

e. To develop professional habits consistent with sound ethical medical practice, including:
   - Effective interpersonal relationships with peers and other health professionals.
   - A compassionate attitude toward patients and their families and friends.
   - Clarity and timeliness of written communication in medical records and elsewhere.

f. To develop General Competencies in areas recommended by the ACGME
   - Patient care
   - Medical knowledge
   - Practice-Based learning and improvement
   - Interpersonal and communication skills
   - Professionalism
   - Systems-Based practice

g. To secure an environment in which the residents can develop mature surgical judgment and technical skills and, at the same time, be able to cultivate their cultural, social and spiritual life.

4. YEARLY EDUCATIONAL OBJECTIVES

a) PGY-1 Residents are expected to accomplish and maintain the following objectives:

1. Establish basic proficiency in the evaluation of patients under routine and emergency circumstances (recognizes surgical emergencies, performs a history and physical examination, orders appropriate basic ancillary studies, effectively communicates findings to other physicians).

2. Establish basic proficiency in providing pre-operative and post-operative care (writes appropriate pre-op and post-op orders for floor patients, handles nursing calls appropriately, and manages most routine postoperative care with minimal intervention by supervisors).

3. Develop a working knowledge of common problems in general surgery, vascular surgery, plastic surgery, and urology (achieves acceptable grade on rotation evaluation).
4. Establish a working knowledge and familiarity with common procedures of the surgical specialties (achieves acceptable grade on rotation evaluation).

5. Acquire basic operative skills necessary to perform less complex surgical procedures, such as hernia repair, central line procedures and minor outpatient surgery.

6. Acquire proficiency in surgical endoscopy (successfully performs colonoscopy, EGD, sigmoidoscopy).

7. Develop personal values and interpersonal skills appropriate for the surgical resident (is available at required times, gives patient care needs highest priority).

b) **PGY-2 Residents** are expected to accomplish and maintain the following objectives:

1. Develop enhanced proficiency in the provision of pre-operative and post-operative care (manages pre- operative and post-operative care of complex patients with minimal intervention by supervisors).

2. Establish a knowledge base and skill proficiency for the management of the critically ill surgical patient and the burned patient (achieves acceptable grade on rotation evaluation, can place endotracheal tube, S-G catheters, arterial lines, and perform Escharotomy).

3. Develop organizational and teaching skills necessary for basic management of a surgical service (attends to organizational duties of service such as organizing rounds and teaching sessions).

4. Acquire basic skills to perform endotracheal intubation and administer conscious sedation.

5. Acquire basic skills to perform ultrasound evaluations of breast, thyroid and trauma.

6. Develop a working knowledge of and familiarity with the management of common problems in thoracic surgery and transplant surgery (achieve specific goals & objectives on these services).

7. Increased skill in operative technique required for procedures of increasing surgical complexity, such as skin grafting, more complex hernia repairs and complex soft-tissue surgery (is able to perform these operations with minimal assistance).

c) **PGY-3 Residents** are expected to accomplish and maintain the following objectives:

1. Continues to develop technical skills necessary for the performance of more complex surgical
procedures in general, pediatric, vascular, endocrine, thoracic and minimally invasive surgery (performs laparoscopic cholecystectomy, small bowel resection, and other procedures of similar complexity).

2. Establish a knowledge base, judgment and interpersonal skills necessary to function as a surgical consultant (successfully manages simple consults and traumas with minimal help).

3. Develop enhanced skills in the management of a surgical service (manages service administrative duties assigned by chief resident or faculty).

4. Proficiency in the rational use of surgical literature and evidence-based medicine (defends discussions and recommendation with scientific evidence).

d) **PGY-4 Residents** are expected to accomplish and maintain the following objectives:

1. Continue to develop knowledge and skills necessary for the complete management of common problems in general surgery, global surgery, acute care surgery, vascular surgery and surgical oncology (manages most common problems with minimal assistance).

2. Develop knowledge and skills necessary to function as the trauma team leader for both adult and pediatric patients (successfully directs trauma resuscitation).

3. Satisfactory performance as a teacher of junior residents and medical students (receives acceptable feedback from students and peers).

e) **PGY-5 Residents** are expected to accomplish and maintain the following objectives:

1. Develop knowledge and skills necessary to assume complete responsibility for the management of the surgical patient, including mastery of the fundamental components of surgery as defined by the American Board of Surgery (achieves acceptable score on written and oral examinations and receives acceptable evaluations).

2. Proficiency in management of complex problems in general surgery, vascular surgery, surgical oncology and trauma (treats complex problems in the discipline with minimal help).

3. Demonstrates personal and professional responsibility, leadership skills and interpersonal skills necessary for independent practice as a specialist in surgery (successfully manages the chief resident services).
5. **ACGME COMPETENCIES**

The Accreditation Council for Graduate Medical Education (ACGME) has implemented a requirement that residents must obtain competence in the six areas listed below to the level expected of a new practitioner. Accreditation of a given residency is contingent on this requirement being met. Your residency program defines the specific knowledge, skills, behaviors, and attitudes required while providing educational experiences needed in order for residents to demonstrate the following:

1. Patient care that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;

2. Medical knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;

3. Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;

4. Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;

6. Systems-based practice, as manifested by actions that demonstrate an awareness of responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

6. **MILESTONES AND CLINICAL COMPETENCY COMMITTEE (CCC)**

The ACGME has implemented the Milestones Project as a way to measure performance for residents. Milestones provide a more explicit definition of expected resident knowledge, skills, attributes and performance in the six general competency domains to be demonstrated by residents during training. By doing this, it helps to expand outcome evidence for accreditation & certification and enhance public accountability.

The Clinical Competency Committee meets at least semi-annually to discuss each resident’s performance data and reaches a consensus decision on the progress of each resident for each milestone.

This serves as an early warning system if a resident fails to progress in the educational program, and will assist in his or her early identification and move toward improvement and remediation.
Membership in the CCC includes core faculty members who have the opportunity to observe and evaluate residents and other members such as administrative staff and non-MD medical educators.

7. RESIDENT ASSIGNMENT EVALUATIONS

An evaluation of resident performance is completed by your attending at the end of each rotation via MedHub and after each operative case with your attending via SIMPL. You are to review your rotation performance with your attending staff member at this time. The evaluation must be reviewed by you and the attending staff surgeon. Rotation evaluations are reviewed by the Program Director and counseling performed when indicated. The evaluations are kept in each resident’s file and are available for review at any time.

8. ATTENDING AND ROTATION EVALUATIONS

Each attending is very interested in an evaluation of his/her performance. At the close of each rotation, you will be expected to complete the faculty and rotation evaluation forms. Faculty/Rotation evaluation reminders will automatically be sent to you via e-mail when you complete the rotation.

Reminders will continue to be sent to you via MedHub through your e-mail address until you submit the evaluation. These evaluations are completely anonymous; this anonymity is guaranteed. The residency office does not have access to, nor can we obtain, your password. These evaluations are reviewed by the Program Director, the Department Chairman, the appropriate Division Chief, and are used in Faculty Evaluations. These evaluations are used to improve the content and quality of the residency program.

9. BI-ANNUAL EVALUATIONS

The Director and Associate Directors of the Residency Training Program will conduct bi-annual evaluations for each resident. These evaluations are meant to provide personal feedback regarding a resident’s performance, future goals, and to identify areas of concern and need. We recognize that a residency can be a significant stress for not only the resident but also his/her spouse. We welcome the concerned spouse to the evaluation meetings.

10. RESIDENT REPRESENTATION

When a resident has a particular problem/concern with the program, he/she has five avenues in which to discuss the problem/concern.

First, the General Surgery Residency Council is an elected group of surgery residents who meet on a quarterly basis with the Program Director to discuss issues, concerns, and changes with the program. Residents at each level of training select two representatives from their level to represent them on this
Second, all of the Chief Residents represent the residents on the Residency Review Committee. This Committee is comprised of the Program Director, Associate Directors, and attending representatives from each hospital. Please contact your resident council representative or the Chief Residents if you have issues you would like discussed.

Third, the resident can bring the problem directly to the Program Director, Dr. Jukes Namm or the administrative office personnel.

Fourth, the resident can bring the problem to one of LLU’s confidential advisors Dr. Naveen Solomon or Dr. Cynthia Tinsley.

Fifth, any resident can send an anonymous message via MedHub to the Program Director and/or Dr. Daniel Giang, Designated Institutional Official for the GME.

11. PERSONNEL FILES

A personnel file is maintained for each resident. Information kept on file consists of applications, correspondence, leave requests, and other miscellaneous items. Rotation evaluations will be reviewed with you at your bi-annual interview.

12. GRADUATE MEDICAL EDUCATION (GME) OFFICE

The General Medical Education Office (GMEO) is the hospital’s representative to oversee that all residencies are approved and functioning appropriately. The GMEO is located in The Westerly Building (Suite C) in the Cape Cod buildings at the intersection of Barton Road and Mountain View. The official address is:

11334 Mountain View Avenue, Westerly Building Suite C, Loma Linda, CA 92354

Dr. Daniel Giang is Director of GME and Marilyn Houghton is the Executive Director of GME. Other GME office personnel include Nicole Dimmitt, Teresa Meinken, Amy Yin, Gloria Mrad and Martie Parsley, PhD. They may be reached at ext. 66131.

The GME office also coordinates all payroll activities and the Resident Forum (which functions to assist residents in negotiations with the hospital and in planning social activities). Representatives to the Resident Forum are elected annually.

13. USMLE STEP 3 (US MEDICAL LICENSING EXAMINATION)

USMLE Step 3 must be passed before you may obtain your CA medical license. GME will reimburse fees
for the first time taking of the USMLE Step 3 only if successful results are submitted and the allocated educational stipend has not been fully exhausted. Once the results are received, a copy must go to residency office and GME.

Residents at LLUMC are allowed 2 days off with pay to take USMLE Step 3 for the first time. If it is necessary to re-take USMLE Step 3, vacation time must be used. Time off requests must be put in as a leave request for “conference away” on the online calendar system on MedHub. You are not allowed to take boards in December - June or the first two weeks in July; please plan accordingly. Please make sure the testing facility is available prior to requesting time off. You are required to complete a time off request and turn it in to the residency office prior to taking the boards. If insufficient notice is given to the service, your request to be off may be denied.

14. POST-GRADUATE TRAINING LICENSE MEDICAL BOARD OF CALIFORNIA

The GME office will assist you in obtaining your California Postgraduate Training License required for your first three years of training as of January 1, 2020. Subsequently, each resident will then be responsible for providing an updated copy of his/her California Medical License, DEA certificate and ACLS card to both the GME office and to the residency office. No fourth-year resident will be employed without a full California Medical License which must be obtained within 90 days of the new academic year. It is important to obtain your license as soon as you are eligible to avoid unforeseen problems.

15. CALIFORNIA MEDICAL LICENSE/DEA CERTIFICATE

Residents are required to obtain and maintain a current non-restricted California Medical License within the time frame required by LLUMC (within 90 days of beginning the fourth post-graduate year) and the Medical Board of California (MBC). It is the resident’s responsibility to obtain information concerning licensing requirements, examinations, and to meet established deadlines.

Once you have your medical license issued you may apply for your Drug Enforcement Administration (DEA) certificate online and should have this within your first 90 days as a PGY-4 resident.

a) ACLS (Advanced Cardiovascular Life Support)

The Department of Surgery requires that all first-year residents complete an ACLS course prior to beginning their first year of training. ACLS courses are conducted free of charge by the Life Support Educational Group at LLU. For more information concerning the ACLS course, please either register through the OWL Portal for the course or contact Life Support Education at x44977 for a schedule of classes. ACLS training is valid for two years. If you allow your ACLS Certification to lapse, you will have to take the full course instead of the renewal.
The General Surgery Residency program requires that all residents be in possession of a valid ACLS certificate.

b) ATLS (Advanced Trauma Life Support)

Advanced Trauma Life Support (ATLS) is required prior to starting as a PGY1. This course will assist in rotations with trauma responsibilities. The course is paid for by the residency program if you take it here at LLUMC. You will be contacted by the residency office regarding dates for the course. The residency program will pay for the ATLS course one time only per resident. The residency program does not require that residents renew ATLS.

c) BLS (Basic Life Support)

The American Board of Surgery requires that you have a valid BLS certificate at some point during residency. It is your responsibility to confirm this credential.

d) FES (Fundamentals of Endoscopic Surgery)

The SAGES Fundamentals of Endoscopic Surgery (FES) program is a comprehensive educational and assessment tool designed to teach and evaluate the fundamental knowledge, clinical judgment and technical skills required in the performance of basic gastrointestinal (GI) endoscopic surgery (endoscopy). This helps provide residents with an opportunity to learn the fundamentals of endoscopic surgery in a consistent, scientifically accepted format, and to test cognitive and technical skills – all with the goal of improving the quality of patient care. Successful completion of FES and FEC (Flexible Endoscopy Curriculum), is required to be completed during residency to be eligible for certification by the American Board of Surgery. A voucher for certification test will be provided by the administrative office once you are cleared by Dr. Yung to take the exam.

e) FLS (Fundamentals of Laparoscopic Surgery)

Fundamentals of Laparoscopic Surgery (FLS) is a comprehensive web-based education module that includes a hands-on skills training component and assessment tool designed to teach the physiology, fundamental knowledge, and technical skills required in basic laparoscopic surgery. The American Board of Surgery requires all general surgery applicants for board certification to have successfully completed the FLS program. A voucher for certification test will be provided by the administrative office once you are cleared by Dr. Yung to take the exam.

f) Sedation Training

Sedation and Analgesia by Non-Anesthesiologists is required prior to Peds Surgery via the OWL portal
(https://lluconnection.org/owl-portal). Please ensure that when the online course is taken and the test is passed, you must notify our office and we will notify Gloria Mrad to add this capability into the system.

16. LECTURES

Important in the training of a surgeon is the acquisition of basic surgical facts. You are encouraged to develop your own study program of regular reading. To facilitate your learning, we have set up a lecture schedule. The upcoming topics are listed on the front page of the website under THIS WEEK IN SURGICAL EDUCATION.

All PGY-1 and PGY-2 residents are required to attend weekly Basic Science lectures held Wednesday, at 6:00 a.m. in A-level Amphitheater. The course is based on the SCORE curriculum (called TWIS “This week in SCORE”) so you will need to be prepared for this each week ahead of time. You are expected to read the assigned materials and do the module PRIOR to each week’s lecture.

A required lecture series for PGY-3, -4, -5 is also given on Wednesday at 6:00 a.m., and is based on the “TWIS” (This week in SCORE) curriculum. This is designed to review current surgical practice and serve as a forum for clinical case discussions. You will need to be prepared for this each week ahead of time. You will need to read the assigned materials and do the module PRIOR to each week’s lecture.

a) Attendance

Attendance is taken at each lecture, and residents must be present and on time, or have an excused absence for all lectures. Excused absences include: vacation, sick all day, on call, and post call if exceeding 24 hours. If you will be on vacation or are sick, please notify the residency office of this. Any absence from these meetings must be explained. If a resident’s attendance falls below 80%, he or she will risk being placed on Academic Remediation.

If any resident is found to be signed in and did not attend the lecture or has had someone else sign in for them, this is a serious professionalism matter and will be addressed individually with all parties involved. This could risk a permanent notation in your file that could affect your future employment references and residency training verifications.

17. M&M CONFERENCE- WEEKLY MORBIDITY & MORTALITY

The monthly M&M presentation schedule is posted on the residency website and it is each resident’s responsibility to know when they are making a presentation. There is a strict deadline of NOON on Monday to submit the following to Amy Albright with a copy to Leilani O’Neill and Sandy Swanson in the Surgery Residency Office:

□ Completed M&M template with case information, including attending list and responsible
resident for cases being discussed.

- A Peer Case Review Worksheet must be completed and submitted for all complications being presented, with the exception of the VA, which are not required. Complications not being presented at M&M must be submitted to the designated QI faculty for each division. (See SR Website for further instruction under the M&M folder).
- On items for discussion, clearly mark 2 complications with an asterisk. If 2 complications are not available, mark 1 complication and 1 interesting case, or 2 interesting cases.
- Submit one high-quality multiple-choice question with the answer included.

Residents will be removed from service at 3 PM on Monday if the above items are not received in full. Additionally, we will contact the Attending on your service and the Chairman of Surgery to notify them of the delinquency. Compliance with deadlines for this process will be reflected in your milestones and evaluations, therefore you should submit these materials prior to starting work on Monday.

18. JOURNAL CLUB

Residents are required to participate in Journal Club (moderated by various Attendings) which occurs once every 8 weeks. You will be notified of the date and this will be mandatory unless on vacation or post-call. (This will be typically on the 6th week of the student clerkship track on Thursday at 5:30 PM)

19. ORAL EXAMINATIONS

Chief Mock Oral Examinations are given to all PGY-5 residents in February and May of each year. The date for this year’s regional mock oral is May 13, 2021. These will be conducted in the same format as the American Board of Surgery Certifying (oral) Examination. Participation is mandatory, as this simulates the Certifying Exam in Surgery, and will point out areas upon which the resident can concentrate study in preparation for this exam.

20. IN-TRAINING EXAMINATIONS

The American Board of Surgery In-Training Examination (ABSITE) will be held this year on Friday, January 30 and Monday, February 2, 2021. This exam tests knowledge and is graded according to level of training. It is a good indicator of surgical knowledge and gives the resident exposure to the type of testing given by the American Board of Surgery. The following guidelines are used by the Residency Committee to evaluate test results:

Residents scoring less than 30th percentile on the ABSITE will be counseled and placed on Academic Remediation; a resident scoring less than 30th percentile will have a study program for the next year outlined. Proof of completion of a current SESAP curriculum of all modules will be accepted in lieu of attending the weekend ABSITE review course purchased by the resident at their own expense.

Residents that continue a pattern of poor academic performance will be discontinued from the program.
Academic performance is based on a combination of conference participation, oral examinations, ABSITE and overall CCC assessment of milestones.

To be recommended to the American Board of Surgery Qualifying Examination, PGY5 residents need to score above 20th percentile in his/her last year or have achieved an average of 35th percentile or above averaged over the PGY3, PGY4, and PGY5 year ABSITE scores. Failure to be recommended to the American Board of Surgery will result in the need to take the ABSITE each consecutive year until the minimum percentage is met to then be recommended.

The residency hopes, by these actions, to provide a motivation for study, a monitoring process for evaluation of knowledge, and an avenue by which residents can prepare and ultimately pass the American Board of Surgery Qualifying and Certifying Examinations. (http://www.absurgery.org/)

21. AMERICAN COLLEGE OF SURGEONS

This organization is the official representative of surgeons in the United States of America. A member of this organization is called a Fellow of the American College of Surgeons. This honor is granted to those who have completed a general surgery residency, have become board certified, have practiced in a local area for two years, and have satisfactorily completed the official interview, (which reviews personal and professional attitudes and standards). Residents can benefit from the privileges and opportunities of the ACS by becoming a member of the Resident and Associate Society of the American College of Surgeons (RAS-ACS). Resident membership in the American College of Surgeons extends the educational and professional advantages of the college to surgical residents. The Candidate Group is composed of graduates from medical schools who are: A) Enrolled in approved surgical residency programs or, B) Fully trained surgeons who recently have entered into surgical practice and aspire to Fellowship in the American College of Surgeons.

The Department of Surgery requires each resident to make application to and participate in the Candidate Group. The fee for filing an application is $20.00; however, the fee is waived during the intern year. To download an application, go to the American College of Surgeons web site at facs.org. The residency will be happy to provide the letter from the department verifying your resident status. A copy of your membership card must be submitted each year to the residency office to confirm your status.

22. SESAP (Surgical Education and Self-Assessment Program)

The Surgical Education and Self-Assessment Program (SESAP) from the American College of Surgeons presents current information that many surgical authorities consider important. The program provides a means of assessing your knowledge as you prepare for your board examinations (including the ABSITE). The Surgery Department strongly recommends your participation in SESAP. Please contact the office for information on how to obtain a copy.
23. RESEARCH

The Department of Surgery Research meeting is held the 3rd Friday of every month at 0700 in the Cancer Center conference room (Shuman Pavilion A217).

Residents have ample opportunities to join their attending staff in pursuing basic science and clinical research studies. Several physicians in the department conduct research projects and should be contacted to arrange research projects. Categorical interns must meet with the Program Director before their Research elective month to discuss their project. For residents in the dedicated research track, it must be for two years after the 3rd year. See the Program Director for further details and suggestions. Please point out areas of particular interest or previous work to the Program Director or attending so work in these areas can be encouraged. Residents should plan on presenting all research and/or QI projects at the annual research day in April; as well as, at a monthly Department of Surgery Research Meeting.

Residents must accumulate four research points over the course of the residency program in order to meet one of the qualifications for recommendation to the American Board of Surgery. Submit completed presentations / publications to the surgery resident office for research credit. Be sure to add all research and presentation information in your Portfolio in MedHub.

a) POINTS can be accumulated at follows:

1. Published manuscript 4 points
2. Oral presentation at national meeting 3 points
3. Oral presentation at regional meeting 2 points
4. Submission of manuscript for publication 2 points
5. Poster presentation 1 point
6. Presentation at internal research day/ or Department of Surgery Monthly meeting 1 point

The involvement of residents in travel related to professional (educational) activities is necessary and encouraged. To facilitate resident research participation, the policy is as follows for resident travel for professional activities.

Criteria for approved travel:

- The reason for traveling is to present the results of original investigative work conducted while at LLU or for participation in educational activities approved by the Academic Manager or Program Director.
- The traveler is a listed author and will be personally making the presentation of the investigative work. Only one presenter will be reimbursed on each presentation if the first author is not
available.

- Confirmation of the work being presented must be submitted to the residency office.
- Time away from clinical duties is minimized. Residents presenting a paper or a poster at a scientific meeting can use one day for a local meeting and can use up to 3 days per year for an out-of-town meeting. (One day travel time to the meeting, one day for the presentation, and one day for return travel). Residents may utilize vacation time to stay longer at a scientific meeting where they are presenting a paper.

The residency program will assist the resident with travel expenses when the resident has a poster or paper accepted at a scientific meeting. Expenses will not be reimbursed if the approval for travel was not obtained prior to the date of departure or if a Leave Request is not completed and submitted within the usual time frames. The residency will reimburse the resident up to $750 in travel expenses (with valid receipts) and subject to the guidelines of LLUHC’s Accounting Department for the first occurrence during each fiscal year. Any approved travel that that exceeds one per fiscal year will be reimbursed up to $375 for a maximum of up to 2 per year. The total number of reimbursements for research will cap out at no more than 4 total reimbursements over the lifetime of the residency.

Allowable expenses include:

- Domestic economy class airfare (includes the United States and Canada)
- Single hotel room
- Usual and customary meeting registration fees
- Meal allowance at LLUHC-approved per diem rate
- Mileage charges and/or ground transportation fees

Additionally, if a resident has vacation scheduled and also is invited to present his/her research during a particular rotation; the vacation may have to be adjusted. The level of care in the rotation cannot be allowed to suffer due to absences. Reimbursement will be limited to no more than two presentations per year per resident as funding permits.

Each resident must apply to the surgery residency office for funding prior to the meeting via the form online remitted to Leilani O’Neill. This reimbursement is solely at the discretion of the program director and will need approval prior to the presentation. Additionally, if approved, all expenses and receipts must be submitted within 60 days of travel or by no later than June 15 of each academic year, whichever is sooner. Funds cannot carry over.

24. CATEGORICAL EDUCATIONAL STIPEND

During the PGY-3 to -5 years, each categorical resident will receive $500 total for all three years to use as an educational stipend. This is in addition to the annual GME allocation. These funds may be applied to
research travel and other educational expenses such as conferences or fellowship interviews.

Please plan accordingly as you will be allowed to spread this out over the three senior years or you may elect to save it until your chief year. If submitted your chief year, all receipts must be submitted no later than June 1 of your chief year.

25. DRESS CODE

Your dress is a demonstration of the quality of your professional skills. It is expected that surgery residents appear well-groomed and professional at all times. White clinical coats and name tags are required at all institutions. It is expected that all personnel will dress in a professional way that represents the Department of Surgery. When you are in clinic, you are expected to be in professional attire, not OR scrubs. When you wear scrubs outside of the operating room, they must be covered with a clean lab coat. You may NOT wear OR scrubs outside of the hospital. Individuals who do not meet these expectations may be asked to go home and change prior to returning to clinical duties.

This year the surgery administrative office will order each resident one set of scrubs that may be worn to and from the hospital. Please see Sandy in the administrative office for sizing and ordering information.

26. MAILBOXES

Mailboxes are located in the Resident Lounge, Coleman Pavilion, 21110. Please check them regularly for important program information and notices, even if you are on an off-site rotation.

27. CLINICAL ASSIGNMENTS

Clinical rotations form the core of surgical training. We have developed clinical rotations that allow for the progressive development of skill and responsibility of a surgical specialist. Every effort is made to ensure that residents have a basic core of clinical rotations with some allowances made to those who wish to pursue special interests or research time.

The rotation schedule is created on a yearly basis around March - May. Improvements in the residency may result in unexpected changes in the rotation schedule. If you have a specific request regarding your rotation schedule, please submit it in writing to Leilani O’Neill prior to March.

28. MALAWI ROTATION

All required paperwork for the Malawi rotation must be submitted to the residency office after notarization (as needed) by the GME office at least three months before the start of the rotation. Please get the official Malawi Handbook that outlines all requirements. This covers topics such as travel clinic information, forms, things to do prior to your departure, travel, living in Malawi, and your return back
29. OTHER CLINICAL MISSION ELECTIVES

You are allowed to participate in other clinical mission electives at LLUMC. However, the American Board of Surgery will not count any of the time that you spend on a mission elective (other than the Malawi rotation) toward your required 48 months per year of clinical surgery training. You must have a clinical sponsor for the mission trip in order to submit your paperwork, which must be submitted at least four months in advance. Once submitted, the GOAC will approve or deny the request. If approved, medical malpractice and benefits will be covered through international insurance via the GME office.

Clinical mission electives are allowed only upon administrative approval. For the actual time that you spend in the clinical setting while on the mission trip, the residency will match the vacation time that you use. For instance, if you take two weeks for the clinical mission, you must use one week of vacation, and the residency will authorize your absence without charging leave time for the second week. If part of the mission is non-clinical, then you must use your leave exclusively for that period of time and this will not be matched.

30. VACATION AND LEAVE POLICY

Year-Specific Vacation Allowances:

- **a) PGY 1 Residents** - 3 weeks (15 working days) vacation. No more than 3 days of vacation per rotation. However, if you are on the same service for 2 consecutive months, you may request 5 days and a weekend as one block of leave. You may request up to 2 vacation days of your 15 in January to study for the ABSITE. No other vacation will be allowed in January.

  No vacation on: LLUH ACS AM/PM, RUHS ACS AM/PM and RUHS SICU

- **b) PGY 2- Residents** - 4 weeks (20 working days) vacation for those continuing on from PGY 1 and 3 weeks (15 working days) if new to LLUH. If you are on the same service for 2 consecutive months, you may request 5 days and a weekend as one block of leave. You may request up to 2 vacation days of your 20 (or 15) in January to study for the ABSITE. No other vacation will be allowed in January.

  The following days of vacation per rotation are allowed:

  - No vacation on CT ICU, LLUH ACS AM/ ACS PM or VA PM.
  - 5 days of vacation for Rotations for VA Green or VA SICU. Vacation days must be taken consecutively (Mon-Fri or Thurs-Wed, example)
  - VA Blue on the PGY 2 level only cannot be gone on Fridays, so a maximum of 4 days may
be taken.

c) **PGY 3-5 Residents** - 4 weeks (20 working days) to include no more than 5 days of vacation used per rotation. You may request up to 2 vacation days of your 20 in January to study for the ABSITE. No other vacation will be allowed in January.

- For those interviewing for fellowships: You may have up to 5 days authorized absence for interviews. Anything over this is used from your vacation bank. However, you cannot exceed time off allowed by ABS. Fill out the online spreadsheet for interview time, and send to Leilani and Amy for accounting purposes. You may not take additional leave on any rotation where you are taking time off for interviews.
- Malawi rotation: You have 2 days to travel to Malawi from the start of your rotation, and 2 days for your return at the end of your rotation. Additional time taken for travel will count as vacation and must be approved.

**A. VACATION PROCESS**

- Vacation requests must be submitted online via MedHub
- Vacation requests are approved in order of receipt not seniority
- Vacation requests must be submitted for the first half of the year (through December 31) by August 1. Vacation requests for the second half of the year (through June 30) must be submitted by December 1. This is a change from previous policy, and during the transition any earlier vacation requests MUST BE submitted by the 1st of the month two months in advance (i.e. if you want September 25th off you need to have the request in by NO LATER than July 1). Exceptions to this will be made for interviews or to present research when it is accepted.
- If you have approved vacation but your rotation is changed, YOU must notify the service IMMEDIATELY and re-submit online. This should be a rare situation. Submit your request as ONE request including the full date range that you are requesting (per rotation), and in the description put the information in the text box about how you want it broken up (eg: 2 days off, 1 vacation). Do not submit multiple requests for a block of time on the same rotation to specify what is days off and what is vacation time.

Once a request is submitted, no changes will be allowed except under extenuating circumstances: interviews, leaving the program at the end of the year, maternity/paternity leave, a death in the immediate family, or illness. If any of these circumstances are foreseen, please communicate them to the residency office right away.

Vacation equals any day off that is over and above your scheduled days off. Days off (including
holidays) as assigned do not need to be logged in MedHub. This is regardless of the actual day of the week.

Chief Residents are given the option to attend the American College of Surgeons meeting in the Fall. A maximum of 3 residents can attend the meeting and are allowed 3 days of Authorized Absence to attend this conference, another pertinent conference, or a board review course as long as it does not conflict with exceeding days per the ABS training time.

Vacations are not approved for the following periods except under the most unusual circumstances:

- July – exception may be made for extenuating circumstances.
- January – you may request 2 vacation days off in the same month prior to taking the ABSITE
- Vacation is not allowed on these Services: LL ACS AM (juniors), LL ACS PM, LL CT SICU, RUHS ACS AM & PM, RUHS SICU & VA PM.
- June - last 2 weeks; exception: those moving to a training program that starts July 1.

If you do not submit all time allowed, you will lose your unused vacation time at the end of the year. You cannot carry over unused days nor will we be mandated to give days off in June due to you not planning in advance.

Vacation time cannot be carried over from one academic year to another.

This vacation and leave policy also applies to residents rotating on the surgical services from other residency programs (e.g. Emergency Medicine, Family Medicine, etc.)

During the months in which there is one legal holiday (July, September, November, December, January, February, May), residents will be given one additional day off, for a total of 5 days off duty that month. In November, where there are 2 holidays, so residents will receive 2 additional days off. There is no need for “comp days”. If a resident works on the actual legal holiday, an additional day off will have already been placed into the call schedule. All vacation must be logged as such in MedHub, BUT ONLY the days that count as vacation (usually Monday-Friday). Do not log “days off” which are typically Saturday or Sunday as MedHub will count this as a violation of not having 1 off in 7.

B. ADDITIONAL MISCELLANEOUS VACATION RULES

- If you are interviewing during a rotation, you cannot take vacation during the same rotation.
- Only 1 request for vacation per rotation can be submitted.
- Only 1 request per month for a weekend off can be submitted.
- Do not submit “no call” requests. If you need to not be on call, then it needs to be a full day off or vacation request.
• For all sick days/call offs, you must notify the LLU coordinator (Amy Albright) via email, fellow team member before the start of your shift, and the office at the facility you are located.

C. FACILITY-SPECIFIC VACATION RULES

i. LLUMC: (Amy Albright, Coordinator for a-c /Sandy Swanson, Assistant Coordinator for d
   a) ACS AM – only one senior can be gone at any given time. Time away cannot be more than 7 days total. No vacation allowed for juniors.
   b) LL GI Surg - Only one person can be on vacation from either team at any given time, and both seniors may not be gone at the same time.
   c) LL SO and Colorectal – Only one senior and one junior resident can be on vacation from all teams combined at any given time.
   d) If you are on Peds Surg, Urology, Vascular, SICU, ENT, GI Medicine, or Transplant, your vacation request will be forwarded to the respective department to be considered.

ii. VAMC: (Leilani O’Neill, Academic Manager and Dr. Aarthry Kannappan)
   a) Plan to take leave that ends with you returning to work on a business day and not encompassing more than one weekend since weekend call is Friday through Sunday, plus any flanking holidays for appropriate sign out of the service. If, for some reason it is imperative that you return to work on a Saturday, Sunday or holiday, arrangements must be made with other residents on the service to ensure a fair and appropriate number of days off for all residents concerned.
   b) Dr. Kannappan will email out the call schedule asking for any corrections/errors to be notified back to her within 48 hours. If there are any errors not brought to her attention during that time frame, you will be responsible for ensuring coverage is resolved or will need to work the scheduled time

PGY 1: up to 3 days of vacation (PLUS WEEKEND):
   VA Blue/VA Green* (if on back to back VA blue/green rotations, then five days plus weekend

PGY 2:
   a) VA Red: up to 3 days of vacation (PLUS WEEKEND)
   b) Up to 5 days of vacation (PLUS WEEKEND)
      VA Blue (but cannot be off on Fridays so Sunday through Thursday only)
      VA Green (cannot be gone if SICU resident is gone)
VA SICU (cannot be gone if Green resident is gone)

ALL SENIORS: Up to five days of vacation (all in one block of 5 days; not split up) PLUS one weekend

c) If PGY 3 Thoracic or PGY 2 SICU is off, VA GREEN/SICU must be present
d) VA RED cannot have PGY 2 and PGY 4 off at the same time
e) VA GREEN and VA BLUE seniors cannot be gone at the same time

iii. ARMC: (Shauna Stires, vacation coordinator)

a) The chief resident at ARMC makes the schedule, but Burn and SICU cross cover call
b) Please note that all ARMC residents are required to submit for all their vacation for the whole year before July 1. This means your request must be put in as early as possible or you risk it being denied.

iv. RUHS: (Celina Heredia, vacation coordinator)

a) ONLY prelim interns can request time off during SOAP week
b) ONLY RUHS Red rotators may submit for vacation
c) No vacation during
   • the first two weeks of July; last two weeks of June
   • The three weeks preceding the ABSITE
d) Vacation must be submitted 45 days preceding the 1st of the month in the month that you are requesting vacation.

D. WELLNESS TIME OFF

For all rotations (except ACS and night float) we will schedule based on availability a half day off for you to be able to take care of personal things. Half days off will be taken either in the am or pm.

E. SICK LEAVE

Residents are provided with ten Monday-Friday days of paid sick leave.

• Residents must notify the assigned service and the surgery residency office via a page or email if they are unable to work due to illness.
• Residents are responsible for keeping their residency/department aware of their status.
• The Program Director will determine whether sick leave used will have to be made up in compliance with program and Board requirements.
The GME office (ext. 66131) must be notified if a resident is hospitalized or is ill/disabled on an outpatient basis for more than seven days. Application for state disability is required if either of these situations arises. It is imperative that a disability application be submitted as soon as possible in order to avoid interruption of pay. Application for benefits must be made no later than the 20th day after the first day for which benefits are payable.

**F. MATERNITY / PATERNITY LEAVE**

The American Board of Surgery (ABS) requires that residents receive training in clinical surgery at least 48 weeks each year. In the event of maternity leave or other illness, the ABS will consider individual exceptions for training of 46 weeks per year. The Program Director will determine whether time off for maternity leave will have to be made up, in compliance with program and Board requirements. Residents must inform the Program Director of anticipated delivery within six (6) months prior to the expected delivery to allow the program to plan for the resident’s absence to minimize disruption to the program.

LLUH allows for paternity leave which may be granted with the use of up to 5 days that will come out of your sick leave bank. Please notify the administrative office with an appropriate upcoming due date so tentative planning may be made as far in advance as possible.

**G. FUNERAL LEAVE**

Three regularly scheduled work days off, with pay, for funeral leave are granted in the case of a death in the resident’s immediate family (spouse, children, stepchildren, parents, stepparents, father-in-law, mother-in-law, brothers, sisters, stepbrothers, stepsisters, only living relative, foster parents and legal guardians). The resident must notify the residency and GME offices in the event funeral leave is required.

**H. JURY DUTY**

Compensation for up to 15 days per calendar year of jury duty is provided. Court verification of time served must be given to the GME office. The GME office, the residency office, and attending must be notified of both potential and actual jury duty. Please contact the residency office for a letter requesting you are excused from jury duty as soon as you receive your jury duty summons. You will need to mail the letter in yourself.

**31. AUTHORIZED ABSENCE/FELLOWSHIP PROGRAMS/INTERVIEWS**

Categorical residents are encouraged to apply for fellowships after graduation. To support this process,
the residency allows 5 days of authorized absence (in addition to vacation) to interview for fellowships. Any additional days spent on interviews will come from the resident’s vacation bank. Additionally, if a resident has vacation scheduled and also schedules interviews during a particular rotation, the vacation will need to be cancelled.

Patient care cannot be allowed to suffer due to absences. Should this occur due to an excessive number of absences due to travel, the residency office and/or the service will be allowed to advise the resident to pare down the number of days of absences (may include missing dinners or flying more red-eye flights).

Preliminary resident physicians seeking a position for the following year will be allowed 3 days of authorized absence (in addition to vacation). Additionally, if a resident has vacation scheduled and also schedules interviews during a particular rotation, the vacation may have to be adjusted. Patient care cannot be allowed to suffer due to absences.

All requests for time off for interviews must be completed via the online system in addition to the fellowship interview spreadsheet on the website being filled out and submitted to the residency office, even though the time off is not taken from the resident’s leave bank. All residents applying for fellowship must denote the rotation(s) affected during their interview block time as no vacation will be allowed during this time.

32. ADMINISTRATIVE CHIEFS

The Administrative Chiefs, Alicia Teferi (August-Dec) and Laurel Guthrie (Jan – June) are empowered to arrange for cross coverage for non-routine service needs and shortages, and to make decisions for extenuating circumstances. It would also fall under the scope of authority for Chief Residents to help with call schedule issues, logistics and helping to assign days off as needed, and to coordinate schedules in a way to help residents comply with duty hours.

33. CALL SCHEDULES

Effective this year, call schedules will be released as early as the 1st of the preceding month. In order to do this, all requests must be entered online by the first of the month that is 2 months prior to the request.

Example: Resident Jones wants October 16-17 off, thus the request must be entered in our system by no later than August 1.

Requests for changes in the call schedule once released will not be made by emailing the person that makes the call schedule. If a change must be made, you will need to find someone to take your shift, then both parties in agreement must email the office and the person below. Whatever is posted on the schedule online is what will be the final. It is the resident’s responsibility that is requesting the change to
confirm that what is posted reflects this.

a) **Loma Linda University Medical Center**: Administrative Chief, Alicia Teferi (August-Dec) and Laurel Guthrie (Jan – June) coordinates the call schedule. Amy Albright in the residency office may be contacted at 909-558-4289 or 44289 for emergent situations not resolved by the chiefs. If you are on any service at LLUMC, you may be part of the ACS Call Schedule call pool. GI Surgery, Surgical Oncology, GI non-surgical and Research rotations all will be assigned at least one shift on ACS AM or PM. It is your responsibility to check all the schedules.

b) **VA Medical Center**: Dr. Aarthy Kannappan coordinates the call schedule and may be contacted at 909-583-6064 or 76064.

c) **Riverside University Health System**: Celina Heredia processes vacation requests (only PGY 4 is allowed time off) and coordinates the call schedule and may be contacted at (951) 486-4381 or c.heredia@ruhealth.org

d) **Arrowhead Regional Medical Center**: The ARMC/KP General Surgery Chief Resident and Shauna Stires processes vacation requests and coordinates the call schedule and may be reached at 909-580-3362 or stiress@armc.sbcounty.gov

Please note that when a call schedule is released for the new rotation it is subject to change at any time. Should you plan on being out of town or not available, you are responsible to let the surgery residency office know that you are unavailable. If you do not plan ahead and do so, you are subject to being called in should an emergency occur and we need adequate service coverage. Please do not assume that because at one point you were not on the “rounding or call schedule” that you can just leave and refuse to take call or come in to round if needed.

**34. INVASIVE PROCEDURES**

All residents must perform a minimum number of invasive procedures under direct supervision. These include, but are not limited to, central line placement, chest tube placement, arterial line placement, endotracheal intubation, etc. Junior residents who are not “privileged” to perform a given procedure must be supervised by an attending or senior resident. Residents are “privileged” to perform invasive procedures after satisfactory completion of the minimum number of procedures are signed off by an attending or senior resident and verified by the Program Director.

You must document the date, hospital, and patient’s medical record number for the procedure performed and have an attending or senior resident print and sign his/her name in the procedure area on MedHub to reflect the number of procedures indicated. Ensure you are doing all you can to obtain your numbers as this is the residents’ responsibility and is critical to determining the proficiency needed to receive privileges.
You will need to log your procedures in MedHub before your bi-annual evaluations for review. The procedures and the required minimum number that must be supervised are as follows:

a) Central Line Placement – Subclavian  5
b) Central Line Placement – Internal Jugular  5
c) Central Line Placement – Femoral   3
d) Arterial Line Insertion    5
e) Chest Tube Insertion     10
f) Endotracheal Intubation    10
d) Foley Catheterization    5
e) Pulmonary Artery Catheterization  3

35. POLICY PERTAINING TO THE SURGERY HAND-OFF PROCESS

For sign-outs, using the hospital EMR, the following information will be created as a handoff note format. Hand-off should be face to face if possible and without distractions.

Information to be pulled from the EMR

- Patient Name/ MRN/ Unit # Attending physician
- Reason for Admission Recent surgery performed Past medical history
- Code Status Allergies / Meds Current diet

Information the Residents will input as a sticky note or update on the patient list

- Current Issues
- To/Do List

Remember communication is key! If you don’t know, just ask.

36. POLICY ON HIGH RISK CLINICAL SITUATIONS: (DNR, End of Life, Change in Code Status, etc.)

Certain high-risk clinical situations require direct communication between residents and the appropriate supervising faculty member. This policy defines those situations with respect to the year-level of training of the resident.

Residents of all year levels must communicate with the appropriate supervising faculty member when any of the following clinical situations occur:

1. There is a change in end-of-life or limitation of treatment decision-making by the patient, family, or guardian. This includes any change in “code status”.

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2. There is a change in clinical condition that requires transfer of the patient to an intensive care unit.
3. There is a change in clinical condition such that the patient requires surgery in the Operating Room.
4. There is a change in clinical condition that results in the patient expiring unexpectedly.

37. CONSULTS

Consults are an important part of surgical training and are to be done in a timely manner. The resident is responsible for all consults on the day he/she is listed on the call schedule.

38. CLINICAL AND EDUCATIONAL WORK HOURS

Clinical and educational work hours and on-call activities comply with ACGME regulations as follows:

1. Clinical and educational work hours are defined as all clinical and academic activities related to the residency program (patient care, administrative duties related to patient care, the provision for transfer of 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.

2. Work hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

3. Residents are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period or month long rotation, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational and administrative activities.

4. In-house call must occur no more frequently than every third night when averaged over a four-week period.

5. Continuous on-site work hours, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.

6. At-home call (or pager call) is defined as call taken from outside the assigned institution. The frequency is not subject to every third night limitation. Residents are provided with 1 day in 7 completely free of clinical responsibilities, averaged over a 4-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit based on the home call policy. In order to provide adequate rest, if the resident on home call is called and in the
hospital for a period of more than 4 hours from 2200 and 0400, then the resident should be given the next day off without duty.

7. The Program Director and the faculty 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.

8. Assessment of the compliance with these requirements will be done through the resident’s feedback on the Internet Evaluation Program and through time studies by the residency office.

A report of the previous week’s work hours (for purposes of hours reporting, the work week runs Monday–Sunday) is due each Monday in MedHub by no later than 0800. Hours are considered delinquent after 0800 Monday morning, and residents who are delinquent in reporting hours may be immediately suspended from duty. The purpose of reporting hours is for the residency office to monitor work hours and keep them within the ACGME guidelines.

The residency uses MedHub (medhub.com) to track duty/work hours to verify residents are in compliance with ACGME guidelines as noted above. Residents are required to record work hours on MedHub on a weekly basis. It is extremely important that hours are accurately reported. Under- and over-reporting of hours is not allowed; it is required that all residents accurately report work hours.

39. MOONLIGHTING

The Loma Linda University General Surgery Residency prohibits moonlighting.

40. OPERATIVE EXPERIENCE

A record of your operative experience is of utmost importance. You should keep a personal record of all operations you do, the date, and whether you were surgeon, first assistant, or teaching assistant. Operative cases are entered through the SIMPL app and/or ACGME Resident Data Collection web-site (https://apps.acgme.org/connect/login). You will receive your password and user name to this site from the residency office. Residents must enter their operative cases weekly. Failure to enter cases by the beginning of each month may result in suspension from your service. You may print your operative experience record at any time to verify correct data entry of cases. 250 cases are required before beginning PGY3, in order to meet the requirements for American Board of Surgery eligibility. Also of importance are your critical care cases where no procedure is done but you are the primary physician during the hospital stay managing at least two organ systems. It is important that these cases be logged, as the board asks for a report reflecting completion of the required minimum numbers of the various cases.

The final five-year operative record for graduating chief residents must be completed before June 30.
This report will be archived by ACGME on July 31st. You are responsible for maintaining a copy of this for future reference. This report will also be submitted to the American Board of Surgery with the board application in April or May. The board application will be considered incomplete until the case log is submitted meeting all of the required case numbers.

41. MEDICAL RECORDS

Chart completion is an important part of your work as a physician. Each hospital has its own guidelines, but as a general rule, operative reports and discharge summaries must be dictated WITHIN 24 HOURS. If you do not complete the medical records per the hospital policy, you will be suspended. During suspension, you are not permitted to participate in any aspect of patient care, including on-call or operative activities. The residency program keeps records of chart completion, and includes these in letters of recommendations to hospitals.

42. MEDICAL STUDENT TEACHING

Medical student teaching is a very important part of the residency, as it encourages the resident to know the material about which she/he is teaching, and is a valuable resource for students. It is important to provide the students with supervised responsibility in patient care and documentation. Students that show interest and ability should be allowed to make decisions about patient care and should be given responsibility to follow and present their patient.

Students should be involved in seeing what typically occurs on a surgical service including: patient care, decisions to operate, and discussions with the patients' families. Junior and senior medical students are not required to work longer hours than the house staff (i.e., 80 hours per week). However, students may opt to work longer hours should they choose to do so to learn. Students are not required to stay for lectures or formal didactic activities if they have been on duty for more than 28 consecutive hours. However, students who have worked more than 28 hours may opt to attend lectures/didactic activities if they wish to do so to learn. Junior medical students are in lecture for most of the morning on Friday.

43. SUPERVISION POLICY

This policy applies to all surgery residents (physicians appointed to and functioning in the LLU General Surgery residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) and under the supervision of the LLUMC Graduate Medical Education Committee (GMEC).

Supervision of surgical residents is to ensure the following: the safety and quality of care rendered to patients today; the safety and quality of care rendered to patients in the future by our residents in independent clinical practice, and a safe and humanistic education environment that establishes a
foundation for continued professional growth. Supervision balances patient safety and resident education with Whole Person Care for resident physicians.

a) Supervision Overview

Supervision is defined as the provision of monitoring, guidance, and feedback on matters of personal, professional, and educational development in the context of the resident’s care of the patient. Supervision is the single most important element in providing graded and progressive responsibility.

The supervising attending physician must be available to participate in the care of patients as if residents were not involved; the presence of residents to “cover” patients on in-patient service or to provide care in ambulatory settings does not diminish the standard of availability required of the supervising physician of record. Only members of the Medical Staff who have been granted appropriate privileges and who have been selected by the residency Program Director shall supervise residents.

b) ACGME Supervision Levels

The following help to establish the competencies, procedures, circumstances and events which require attending supervision according to the classification established by the ACGME for Levels of Supervision:

i. Direct Supervision
   o The supervising physician is physically present with the resident and patient.

ii. Indirect Supervision with Direct Supervision Immediately Available
    o The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision.

iii. Indirect Supervision with Direct Supervision Available
    o The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone and/or electronic modalities, and is available to provide Direct Supervision.

iv. Oversight
    o The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

c) PGY-1 Residents must be supervised either directly or indirectly with direct supervision
immediately available.

d) **PGY-2 through PGY-5 Residents** may serve in a supervisory role of junior residents; however, in all cases the final responsibility for the supervision of residents and fellows who have not been granted Medical Staff privileges lies with the supervising attending physician. This responsibility includes ensuring the quality of care provided to patients, patient safety and provision of high quality education.

Documentation of supervision shall be demonstrated by counter-signature of the resident’s note or by referring to the resident’s documentation in a separate attending note. The supervising physician shall personally interview and examine the patient each day to confirm the resident’s finding and to evaluate and educate the resident’s clinical care.

e) **All Residents** are expected to provide appropriate care in an emergency to include being able to run a code. Each resident is responsible for knowing the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.

f) **Resident Physician Privileges**

Resident physicians do not have hospital privileges as defined by the Medical Staff bylaws. Based on the prerequisites for appointment to GME program, all residents, regardless of their level of training, have been judged capable of performing the following procedures with indirect supervision by the Supervising Physicians on the Medical Staff:

i. **Patient Management Competencies**
   a. Evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests.
   b. Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
   c. Evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
   d. Transfer of patients between hospital units or hospitals
   e. Discharge of patients from the hospital
   f. Interpretation of laboratory results

ii. **Procedural Competencies**
   a. Performance of basic venous access procedures, including establishing intravenous access
   b. Placement and removal of nasogastric tubes and Foley catheters
c. Arterial puncture for blood gases

g) Direct Supervision Requirement

Direct supervision is required until competency is demonstrated for:

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

ii. Procedural Competencies
   a. Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
   b. Repair of surgical incisions of the skin and soft tissues
   c. Repair of skin and soft tissue lacerations
   d. Excision of lesions of the skin and subcutaneous tissues
   e. Tube thoracotomy Paracentesis
   f. Endotracheal intubation
   g. Bedside debridement

iii. Other Procedures

All other procedures shall be subject to the ACGME Levels of Supervision as previously described above under section 2. A listing of procedures each resident to perform is available to hospital staff on the Medical Center Intranet under “Practitioner Privileges”. If hospital staff questions the proposed level of supervision, they must contact the supervising attending physician.

The resident’s profile is updated as progression through the program and acquisition of skills is acquired. In addition, the residency program has a program to monitor interns in the acquisition of skill for invasive procedures. Once a predetermined number of specific
procedures have been completed satisfactorily, the resident may then perform such procedures with attending approval but without direct supervision.

The first year of training emphasizes surgical diagnosis, pathophysiology and pre- and post-operative care. The intern, along with the more senior resident, is involved in the daily presentation of the patient to the attending surgeons where treatment decisions are finalized. The intern follows the patient to surgery, where he acts as one of the surgical assistants. In less complicated cases, such as hernia or appendectomy, the intern often performs the operation as directed by the attending surgeon.

Residents who perform well can be given responsibility for independent judgment and surgical decision-making with continued attending supervision. By the third year, residents are also given more responsibility for evaluating surgical patients in the emergency room, initiating preoperative treatment and arranging for further surgical care. In addition, they are more involved with the technical aspects of the surgery in the operating room.

During the fourth and fifth years of residency, residents are considered the senior/chief of the service and supervise junior residents and medical students. Senior residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while attending surgeons monitor their progress and continue to supervise the service. Senior residents are allowed and encouraged to exercise independent surgical judgment to the degree that is consistent with good patient care.

Residents must be aware of the supervisory lines of responsibility. If there is a serious concern related to supervision or any other aspect of the training, any resident can bypass the supervisory lines and communicate directly with the Program Director or the Chairman of the Department of Surgery.

44. DISCIPLINARY PROCEDURES

These disciplinary measures are designed to help the failing resident. To accomplish this, all problem areas are documented and communicated between resident and attending staff. These guidelines apply to General Surgery residents at each of the integrated and participating institutions.

Representatives from the appropriate hospitals will be involved in the decision-making process. The Department of Surgery has a real commitment to working with the resident to resolve problem areas.

45. REMEDIATION

1. Remediation may be given to a resident at the decision of the Program Director (PD) or the Surgery
Residency Review Committee (RRC).

2. Examples of situations resulting in remediation:
   - Poor academic performance or attendance to academic functions
   - Poor clinical performance or attendance to academic functions
   - Poor medical records completion

3. This is communicated to the resident by a meeting with the PD and a follow-up letter outlining the problem and expected solution.

4. Further follow-up at the PD or RRC’s discretion. Repeat similar poor performance by the resident may result in him/her being put on probation.

EXAMPLE:

- Resident with documented poor academic performance on evaluations and poor performance on ABSITE or quarterly tests.
- Failure to log work hours weekly by due date
- PD or RRC reviews evidence and decides if a warning is appropriate.
- PD meets with resident and reviews situation.
- Follow-up letter from PD to the resident reviewing steps later and warning given.
- Further follow-up at discretion of PD or RRC.

46. PROBATION

1. Probation is instituted by the RRC or the PD.
2. Examples of situations resulting in probation are as follows:
   a. Repeated poor evaluations from clinical services.
   b. Repeated poor academic performance.
   c. A consistent problem with medical record completion.
3. Probation usually follows a warning, but may be instituted without an initial warning if the PD or RRC feels that such a course is dictated by the severity of the problem.
4. Probation is communicated to the Resident by a personal visit with the Program Director and a follow-up letter outlining the problem and the expected solution - including time frame. Appeal of the case may be taken to the RRC if the Resident so chooses. Copies of the probation letter will be sent to the Chairman, Graduate Medical Education Committee and Dean, School of Medicine.
5. Probation cannot continue for greater than six months without review by the PD or RRC and resident.
6. Completion of the probation period will be documented by a letter from the PD to the resident. Copies of this letter will be sent to the Chairman, Graduate Medical Education Committee and Dean, School of Medicine.
of Medicine.
7. The resident may appeal a decision for probation to the Graduate Medical Education Committee

EXAMPLE:

- Resident with repeated poor performance or extremely poor performance.
- Placed on PROBATION by RRC. Communicated by meeting and letter.
- Review of Resident's performance at the end of the probationary time period.
- Letter to remove Resident from PROBATION.

47. DISMISSAL: FOR CASES OF INCOMPETENCE OR POOR PERFORMANCE.

1. The Resident has already been placed on probation or given a warning. This implies documentation of the problem and communication with the Resident and possibility of appeal.

2. If the problem recurs or continues, the poor performance will once again be documented and discussed with the Resident by the PD. In discussion with the PD, the Resident will sign that evaluation form or discussion summary.

3. Review of the Resident's case by the RRC with possible recommendation of initiation of dismissal. This action will be documented with a formal letter to the Resident, Chairman, Graduate Medical Education Committee and Dean, School of Medicine.

4. Resident may appeal the initiation of dismissal action with Graduate Medical Education appointed committee consisting of:
   a. GME Representative
   b. LLUMC Administration Representative
   c. Chairman, Department of Surgery
   d. Resident's choice of attending to represent him.

EXAMPLE:

- Failing to meet the RRC or PD's requirements of the probationary time period.
- At the discretion of the RRC or PD for a Resident who is placed on probation twice or more for the same or similar problem.
- Resident on Probation.
- Repeat poor performance or failing to satisfy probationary terms.
- Meeting with Program Director.
- Residency Committee recommends dismissal, refers case to GME.
- Resident informed by meeting with PD, Chairman, GME and formal letter.
• Optional Case Review Committee.

48. IMMEDIATE SUSPENSION

For the worst-case situations. (i.e., patient harm). In agreement with the complete Article X from the House Staff contract.

2. An inability of the Physician to fulfill responsibilities.
3. Disciplinary action imposed by the California Medical Board.
4. In the event the Physician is convicted or pleads guilty or nolo contendere to a felony or any crime involving moral turpitude.
5. Conduct not commensurate with good moral standards.
6. When capacity is diminished by use of drugs or alcohol.
7. When responsible Attending Staff, in conjunction with the Head of the Department and the Chairman of the Graduate Medical Education Committee, feels that the Physician's effective capacity has been seriously diminished by emotional, mental or physical factors.

In the event the physician is suspended for any reason, the physician may request a hearing before the Graduate Medical Education Committee or Sub-Committee thereof, pursuant to such grievance procedures as may be adopted by the Graduate Medical Education Committee. Hearing shall be arranged by the Chairman of the Committee where a review of the facts shall be made and the physician may be heard.

1. Any dispute concerning the Physician's eligibility to receive the certificate referred to an ARTICLE XI, or with regard to termination of this Agreement prior to its expiration date, shall be reviewed and adjudicated, if Physician so requests, by the Committee on Graduate Medical Education after a hearing before said Committee at this Physician shall have the right to appear and present any evidence he/she may have regarding his/her right to continue to participate in the Program or receive said certificate. Physician may select a member of the Hospital's Medical Staff to accompany and represent him/her at such a hearing.

2. The decision reached by the Committee on Graduate Medical Education in concurrence with Hospital Administration, which shall be rendered in the form of a written opinion designating the basis for such decision, shall be final between the parties to this Agreement. A copy of the decision shall be made available to Physician if he/she so request.
EXAMPLE:

- Severe resident misconduct or action documented by attending.
- Cases reviewed by RRC and PD and subsequent meeting with resident.
- Graduate Medical Education, LLUMC Administration, Chairman of Department and resident’s choice of attending will review case. Decision reached will be final.
- Resident will be suspended immediately from clinical duties and will receive full pay and benefits for 30 days, at which time he/she will be dismissed.

49. CONTINUATION IN RESIDENCY

Continuation in the residency program is determined by clinical and academic performance and the number of positions available. Clinical performance is based on attending evaluations of the residents. These evaluations are completed after each rotation and are reviewed and signed by both the resident and attending. Academic performance is based on a combination of conference participation, quarterly tests, oral examinations and the ABSITE.

The residency contract is issued for one year only. Admittance to the program in the first year does not guarantee a full five years of residency training. Continuances are year by year based on overall performance as determined by the Clinical Competency Committee (CCC) and the Residency Review Committee (RRC). Those residents whose poor performance does not allow them to complete even a single year will be given consideration under the terms for due process.
50. SURGERY RESIDENT ANNUAL REQUIREMENTS CHECKLIST BY PGY LEVEL

a) PGY-1
- ATLS
- BLS/ACLS
- ACS membership
- FES modules in SCORE (Colonoscopy and Esophagogastroduodenoscopy, prior to GI rotation)
- Safe Cholecystectomy Module in SAGES
- FCCS prior to PGY2
- Begin QI Research Project

b) PGY-2
- Sedation training (prior to Peds Surg Rotation)
- Simulation Training
- Log 40 Crit Care Cases (two types of management per patient to count) suggested by end of PGY2
- Complete Case Log Requirement of 250 cases as shown on PGY2 minimum report
- FEC Modules 1, 4, and 5 in FESDIDACTIC.org
- Renew ACLS before expiration
- Obtain DEA before starting PGY3

c) PGY-3
- Renew ACLS before expiration
- Complete three OSATS (operative assessments)
- FEC Modules 2, 3, 6, 10, and 11 in FESDIDACTIC.org
- Begin process of CA State Medical Licensure

d) PGY-4
- Obtain Full CA State Medical Licensure within 90 days of start of PGY4
- Complete FEC Modules 7, 8, 9 and 12 in FESDIDACTIC.org
- FES certification
- Possibly FLS certification (or in PGY-5)
- Work on Operative and Clinical Assessments (required by PGY5)
- Start Logging Teaching Assist Cases in ACGME
- Start Logging Team Lead Resuscitation Cases in ACGME

e) PGY-5
- Renew ACLS
- All Operative and Clinical Assessments completed
- FLS Certification
- Robotics Certification
- All ACGME Case Requirements by the end of PGY5
- (Defined Category Requirements)
- All cases required by ABS must be completed before April 15 for Board Application (850 total cases, 200 chief cases, 40 critical care, 25 TA)

f) Additional ABS Requirements
- 12 months chief rotations (as approved by ABS)
- 48 clinical weeks in each year (or average totaling 96 weeks PGY1-2, 144 weeks PGY3-5) Submit ABS Application by due date (around April 15)
- Pay for ABS Application (about $500), and separate fee for actual test registration to follow
## 51. RESIDENCY PROGRAM REQUIREMENTS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Requirement</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture/Grand Rounds/Journal Club</td>
<td>100%</td>
<td>Write paper on week’s topic. &lt; 80% participation means potential academic remediation</td>
</tr>
<tr>
<td>Anatomy Lab</td>
<td>100% participation in labs assigned to pertinent PGY level if not excused</td>
<td>If lab missed meet with Program Director and possible remediation</td>
</tr>
<tr>
<td>Simulation Training</td>
<td>100 %</td>
<td>If assigned lab missed, additional labs will be assigned + potential academic remediation</td>
</tr>
<tr>
<td>ABSITE Scores (Chiefs)</td>
<td>Score &gt; 20 percentile in last year or have an average of &gt;35th percentile for third, fourth, fifth year scores</td>
<td>Denied ability to sit for exams upon graduation</td>
</tr>
<tr>
<td>ABSITE Scores (Others)</td>
<td>Scores &gt; 30th percentile</td>
<td>Study program outlined + academic remediation</td>
</tr>
<tr>
<td>Online Attending’s Evaluations</td>
<td>80% at quarterly check</td>
<td>Give GR presentation on topic of own choosing at next opening</td>
</tr>
<tr>
<td>Online Rotation Evaluations</td>
<td>80% at quarterly check</td>
<td>Give GR presentation on topic of own choosing at next opening</td>
</tr>
<tr>
<td>ABS Chief Application</td>
<td>100% by ABS deadline</td>
<td>Extended deadline costs more; failure to register = no exam</td>
</tr>
<tr>
<td>Work hours submission</td>
<td>100%</td>
<td>Miss 3 in 8 week period = academic warning</td>
</tr>
<tr>
<td>Mock Orals</td>
<td>100%</td>
<td>Personal oral exam with Program Director</td>
</tr>
<tr>
<td>Log Cases with ACGME</td>
<td>100%</td>
<td>Academic remediation</td>
</tr>
</tbody>
</table>
52. ANNUAL ADVANCEMENT REQUIREMENT SUMMARY

- Lecture attendance / Grand Rounds
- Journal Club / Anatomy Lab / Surgical Ethics Conference attendance ABSITE score
- On-line evaluations of peers and Attendings/Online rotation evaluations Surgery Residency/Resident Review Committee evaluation
- Medical Records at each site USMLE
- ACGME Case logging: Operative Case entry
- Simulation Training: Completion at the appropriate levels for training year Procedure Log Book: Now on MedHub
- End of rotation Mock Orals for senior residents ABS-Chief application
- GME Office compliance, TB testing, FIT testing, etc.

WEB LINK RESOURCES:

- LLUH ONE Portal: https://one.lluh.org/
- OWL Portal: https://myllu.llu.edu/apps/training/
- MedHub: https://lomalinda.medhub.com/
- Surgery Residency: www.llusurgery.org
- SCORE: www.surgicalcore.org
- ACGME Case Logs: www.acgme.org
- American Board of Surgery; www.absurgery.org
- FLS/SAGES: http://fls-online.org
- FES/FEC/SAGES: www.fesdidactic.org
- FES/FLS Online Test Registration: www.webasessor.com/sages