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MISSION STATEMENT

Michigan State University - Integrated Residency in General Surgery (MSU Integrated Residency in General Surgery) General Surgery Program is a university program integrated into two communities (Lansing and Flint) committed to the education of compassionate and competent surgeons committed to their patients and the advancement of the art and science of surgery.

VISION STATEMENT

The MSU Integrated Residency in General Surgery General Surgery Program will:

1. Recruit the courageous, the extraordinary, the curious and the extroverted adventurers. Intrigued by others, the unknown and surgery.
2. Pursue shared discovery of evidence-based patient-centered care.
3. Educate future surgeons to be leaders in their respective surgical communities.
4. Promote research to advance the science of surgery and excellent patient care.

VALUES

Compassionate and Expert Surgical Care:
Provide the highest quality of patient-centered surgical care to all persons while understanding, respecting and accepting their diversity.

Leadership:
Educate future surgeons to be leaders in surgery by inspiring a commitment to accountability, open communication, and the highest standard of ethical and professional behavior.

Commitment to Excellence:
Pursue the highest level of performance by promoting and facilitating both clinical and basic science research to advance excellence in the surgical and medical care provided.

Systems Perspective:
Prepare surgeons to thrive in the 21st century. The program will function in a fully interconnected, unified, and mutually beneficial manner that is patient-centered and learner-focused. Educate the workforce to provide evidence-based, patient-centered care and conduct research that will improve it.

Visionary Leadership:
Improve the health of the community, enhance the patient experience and reduce the cost of care while working to make this a great place to live, work and play.

Student-Centered Excellence:
Focus on the needs of our learners to obtain their approval, loyalty and contribution to our organization’s success.

Valuing People:
Engage/develop our learners and promote wellbeing.

**Organizational learning and Agility:**
Develop the capacity to adapt to a rapidly changing environment by maintaining a healthy and flexible organization that is continuously learning and improving.

**Focus on success:**
Succeed through intelligent risk taking, balancing short and long-term demands in pursuit of sustained growth and performance leadership.

**Managing for Innovation:**
Improve the organization’s educational programs, services, processes, operations and business model, creating new value for stakeholders.

**Management by Fact:**
Maintain a disciplined approach to measure and analyze performance that will support evaluation, decision-making, improvement and innovation.

**Societal Responsibility:**
Contribute to our community in order to build a great place to live, work and play.

**Ethics and Transparency:**
Promote a culture that strives towards the highest of ethical standards. Maintain candid and open communication sharing clear and accurate information.

**Delivering value and Results:**
Build loyalty to the organization; contribute to growing the economy and to society.

**RESIDENT EXPECTATIONS OF THE FACULTY**

Members of the surgery faculty make the following commitments to the residents:

Education of the resident is the primary focus beyond the compelling issue of patient care. It is a hands-on graduated continuum in the ambulatory clinic, emergency room, hospital patient-care units, and operating rooms. The residency program is designed to provide an education that leads to certification by the American Board of Surgery.

Faculty teaches technical skills and supervisors trained in a broad, diverse range of programs throughout the Unites States, providing experience in every likely technique. A skills simulation laboratory allows practice for laparoscopic and endoscopic skills, assessment of skill level, and in some instances may provide diagnostic input to the resident-in-training regarding the need for technical and clinical improvement.

Training activities will be designed to facilitate each resident’s development to achieve satisfactory performance in each of the general competencies outlined by the Accreditation Council for Graduate Medical Education (ACGME). These general competencies include: **Patient Care, Medical Knowledge, Communication and Interpersonal Skills, Practice-based Quality Improvement, Professionalism, and Systems-based Practice Improvement**. Communication
skills will be emphasized so that the curriculum will encourage practice in every form, from oral presentations to computerized digital telecommunications and the use of the internet.

Graduated responsibility is planned through a curriculum of added expectation and responsibility as experience is gained.

Evaluation with positive feedback is an important part of education, and will take place informally daily and formally at least twice a year. It is hoped that such evaluation will become part of a resident-specific action plan and a reference for the resident to use to determine when established goals have been met. The resident will set goals with the assistance of the faculty; the resident’s mentor and the Program Director have been met.

Personal support in its broadest sense is available for guidance in all aspects of decision-making and problem solving.

Supervision by full-time, part-time, or community-volunteer faculty surgeons is provided for every case, consultation, and procedure.

FACULTY EXPECTATIONS OF THE RESIDENTS

Members of the surgery faculty expect efforts toward and will formally evaluate each resident’s progress in the following general competencies:

1. **Patient Care**
   Each resident will show an intense interest, sense of responsibility, and capability in each patient's care, especially in those patients on whom the resident has performed any surgical procedure. The resident must demonstrate a whole-hearted commitment to the concept of patient-centered care. Each resident must develop the technical skills to assure that safe and efficient operations (surgical procedures) are performed to the benefit of their patients, and the highest overall quality of the care is provided. Daily observation in the operating room will be used to evaluate the extent to which the resident appropriately satisfies this competency.

2. **Medical Knowledge**
   Each resident must accumulate didactic knowledge pertinent to the practice of surgery at a rate that leads to the successful completion of the qualifying examination of the American Board of Surgery, preferably on the first attempt. This is currently best measured annually by the American Board of Surgery In-Training Examination (ABSITE). Scores lower than those obtained by 30% of a resident’s peers nationally will require special study and effort for which an approved individualized study plan will be required. Furthermore, scores below the fiftieth percentile on the ABSITE may result in the Program Director adjusting the resident’s eligibility for participating in any or all activities that are not specifically part of the resident’s overall efforts and study plan to improve their future performance on the ABSITE or program tests. For example, this may make a resident ineligible to be elected by his/her peers to represent their interests on any or all committees until the respective resident has demonstrated improvement in areas deemed relevant by the Program Director.

3. **Practice-based Learning and Quality Improvement**
   Each resident will complete at least one quality-assurance or quality-improvement (QA/QI) project or activity in the Department (General Surgery) related to the academic practice. This project must be either outpatient or hospital-based, and result in the development of a planned intervention, and post-intervention follow-up assessment and evaluation. The themes for such activity will usually be related to the goal of improving patient care or enhancing some aspect of health care delivery to
patients. It is expected that each resident will actively participate in the Department’s Surgical Morbidity and Mortality (M&M) Conference by presenting all surgical morbidities and mortalities of patients on whom they have participated in the surgical care. They will inform the respective supervising surgical faculty of each such instance, and the supervising surgical faculty will assist them in assessing the care provided and making recommendations on how to improve that care in the future. It is required that the respective and responsible faculty surgeon will attend the resident’s presentation to support and enhance the discussion. The sole purpose of these discussions/presentations will be to teach, learn and improve the quality of care provided to patients.

4. **Interpersonal and Communication Skills**
   Each resident must demonstrate the acquisition of interpersonal and communication skills which will lead to effective, efficient, and appropriate patient care and successful certification by the American Board of Surgery. Demonstrable ability in this area will be assessed in part by the timely and satisfactory completion of their respective medical records. In addition, competence here will be tenable when the resident can show a proactive and positive approach to effective communication with faculty, nursing, ancillary health care providers, and health information and technology staff. The resident’s ability to assume the care of patients or effectively transfer patient care to subsequent providers on call will also be considered an important skill and attribute that will need to be cultivated and evaluated during the course of their training.

   Competence in these regards will be demonstrated further by the resident's ability to make clear and concise: clinical case presentations, discussions of assigned medical topics, presentation of cases at weekly morbidity and mortality conferences, and more formal presentations at surgical grand rounds and assigned conferences.

   Finally, the resident's willingness and effectiveness to teach others, especially more junior and/or less experienced residents and medical students will be evaluated.

5. **Professionalism**
   Each resident must demonstrate ethical and moral behavior as well as the utmost concern for every detail of his/her patient’s welfare, even when not on call. Such behavior will be viewed to be an essential attribute of appropriate professional conduct; and therefore, the resident's demonstration of such behavior will be a critical component of his/her evaluation. The resident will need to document longitudinal care through timely and appropriate outpatient, preoperative, and postoperative activity and progress notes detailing timely and appropriate patient care management, as well as, the daily interaction with other members of the patient-care team. Please note that preoperative and postoperative care skills are considered to be as important as operative skills in these regards.

6. **Systems-based Practice Improvement**
   Each resident must become involved in a MSU Health Team, Department of Surgery or hospital-based committee charged with some aspect of system-wide control of issues supporting quality health care delivery at the respective institution. In so doing, it is expected that the resident will acquire a basic understanding of some of the factors that contribute to and control quality patient care in the respective health care delivery system. Active participation in at least one such committee during their training will be considered a minimum requirement for a resident to demonstrate learning and competence in this core skill. Effective transfer of patients to other facilities (rehabilitation, nursing home, etc.) will also be proctored and evaluated.
MISCELLANEOUS

Advancement to the next level of training will be based on successful graduated accomplishment of these general competencies. An overall evaluation of each resident will be completed semiannually by consensus of the Program Director and the full-time faculty in consultation with the community-volunteer faculty. A significant deficiency will result in remediation planned by the Program Director or his/her designee (for example, an appointed academic advisor or formally assigned mentor). Any deficiencies may be justification for suspension or delay in advancement until remediation is accomplished to the satisfaction of the Program Director. The inability to remediate any identified deficiency, multiple deficiencies or any egregious deficiency or unprofessional behavior may justify the resident’s dismissal.

Evaluation by Residents

An annual evaluation of the program, clinical experiences and rotations, faculty, and fellow residents, will be required of each resident at a minimum of once a year. Recommendations for improvements along with comments on weaknesses, strengths, satisfactions and dissatisfactions will be expected, encouraged and appreciated. Every year, each resident will be asked to complete an anonymous program evaluation of the General Surgery program for institutional use before proceeding to the next level of surgical training. The program will receive feedback on the basis of this evaluation.

Evaluation by Faculty

Faculty will be asked to evaluate resident performance and competency at least twice a year. Faculty may submit formal and/or informal evaluations of any aspect of the General Surgery program, its curriculum, its faculty, its director or its staff at any time and as often as wished. Such evaluation can be submitted directly to the program (program coordinators), Program Director, department chair or institutional Designated Institutional Officer (DIO). Scheduled and routine evaluations will occur via New Innovations when assigned but usually after each rotation.

RESIDENT DUTY HOURS

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), 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 either personal study time (wherever it may occur), or reading and preparation time spent away from the duty site.

Resident duty hours will be limited to 80 hours per week on average over a four-week period.

Resident in-house call will occur no more frequently than every third night. At-home call is not subject to the every third night limitation and the hours on at-home call do not contribute to the 80-hour work week limit; however, when residents are called into the hospital from home, their hours spent in-house will count toward the 80-hour limit.

Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours plus six hours, to allow for either the appropriate transfer of patients’ care or participation in educational activities, i.e., continuous duty will be no greater than 30 hours total at any time. Residents will be allowed to go to surgery to complete the care of patients acquired while on call; but this activity cannot and must not take them over the 30 hour limit. All clinical and programmatic activity will be monitored to assure that the resident does not work more than the 80 hour limit on average as stipulated above. No new patients will
be accepted after 24 hours on continuous duty. A new patient is defined as any patient for whom either the academic surgery service or MSU Department of Surgery has not previously provided care.

Residents will be provided with a rest period of at least 10 hours, free of all duties, between daily duty periods and after in-house call.

Residents will be provided at least one day in seven free from all educational and clinical responsibilities, averaged over a four-week period; but preferably one day in every seven days (meaning every successive seven days, one 24-hour period will be free from all program educational and clinical responsibilities). One day is defined as one continuous 24-hour period.

**Moonlighting is not permitted while participating in this Residency Program. There are no exceptions.**

Any resident who consistently exceeds any of these work hour limits will be counseled by the Program Director to discontinue doing so. If the resident continues to exceed these limits, the resident will receive a formal verbal warning. A formal verbal warning is the first step toward suspension and potential dismissal as described later.

**Definition of six-hour post-call period: Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.** Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, work in outpatient clinics (may see established patients and postoperative patients but no new patients), perform and/or participate in operations on established patients, and maintain continuity of medical and surgical care.

**Definition of new patient:** No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the General Surgery academic surgical service or department has not previously provided care. It is understood that a participating faculty member may have an established patient who is not an established patient of the academic surgical service. In such instances, the resident will not assume care of this ‘new’ patient after 24 hours of continuous duty.

### RESIDENT DUTIES AND ON CALL

The teaching day generally begins each morning (approximately 5 - 6:30 a.m.), at a time as is necessary for the completion of daily rounds on patients assigned to the academic surgical services and the preparation for surgery in either hospital. The day ends at the completion of the day’s work and afternoon rounds for those on-call or designated to be present by the Chief/senior resident, depending upon the requirements of the academic surgical (MSU Integrated Residency in General Surgery) service at the time and subject to the current work-hours policy.

Prior to afternoon rounds, all residents who are not post-call or otherwise excused by the Chief Resident and/or the Program Director will be available to the other residents, academic surgical service and any of the approved attending faculty. All respective pages will be answered promptly. If it is necessary to be absent between the hours of 6:00 a.m. and 5:00 p.m., the resident will make appropriate arrangements with chief and fellow residents and notify the program coordinator(s) and hospital operator, after receiving approval from the Chief Resident or Program Director. Excused absence from the hospital will be covered by appropriate resident cross coverage.

In-hospital, on-call duty will be no more than one in three nights on average over a four-week period. Clinical responsibility will be no more than six days out of seven days consecutively as the desired standard. Off-service residents (residents from residency programs other than General Surgery) will be expected to take on-call, in-hospital duties at least up to six times per four-week block. Despite the above policies, it
is understood that clinical circumstances may arise that require rare exception(s) to these expectations. When the rare exception occurs, the respective individual’s schedule will thereafter be adjusted to meet the spirit and intent of the policies described above. Adequate on-call rooms will be made available. Food is provided for all residents on duty.

**ABSENCE**

Unexcused absences from the hospital, from required conferences, or from assigned responsibility will be graded as unprofessional behavior(s) and counted toward the individual’s evaluation and assessment of adequate performance in the appropriate core general competencies. *No unexcused absence from hospital responsibilities, required conferences, or assigned responsibility will be acceptable.* Any resident who is absent without an excuse by the Program Director will be issued a verbal warning by the Program Director. All such verbal warnings will be documented in the resident’s portfolio (program record). Three or more unexcused absences resulting in three verbal warnings within a single academic year (July 1 to June 30 of following year) will result in automatic suspension from the program.

Chief residents will be permitted to schedule an unlimited number of interviews and senior residents applying for fellowships will be permitted to schedule an unlimited number of invited interviews (proof of invitation required) for the purpose of securing a job, practice, or fellowship position, respectively. If this privilege is abused, a policy restricting the number of interviews that senior residents can participate in will be established.

Any and all absences from the program must be approved and documented by completion of the appropriate paperwork for a leave of absence. There are no exceptions to this policy. It is understood that depending on the nature of an emergency requiring a resident to take an unplanned and temporary leave from the program, such paperwork may need to be completed after the resident has left or upon their return, subject to the discretion of the Program Director or a designee.

**TRANSITIONS**

All new categorical residents must begin their residency on the first day of orientation (usually the 2nd or 3rd week of June).

When the new interns (PGY-1’s) start orientation, all other residents will advance on that day to their next level of training assuming that they were previously approved for advancement. Any resident not approved for advancement will have been previously notified, and will then proceed to their respectively planned next stage for remediation and/or reinstatement as previously outlined in writing by the Program Director.

Chief residents must remain available and accountable until either the first day of orientation for the new PGY1’s, or until their contract period expires, whichever comes last.

PGY-4’s advancing to their fifth and final clinical year in the training program may assume primary responsibility for the Academic Surgical Service on the Monday beginning the second full week of June, but not before, unless formally approved by the Program Director. A full week is defined as a Monday through Sunday. Thereafter, the graduating Chief Resident will be available on an ‘as needed’ basis at the very least, but may continue to exercise authority over the selection of operative cases and clinical duties personally desired, subject to the approval of the Program Director and/or the patient’s primary attending surgeon.
No resident may leave the program before completing their sign-out process. The final stage of the sign-out process includes sign-off by the Program Director. Attendance at the formal graduating ceremony is one of the steps in the sign-out process. Any resident who leaves the program before completing the sign-out process will be documented to have left prior to completing their year of training. In such an instance, the Program Director will define what requirements must then be completed to verify that the resident has completed their training for that year.

**ACADEMIC PROBATION**

Residents risk being placed on academic probation for one or more of the following:

- Scoring below the twentieth percentile on the ABSITE
- Consistently performing below expectations for their level of training
- Failing Mock Oral
- Averaging a failing grade on weekly quizzes

A resident placed on academic probation will not be eligible to represent the residents in an elected capacity on committees, and will be required to adhere to a strict planned course of study to be supervised by the resident’s assigned faculty advisor or mentor and the Program Director collectively. The resident will be required to meet with the Program Director or faculty academic advisor and/or mentor on a weekly basis so as to oversee the resident's progress during a course of concentrated and guided study.

Any resident on probation who fails to adhere to the study and/or remediation plan prescribed by the Program Director will be dismissed from the program subject to a due process procedure outlined by the MSU institutional policy (see Appendix B).

**SUSPENSION**

A formal letter of suspension will be sent to the respective resident and entered into the resident’s portfolio, thus documenting their status. This letter will be copied to the institutional DIO and Department Chair. Suspension from the program will be for a minimum of one week (or as otherwise stated in the formal letter of suspension) during which time the resident will be required to spend 100% of their time bringing all of their operative cases up-to-date by entry into the ACGME case log website, and completing all assignments issued by the Program Director. The resident will be excused from all clinical activity including call. Any assigned call that is missed as a result of such suspension will have to be covered by other residents. The suspended resident will have to make up all missed call by assignment in subsequent rotations (in a manner consistent with work hour policy). The resident must submit a letter to the Program Director requesting reinstatement to the program and explaining how they intend to avoid the reason for the suspension for the rest of their residency. This letter will need to be endorsed by their faculty academic advisor and/or mentor, if those had been previously assigned, and the institutional DIO before submission to the Program Director. The Program Director may elect to reinstate the resident on the strength of their letter requesting reinstatement. If the Program Director chooses not to reinstate the resident; the resident will then be required to appeal their suspension through an established policy as described in the MSU institutional policy. The resident will be advised of the appeals process by the institutional DIO. In the event that the suspended resident does not request reinstatement by means of a letter stating such intent by 90 days from the date their suspension is active, the suspension will automatically convert to a dismissal from the program.
DISMISSAL

Failure to graduate from the residency training program and/or dismissal may result when:

- A resident fails to achieve competency in any of the general competencies as defined by the ACGME;
- and/or as stated above;
- and as judged by the Program Director and faculty on the basis of documented persistently inadequate performance;
- With the concurrence of the department chair, institutional DIO, and the GMEC when institutional policy requires.

However, a resident is subject to immediate dismissal by the Program Director or his/her designee with the concurrences stated above, at any time during the term of the resident’s appointment for the following reasons:

- Resident’s performance presents a serious compromise to acceptable standards of care or jeopardizes patient safety and/or welfare.
- Resident is impaired (as defined by the American Medical Association).
- Resident displays unethical behavior.
- Resident engages in illegal behavior.
- Resident fails to report to work as scheduled without justification acceptable to the Program Director, institutional DIO, and/or department chair.
- Resident violates rules, regulations, and policies of MSU CHM and/or the General Surgery program.

A resident who does not satisfactorily complete training or fails to graduate will not be recommended to the American Board of Surgery to be eligible for certification.

A resident may be dismissed from the program for any unprofessional behavior or conduct that recklessly endangers the life of a patient or person, or is found to have committed a felony. A resident who fails to satisfactorily make progress in the training program or who does not adhere to the conditions of a prescribed remediation program may be dismissed. A resident who is recommended for dismissal will have the right to an appeal through a process to be coordinated by the institutional DIO and defined by policy outlined in the MSU Health Team institutional policy manual. Appendix B of this document outlines that policy.

ADMINISTRATIVE CHIEF RESIDENT

An Administrative Chief Resident will be assigned by the Program Director for at least a three-month period each year. Each Chief Resident must accept Administrative Chief Resident duties and responsibilities at least once each academic year. Failing to do so will constitute a failure to meet the expected performance in the area of Professional and Practice-based competencies. Unless otherwise stated, the Administrative
Chief Resident will be the Chief Resident assigned to the Sparrow Hospital Academic Surgical (MSU Integrated Residency in General Surgery) Service (Green Service) at that time. Hospital-specific problems in Lansing will be resolved by the Administrative Chief Resident and McLaren-specific problems will be resolved by the Chief Resident assigned to McLaren hospital at the time. All other program-wide problems and activities will be referred to the Administrative Chief on an as-needed basis. Some duties will include but are not restricted to:

- Approving vacations by General Surgery and visiting residents rotating on surgical services.
- Assisting the Program Coordinator in addressing or resolving scheduling issues.
- Assisting the Program Director or his/her designee to develop conferences, teaching rounds or manage any and all resident-related issues pertinent to the General Surgery program.
- Serving as the official contact for any and all residents regarding any issue pertinent to the function of the General Surgery program or the care of patients assigned to the academic surgical services.

**ACADEMIC SERVICES**

Residents will be assigned to one of four surgery services/rotations, each based on the respectively assigned designated faculty whose patients are assigned. The academic surgery services at Sparrow are currently divided into the White Service and the Green Service the academic surgery services at McLaren are divided into the Green Service and the White Service. The faculty preceptors for these respective services will be posted on a monthly schedule list. The number of residents on the service will vary but “on call” will not occur more than one in three nights on average each month.

The Chief Resident in General Surgery under the supervision of the admitting surgeon, or full-time faculty (ultimately the Program Director) will be primarily responsible for the functions and activities of the academic surgical service. The Chief Resident will make decisions on the number of, and which patients will be cared for by the academic surgical service subject to the invitation and/or acceptance of the admitting surgeon.

The decision to accept responsibility for a patient by accepting the patient onto the academic surgical service will be based primarily on the educational value and opportunity for learning provided by the patient’s clinical problem. Additional considerations include the specific needs of the patient in question as well as the respective admitting surgeon’s commitment to surgical education and the education of the surgical residents. Any and all disputes in this regard will be adjudicated by the Program Director or his/her designee. The decision rendered by the Program Director will be final.

The admitting surgeon will have full authority over his patient(s) even if and while the patient is under the care of the academic surgery service. A junior resident may not participate in the care of a patient that has not been accepted onto the academic surgery service by the Chief Resident.

If a junior resident admits a patient while on call, the resident may continue to participate in the care of the patient under the supervision of the admitting surgeon until the following morning.
when the Chief Resident either accepts the patient onto the service or informs the attending that
the residents will not be following the patient.

Any patient that a resident operates on under the supervision of the admitting surgeon will
automatically be a part of the academic surgery service unless the admitting surgeon informs the
Chief Resident that he/she does not want the residents to care for the patient.

If a medical student participates on a surgical case, i.e., “scrubs on a case” this does not and will
not imply that the resident team or academic surgery service is responsible or will automatically
accept responsibility for coverage of the patient.

Residents are required to work up all elective and emergency admissions accepted onto the
academic surgery service by the Chief Resident. Only the Chief Resident or his/her designee can
accept patients onto the Academic Service regardless of the admission activities on a prior evening
and night of call. In other words, if a resident on call in-house admits a patient during call, the
Chief Resident must accept that patient onto his/her service the following morning for the patient
to be formally accepted onto the academic surgery service and be followed accordingly thereafter.
The only exception to this rule will be if a resident on call operates on a patient during the night
on call (as always, under the supervision and presence of an attending surgeon). In such cases, that
patient will automatically become part of the academic surgery service thereafter (this includes all
care until discharge and any subsequent readmission by the patient within 30 days of operation).
If a patient has not been operated on by a resident, but the attending wishes to have the patient
followed by the residents, the attending must discuss the case with the Chief Resident. The Chief
Resident is empowered to accept or not accept the patient onto the academic surgery service on
the basis of educational value or patient-specific needs for optimal patient-centered care. Any
disputes in this regard will be settled by the Program Director or his/her designee. The Program
Director’s decision in this regard will be final.

Academic surgery service. The history and physical examination for a same-day admission for
surgery or an outpatient procedure may be updated or performed by the resident assigned to
participate in the planned procedure whenever an updated history and physical examination is not
available. It is very important that the resident assigned to the surgical care of a patient (“the
operation”) be significantly involved in the preoperative workup whenever possible and to the
fullest extent possible. The resident is expected to properly document their completion of such
preoperative assessment. At a minimum, the resident will perform a focused history and physical
exam, review available presenting patient data and address any questions the patient may still
harbor about the planned site and surgical procedure. In general, the resident participating in the
surgical procedure will be responsible for the discharge summary, transfer documents, and all
medical chart completion responsibilities that are outstanding for a given patient. When no
resident has participated in the surgical procedure for a patient, the Chief Resident will assign
responsibility for medical record completion at the time of discharge when the patient has been on
the Academic Surgical Service (Green or White). The resident responsible for completing the
medical record should be designated at the time of discharge in the physician discharge orders
whenever possible. The attending surgeon will remain ultimately responsible for all medical
records for all respective patients under his/her care.
Whenever a properly assigned chart-completion task is not completed in a timely fashion by the responsible resident, a verbal warning may be issued by the responsible attending surgeon or the Program Director. If the resident does not complete their responsible component of a patient’s medical record within 72 hours of a third verbal warning, and a complaint is submitted to the Program Director or program coordinator, such behavior will be documented in the respective resident’s portfolio as an incidence of noncompliance with the core competencies of, Communication and Interpersonal Skills, and Professionalism. If the respective resident continues to accumulate incidents of noncompliance with medical record completion, the resident will receive documentation of noncompliance and incompetence in the core area of, Practice-based Learning and Patient Care in addition to those mentioned above. It should be noted that the resident who accumulates documented incompetence in any of the six core competencies as outlined in the beginning of this document will be at risk for not progressing in this General Surgery residency program, i.e., by so doing, the resident will be eligible for dismissal.

Assignments of patients to residents are made by the most senior resident (the Chief Resident in most cases) or his/her designee. When a resident is going away for a conference or vacation, it is that resident’s responsibility to make arrangements for coverage of his/her patients, usually with the help of the Chief Resident of that service. The resident who is making such arrangements for transfer of care of a patient must inform the residing senior resident and faculty who will be assuming responsibility of the patient. If such arrangements have not been made by the resident leaving, it will be the responsibility of the senior resident (Chief Resident in most cases) to assign a resident to care for the patient until the resident who has left returns. Prior to his/her departure, the resident should so note on the chart who is the covering resident. The Chief Resident is primarily responsible for the academic surgery service with oversight by the respective attending faculty and/or Program Director. In all cases, the respective attending surgeon who is the admitting physician will have final authority and responsibility for the patient under her/his care.

If a resident who has been assigned cannot be present for one of the attending’s operative cases, it is that resident’s responsibility to inform the Chief Resident, the operating room, and the respective attending and/or faculty surgeon in advance; so that appropriate arrangements for surgical assistance can be made.

The operating resident will write a preoperative note into the patient’s medical record documenting the justification of the procedure, the concurrence by and the name of the supervising faculty, the patient’s understanding of the options for care, indications, risks and complications associated with the planned procedure as well as the concurrence of the patient or his/her advocate for the proposed procedure.

A preoperative note outlining the anticipated procedure, the diagnosis, the clinical evaluation of the patient indicating the patient’s readiness for surgery will be written on each inpatient on the academic surgery service scheduled for surgery (using the preoperative H&P and Assessment forms developed by the MSU Department of Surgery, Quality Improvement Committee [heretofore referred to as “preop forms”]). The minimum preoperative evaluation will include: completed preop forms; chest x-ray within six months for patients older than 50 years of age or having either symptoms, signs, or a positive review of systems regarding the respiratory system; a 12-lead electrocardiogram for men age 45 and older or women age 60 and older, or any patient with a history of angina, prior myocardial event, or currently under the care of a cardiologist for
any reason. A protime (PT) and international normalized ratio (INR) for any patient on warfarin, a partial prothrombin time (PTT or APTT) for any patient on heparin will be obtained as part of a routine preoperative evaluation. Any patient with a history of a bleeding diathesis will require a PT, PTT, and platelet count as a minimum. It is understood that a bleeding time and/or further workup may be required as appropriate and/or directed by a Hematologist consulting on the patient with a significant history for bleeding or abnormal coagulation function. Otherwise, the respective hospital’s preoperative protocol workup should be adhered to and the results documented in the preoperative note by a resident surgeon and/or assigned physician assistant prior to any surgical procedure or visit to the operating suite.

**Preoperative Note Format**

(If and when the pre-op form is not used or is unavailable):

- Procedure
- Surgeon
- Indication
- Co-morbidities
- Medications
- Allergies
- Laboratory tests and diagnostic procedures
- Studies
- Consultations
- Consent(s)

Postoperative notes on the appropriate sheet and postoperative orders are to be completed immediately following the surgical procedure by or under the direction of the operating resident surgeon unless otherwise directed by the attending surgeon.

Verbal orders may be signed by residents taking care of the patient regardless of whether the verbal order was given by an attending or another resident. All verbal orders must be signed, dated and timed within 24 hours.

The operative report is to be dictated immediately, but not later than 24 hours postoperatively. Failure to do so will be documented as unprofessional behavior and as a failure to meet the expected requirement of demonstrating proficiency and competence in three general competencies: Patient Care, effective Interpersonal and Communication Skills and Professionalism.

The discharge summary will be dictated according to the dictation policies stated later in this document.

A label identifying the Academic Service Surgery and the name of the responsible resident or pager to call will be placed on all the charts of patients on the service unless otherwise directed by the attending surgeon or Program Director.

**DUTIES ON NIGHT AND WEEKEND CALL**

Rotations on the General Surgery service at Sparrow Hospital (Green and White Services) and at McLaren Hospital (Green and White Services) require in-hospital, overnight stay, not more than one in three nights
averaged over four weeks. The current night float system at Sparrow Hospital, however, makes this irrelevant.

On other services, a resident is expected to be present in the hospital when required by the patients on the service and the attending staff. When on call, and when ordinary and routine work is completed, it is necessary that the residents be available by telephone and immediately available in the hospital within 20 minutes.

The “on call” resident will cover all emergency work. If, for some unusual reason there is no resident who is free, then the attending staff should be notified as to how long the resident expects to be unavailable. The resident junior first assistant should be freed from an operation to answer emergency calls, whenever possible and/or appropriate.

When the resident on call consults on a patient in the emergency department or by phone, and when that patient, after consultation requires followed up in the MSU Surgery clinic, the resident will leave either a message for the clinic nurse on voice mail, route a phone message, or enter a task into the Centricity electronic medical record (EMR) for the respective nurse or physician.

It is recommended that residents on service and in town wear their pagers (turned on) at all times even when they are not on call. This will facilitate communication and the ability to contact them for non-clinical matters and pertinent purposes at all times.

The monthly call schedule will be made by the Chief Resident and approved by the Program Director. Major-holiday coverage will be assigned as fairly as possible. In any and all scheduling disputes, if the matter cannot be resolved by the Chief Resident and/or the Program Coordinator, the Program Director’s decision will be final. The call-schedule is to be completed no later than the 21st day of the preceding four-week (block) rotation.

**RESIDENT RESPONSIBILITIES TO PATIENTS**

Patients who claim no private surgeon are the responsibility of the Chief Resident under the supervision of the MSU full-time faculty and/or part-time teaching faculty surgeon on call at the time; however, at no time is the resident to do any procedure or make major therapeutic decisions pertaining to the patient’s care without the prior consultation, consent and supervision of an attending surgeon. Life or limb saving procedures where minutes count may be rare exceptions. In such instances, the supervising surgeon must be notified as soon as possible.

Resident consultations require the same supervision as do operations/surgical procedures by a teaching/faculty surgeon, regardless of the source of the referral.

Consultations are to be **dictated** using the respective hospital transcription services in the name of the respective supervising (teaching) surgeon. The format should approximate the following, “This is Dr. Resident dictating this consultation note on behalf of Dr. Attending Surgeon, who was asked by Dr. Requesting Physician to see Patient’s Name for the purpose of …, etc., etc.”

Consultations from another academic residency service leading to an operation require that the patient be formally transferred to the academic surgery service preoperatively when necessary, but postoperatively in all instances. The patient should remain on the academic surgery service for the postoperative period until acute recovery is accomplished and the patient is stable. Exceptions may be minor procedures, such as those for vascular access, for example. In all instances, there should be attending-to-attending- and/or
Chief Resident-to-Chief Resident- (or closest approximation) communication of the mutually agreeable plan for primary responsibility of the patient’s care.

Autopsy requests are urged for all mortalities. Special effort must be documented in the following circumstances surrounding the death:

- infants and children with congenital malformations;
- unexpected intraoperative or intraprocedural death or death occurring within 24 hours of such;
- unexpected death while patient is treated under an experimental regimen;
- any unanticipated death or if the cause is clinically obscure;
- Death to pregnancy or within seven days of delivery.

Organ and tissue donations are strongly encouraged and supported. Brain death must be established for organ donation in both Sparrow Hospital and McLaren Hospital. Once brain death is declared, acceptable indications are very liberal for kidneys, heart, lungs, pancreas and liver. A call to the Transplantation Society of Michigan (1-800-482-4881) is recommended for all questions about donation of tissue or organs.

**SUPERVISION OF RESIDENT**

Residents are to be supervised by licensed (State), board-certified (American Board of Surgery) attending surgeons for all patient care. If a supervising surgeon does not meet these criteria, he/she must otherwise be approved by the Program Director to participate in the training program as a supervising faculty member. All faculty supervising residents must be formally approved by the MSU Integrated Residency in General Surgery Program (MSU-IRGSP). The list of approved faculty is stated on each four-week rotation (block) distributed calendar schedule.

Supervision by approved full-time, part-time, or voluntary community faculty surgeons is provided for every case, consultation, and procedure. This is done on a graduated basis of responsibility at the discretion of the supervising faculty member and within the guidelines of hospital practice and other regulatory forces. Most of the supervision will be in the form of physical presence, at the very least, during the critical portions of a given activity. Occasionally for repetitive small procedures, e.g., placement of venous access, when resident competence has already been established with respect to the performance of a given procedure or task, physical presence of supervision may not be necessary. Nevertheless, the ultimate responsibility to the patient will always be the attending surgeon.

The following outlines the policy for the supervision of residents. Residents must:

- Consult and receive approval from the appropriate attending surgeon/faculty member before admitting a patient to, or discharging a patient from the hospital.

- Consult, discuss and receive approval from the appropriate attending surgeon/faculty member before performing any procedure on a patient. In the case of a need to save life or limb, the resident may act in the patient’s best interest and contact the responsible attending surgeon as soon as possible under the given circumstances.

- Notify the responsible attending surgeon of any deterioration in patient’s clinical status, especially for cardiac arrest, hypotension, change in mental status, or deteriorating functional status.
• Notify the responsible attending surgeon, as soon as possible, of any transfer of a patient to an intensive care unit or clinical unit that provides a higher acuity and level of care than that which the patient was previously receiving.

• Notify the responsible attending surgeon of the need for intubation or the provision of mechanical ventilation to a patient.

• Notify the responsible attending surgeon of the development of any major wound complication.

• Notify the responsible attending surgeon of any medication error that requires clinical intervention.

• Notify the responsible attending surgeon of any significant clinical problem that requires an invasive procedure or operation.

Any PGY-2 to PGY-5 General Surgery resident may book a case in the operating room; but only after having discussed the case with and received approval from the respective responsible attending surgeon.

An attending surgeon or member of the teaching faculty should not knowingly ask a resident to perform an activity that will violate any of the work hour rules or any other policy described in this document. If so asked, a resident is required to inform the requesting surgeon of the understood terms of the pertinent guideline and/or policy and refer the faculty member to the Program Director for further clarification if needed. A resident will not be excused from any of the consequences of violating policy as described herein because of the request of a faculty surgeon.

It is understood that for purposes of case- and patient-assignment by faculty, residents must be given priority for responsibility, case selection and patient involvement according to the following established hierarchy: PGY-5 > PGY-4 > PGY-3 > PGY-2 > PGY-1 > PA-C.

The need to save life and/or limb of a patient supersedes any and all policy. However, in matters of retrospective dispute regarding patient care concerns, the discretion of the Program Director will be final upon review of the relevant circumstances.

A resident who cannot reach an attending surgeon regarding patient care issues must adhere to the following algorithm:

a. Page the faculty person using the paging number on record or provided by the hospital operator, if no contact, then;

b. Call the attending surgeon’s answering service, if no contact, then;

c. Call the attending surgeon’s home, if no contact, then;

d. Contact the hospital operator and ask the operator to try and contact the attending, if no contact, then;

e. Contact the respective attending surgeon’s partner on call, if no contact or no identifiable partner is available, then;

f. Contact the MSU-IRGSP faculty surgeon on call who will then assume responsibility for care of the patient until the patient’s surgeon/physician can be contacted.

g. If the MSU-IRGSP faculty on call is not available, contact the Program Director for directions from that point on. In such an eventuality, the Program Director or designated
surgical care of both the patient and the resident(s) involved.

**BACK-UP SUPPORT**

This policy establishes parameters for General Surgery resident back-up support. This policy takes into consideration the educational needs of the resident, their personal well-being, the safety and health care needs of the patient and service needs of the department.

All General Surgery residents provide surgical and medical care to patients under the supervision of either the patient’s personal attending surgeon and/or the MSU Integrated Residency in General Surgery full-time faculty attending surgeon on-call that day. When the supervising attending surgeon is not physically present, they are required to be immediately available by pager or phone. If a supervising attending surgeon is not available or does not respond to their page or phone calls to their office and home, then the person on-call for that surgeon must be immediately available to the resident by pager or phone. If for any reason, neither the respective patient’s attending surgeon nor the surgeon on-call for that attending surgeon are available nor do they respond to their page and phone calls, then the resident will contact the full-time faculty attending on-call for MSU Integrated Residency in General Surgery that day to address immediate needs.

If the resident cannot contact the respective supervising attending surgeon and the MSU Integrated Residency in General Surgery full-time faculty attending on-call is not available, the resident will contact the Program Director or his/her designee who will be available 24/7 by pager and phone. The Program Director will serve as surrogate supervising surgeon or assign one to the resident until the respective supervising attending surgeon can be located and contacted.

In the unusual event that neither the patient’s personal surgeon, the surgeon on-call for the patient’s personal surgeon, the MSU Integrated Residency in General Surgery surgeon on-call and the Program Director and/or the Program Director’s designee are not available at a time when the resident needs assistance, the resident should seek help from any one of the available surgeons on active staff of the respective hospital.

It is expected that residents will always have access to more senior residents for assistance above and beyond the protocol described here.

**COMPLAINTS**

At any time and under any circumstance, every resident is free and has the inherent right to bring a complaint or a point of concern regarding any aspect of the residency program directly to: the Program Director, Department Chair, MSU DIO, or Assistant Dean of MSU CHM who oversees the graduate medical education (GME) programs in Lansing. This may involve, or be regarding: faculty, other residents, hospitals and or hospital administration or services, including the Program Director, department chair, etc.

This right cannot be interfered with or discouraged in any way. Any attempt to prevent or discourage a resident from bringing any issue, point of concern or complaint to the attention of the appropriate authority (Program Director, department chair, DIO or Assistant Dean of MSU CHM) will be considered unprofessional behavior and grounds for sanction. In this regard, faculty should not discourage residents from bringing any point of concern or any issue pertaining to the residency program to the attention of the Program Director or, in the case that it involves the Program Director, to the Institutional DIO and/or Assistant Dean of MSU CHM (the DIO and Assistant Dean are usually the same individual in our setting).
Further, any faculty member or other individual who retaliates by expression or deed to communicate their displeasure to a resident who has brought a legitimate concern or complaint to the proper authority or any other resident in the program will be considered to be conducting themselves unprofessionally. Such conduct will be considered grounds for suspending or removing them from the teaching faculty of the program.

This policy is intended to protect the resident from any and all forms of abusive behavior and/or intimidation that might arise from the resident bringing to the attention of proper authority an appropriate concern, issue and/or complaint.

The home page of New Innovations has three ways to report items. They are:

- **Sparrow Confidential Reporting**
  - (517) 364-3996
  - The Sparrow phone number is confidential and does not have your phone number that you are calling from associated with the call.

- **Sparrow Safety Concerns**
  - GMEPatientSafety@sparrow.org

- **MSU Reporting**
  - residentvoice@hc.msu.edu
  - (May not be confidential if sent from your personal email address.)

You may also write a letter and send it through Sparrow interoffice mail to ATTN: Diane Sanders, MED ED, Med Arts Building, Suite 202B or through the US mail to Sparrow Med ED, 1322 E Michigan Ave, Suite 202B, Lansing, MI 48912.

### USE OF PROGRAM EDUCATIONAL MATERIALS

Any resident, physician assistant, or faculty member may sign out any educational textbook, video or computer for personal use. However, it is understood that any item that is subsequently missing will be the responsibility of the person on record who last signed the item out. The responsible person will have to replace the missing item. There will be no exceptions to this policy. This may require payroll deduction(s) until the purchase price for replacing the item has been collected. To avoid being held responsible for an item, it must be returned in the same condition in which it was taken. If an item is missing and no one has signed it out, it will be assumed that the item has been stolen and the program will have to replace the item if so desired. Thereafter, security will be tightened until no item can be obtained except being signed out through the program coordinators. In such an event, when an item is returned it must be returned to the program coordinator who can verify that the item has been returned in good condition and have the borrower sign the item as returned, thus relieving them of subsequent responsibility for damaged and/or missing items. An educational item missing or stolen may not be replaced subject to the resources available to the department.

### PROCEDURE COMPETENCY

In an effort to effectively communicate with hospital leadership regarding a surgeon’s procedural competency, a punch card system is in place. Upon hire, procedural competencies need to be acquired in a timely fashion and authorized by a faculty member/chief resident. The steps for obtaining procedural competency are:
1. Upon competency completion, request a confirming signature of a faculty member or chief resident. Signatures should be collected in a ‘Resident Procedure Competencies’ booklet. The booklets are distributed during a new resident’s orientation.

   a. Abscess Draining - (3)
   b. ACLS Training - (1)
   c. BCLS Training - (1)
   d. ATLS Training - (1)
   e. American Heart Assoc (AHA) Guidelines - (1)
   f. Arterial Line - (3)
   g. Arterial Puncture - (1)
   h. Basic Laparoscopic - (1)
   i. Central Venous Line - (10)
   j. Chest Tube - (5)
   k. Forceps/Needle (Large) - (1)
   l. Forceps/Needle (Small) - (1)
   m. Hemostasis - (1)
   n. Incision & Drainage - (1)
   o. Knot Tying - (1)
   p. Nasogastric Intubation - (2)
   q. Peripheral IV Line Placement - (1)
   r. Skin Biopsy - (1)
   s. Wound Closure - (1)

2. Faculty and/or chief resident booklet signatures are required prior to punch card ‘punching’. Booklets’ signatures are communicated to the residency coordinator and, in-turn, punch cards are punched and confirmation is retained for accreditation purposes.

3. The ‘General Surgery Resident Procedure Competencies’ badge card should be kept up-to-date and displayed alongside a residents’ name badge for continual hospital staff reference throughout the residency’s entire duration.

4. After all procedural competencies are obtained, the ‘Resident Procedure Competencies’ booklet is returned to the residency coordinator.

**CONFERENCES**

Mandatory conferences take priority over operations and consultations except in life-or-limb-threatening situations.

Under no circumstance is the resident to miss a conference designated as required for other than life saving situations, vacations, illness, or conflicting legitimate travel.

Any resident who misses a mandatory Thursday morning conference without permission of the Program Director will be eligible and at risk for immediate suspension from the program without further discussion. In such an event, the Program Director will convene at least three members of the full-time faculty and present the circumstances and grounds for immediate suspension of the resident in question. By a majority vote of at least three full-time faculty members, the resident’s suspension will be either implemented or downgraded to a formal written warning by the Program Director. The duration of suspension will be determined by the Program Director at the time of the infraction, but will not exceed one month. Such
suspension or formal written warning will be documented in the resident’s record and will become a permanent document in the resident’s portfolio.

Any faculty who involves a resident in an elective procedure that causes the resident to be absent from a required conference will not be allowed further involvement with the residents (any resident) for at least 30 days subsequent to the day the resident misses the required conference.

If an attending surgeon requires help that conflicts with the above policy, then he/she should make arrangements with the Program Director for resident assistance or with another appropriate attending surgeon for assistance.

A resident who is absent without excuse (i.e., not on vacation, at a conference nor other educational activity formally approved by the Program Director) from any required conference other than a Thursday morning conference will be given a verbal warning and such warning will be documented in their respective portfolio.

A resident who receives three or more such verbal warnings in any six-month period will be given a letter in writing advising them that any additional unexcused absence, for any reasons whatsoever, will result in a one-week suspension from the program. Such suspension will become permanently documented in their residency record/portfolio and may become the basis for demonstrated incompetence in the core areas of Medical Knowledge, Interpersonal and Communication Skills, Practice-based Learning and Improvement, and Professionalism. Such incompetence may be grounds for dismissal from the program and/or failure to be recommended for certification by the American Board of Surgery without the satisfactory completion of additional training.

Residents are expected to attend a minimum of 90 percent of all scheduled conferences. If a resident repeatedly falls below this attendance benchmark (on three successive audits), the resident will be documented to be incompetent in the four core areas identified above.

Journal club attendance is mandatory even for residents post call. This does not violate any of the resident work hour limitations because it does not exceed the 30 hour limit for continuous work and will not prevent the resident from having more than 10 hours of off-time prior to returning to clinical duties the following day. It does, however, count toward the 80-hour work-week and should be recorded appropriately.

For the purpose of clarifying resident responsibilities during mandatory Thursday morning conferences, which will be considered "protected time" for educational purposes, the following policy will apply:

For all trauma alerts/call downs, the senior resident assigned to the Trauma service for that month (usually the PGY-4 on Trauma) alone will respond to the Emergency Department or unit in need and evaluate the patient. After completing an abbreviated evaluation, the senior Trauma resident will discuss the case with the Trauma attending on call and if they agree that there is a compelling need to involve another resident on the Trauma team, then and only then will the senior Trauma resident do so. All instances in which a resident other than the senior Trauma resident is required to leave conference during protected time will be reviewed by the Program Director; and if in the opinion of the Program Director, the involvement of other resident(s) was unnecessary, the respective Trauma attending will be asked to document the reason for pulling the resident away from conference. If an adverse pattern specific to a particular resident or Trauma surgeon is identified, it will be addressed toward the goal of ensuring that residents' protected time for educational conferences is assured.

For all General Surgery consultation requests, the respective PGY-3 assigned to either the Green or White service (each month the assignment will follow Green Service in July, White Service in August and then alternate for the rest of the academic year) will respond, evaluate and assess the patient and/or circumstance.
and appropriately provide the level of care needed to expedite the patient's immediate needs for care with the plan to fully complete or address the patient's needs within or concurrent to the completion of educational activities during that protected time period. The PGY-3 will carry the pager(s) for the respective service(s) during this protected time and answer calls until noon or all scheduled conferences are completed, whichever comes first.

In both instances described above, the respective resident will discuss the matter with the MSU-IRSGP attending on call (Teaching Attending of the Day) to develop a treatment plan and then communicate that plan with the attending or responsible resident requesting the consultation. Failure to communicate the plan for care to the appropriate attending and/or resident to their satisfaction will be considered unacceptable performance on the part of the General Surgery resident.

### Conference and Daily Rounding Schedule

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**DRESS CODE**

The following dress code applies to presentations at Surgical M&M Conferences and Surgical Grand Rounds, as well as, seeing patients in all MSU Department of Surgery ambulatory clinics. Residents will wear a white coat over clean surgical scrubs, shirt and tie, and/or professional dress for women.
MOONLIGHTING POLICY

Graduate Medical Education in General Surgery is a full-time commitment. Residents will not be allowed to be diverted from this primary responsibility to their own education and to the patients charged to their care.

AMBULATORY CLINICS

The ambulatory clinics are set up for resident education. Patient care, however, is not to be sacrificed for the convenience of the resident staff. The responsibilities and duties of the resident will be determined by the attending physician of the clinical services involved. Clinic responsibilities take precedence over operations, procedures or consultations except in life-or-limb-threatening situations. The Chief Resident of each respective ambulatory clinic for his/her service will have primary responsibility for the clinics under the supervision of surgery faculty. Each resident, including Chief Residents, must see patients in an ambulatory clinic setting for at least one half-day each week (residents must document such activity by returning to the General Surgery program coordinator(s) the list of patients seen and their respective diagnoses by Friday noon of the respective week. Failure to provide such documentation in the time described above will be considered a measure of incompetence in two core competencies: Interpersonal and Communication Skills and Professionalism.

Any conflict or discrepancy regarding the management of clinical services or clinical patients should be reported to the Program Director.

A list of required clinics will be provided for all rotations. All surgery residents are required to spend at least one half-day per week in ambulatory care. Guidelines for clinic rotations are as follows:

- All General Surgery residents will rotate through one of the MSU Department of Surgery ambulatory clinics at least one half-day per week.
- PGY-4’s and PGY-5’s rotate a half-day per week through ambulatory clinics so as to see, whenever possible, preoperatively and postoperatively those patients on whom they perform surgery.
- Residents rotating on Transplant and Pediatric Surgery will not attend any General Surgery clinics or rotations for that rotation.

Residents are expected to see the patients in the academic service clinics. If present, medical students may see and present patients to or with the resident. The resident will then subsequently present the patient to the supervising attending physician. The management of all patients seen in clinic must be reviewed by and/or discussed with the supervising, attending surgeon.

Medical student notes will not be acceptable for purposes of chart completion or documenting billable professional activity. The resident must dictate or type into the electronic medical record (EMR) all clinic notes and history and physicals under the supervision of the attending surgeon present in clinic that day and time. The resident should mention in their dictation or indicate in their structured notes the name of the attending surgeon who supervised the patient’s clinic visit.

The resident will send a letter to the respective referring physician for patients seen in the ambulatory clinic unless instructed not to do so by the supervising faculty or surgeon.
Appropriate professional dress is required when seeing patients in the ambulatory clinic. A shirt with a collar is preferred, as well as a tie for men. Scrubs are, for the most part, inappropriate clinic attire outside of the procedure rooms. A resident who wears scrubs in the clinic may be asked to change into appropriate attire. As the need arises, however, a resident may wear surgical scrubs with a white overcoat. The overcoat should have their name inscribed on it, or they should wear a name badge in clear sight of patients at all times.

Residents must complete the notes on patients seen in the ambulatory clinic within 24 hours of the patient’s visit. It is recommended that residents come early to the clinic, review and complete their outstanding TASKS in the electronic medical record (EMR) whenever they are in clinic and/or time allows. Residents must review and sign their documents on the EMR within one week of the patient’s visit. TASKS that are outstanding for more than one week will be considered unacceptable and evidence of incompetence in the core areas of Patient Care, Interpersonal and Communication Skills, and Professionalism. If a trend in this regard is identified by faculty, the resident may receive further instruction, counseling, or a verbal warning, as the circumstances warrant, by any member of the faculty or the Program Director. All verbal warnings will be handled in the manner previously described for attendance at mandatory conferences.

HAND WASHING

Hand washing is mandatory before and after all procedures and patient encounters. The washing should be less than a “surgical scrub” unless it is for a sterile procedure such as for breast biopsy. Minimal hand preparation for a patient examination is a brief washing (with warm water) after the previous patient examination. Another added benefit to pre-examination washing of hands is patient comfort and satisfaction.

SURGICAL SCRUB GOWNS, CAPS, AND MASKS

For the persons doing incisional and excisional procedures in ambulatory clinics, lab coats and street clothes above the waist should be removed, and scrub tops and caps put on. Anyone in the room of a sterile procedure when the patient’s integument is to be incised should wear a mask. Protective clothing and non-sterile gloves are required for all endoscopic procedures.

SKIN SCRUBBING AND DRAPING

Chloraprep is recommended for skin preparation before a procedure. The extent of the preparation and draping is predetermined by the person doing the procedure. Sterile towels and multiple sized drapes will be available.

DICTATION

Histories, Physical Examinations, and Consultations

All inpatient histories, physical examinations, operative reports and consultations will be dictated on the hospital transcription system. This is mandatory to ensure that copies will be forwarded to the ambulatory clinic record at the MSU Integrated Residency in General Surgery. Details of the plan of action will be included along with the name and documentation of either the discussion defining the treatment plan, or the agreement and approval of the treatment plan by the supervising faculty member.
Operative Notes

A brief preoperative note explaining the operative plan; its justification; the supervising surgeon’s name and agreement to the plan; the patient’s and/or surrogate’s consent, understanding, and concurrence; and other pertinent information will be handwritten on the progress sheet by the responsible resident. In most cases, the responsible resident will be the resident who performs or assists with the surgical procedure.

Irrespective of the urgency or immediacy with which a procedure is performed, any and all invasive procedures, as defined by the Centers for Medicare and Medicaid Services (CMS) and recapitulated in the Sparrow GME document 0050 (see Appendix), will be preceded by a ‘Time Out.’ The ‘Time Out’ will be documented in the EMR and will include: (1) Confirmation of the correct patient with use of two patient identifiers (Name, DOB, or MRN), (2) Confirmation of the correct procedure, and (3) Confirmation of correct surgical site. Routine adherence to performing the pre-procedural ‘Time Out’ is essential to establishing a culture of safety in the hospital setting and deviation from this practice will result in a critical deficiency in resident performance in the following ACGME Milestones— the Patient Care (PC3) and Interpersonal and Communication Skills (ICS3) competencies under the Performance of Operations and Procedures (POP) domain, as well as for the Systems-Based Practice (SBP2) competency in the Improvement of Care (IC) practice domain. In the interest of patient safety, blatant disregard for the ‘Time Out’ rule cannot be tolerated and is cause for immediate suspension.

These critical deficiencies will be reviewed as part of the resident’s Clinical Competency Committee evaluation on a bi-annual basis to determine readiness for promotion and/or need for remediation. Multiple critical deficiencies may be grounds for failure to advance in the program until such deficiencies have been satisfactorily remediated (as judged by the CCC and/or the PD); as well as possible dismissal from the program if such deficiencies are not remediated satisfactorily in a timely fashion.

A comprehensive and detailed operative note will be dictated postoperatively within 24 hours of the operation. The dictated operative note should include a statement of pause to identify the patient, the planned procedure and intended surgical site or acknowledgement of the completed Keystone briefing and debriefing process, as well as a statement verifying the presence and/or time of involvement of the attending surgeon. In addition, a note will be handwritten on the appropriate progress note form in the immediate postoperative period. This postoperative progress note will include the elements of date, time, preoperative diagnosis, postoperative diagnosis, surgeon(s), name of the procedure, anesthesia used, estimated blood loss, fluids administered, findings, drains placed (if any), specimen(s) sent, complications, and the condition of the patient at the end of the procedure.

SUGGESTED OPERATIVE NOTE DICTATION FORMAT

Preoperative diagnosis (dx):
Postoperative dx:
Procedure:
Surgeon:
Assistant(s):
Anesthesia:
Indications for surgery (brief history):
Findings at surgery:
Description:
   Body:
   Prep:
   Position:
Pause:
Neutral zone:
Narrative:
Conclusion:
Estimated Blood Loss (EBL):
Fluids:
Counts:
Drains:
Attending was present throughout the procedure (or during the critical portion of the procedure)
Disposition:
Complications:

Responsibility for dictating the formal operative note belongs to the resident or the attending surgeon who performed the procedure. Assignment of the task must be clearly understood prior to the completion of the operation.

Delinquent operative notes by residents will be closely monitored by the Program Coordinator, faculty and Program Director. An accumulation of three or more delinquent operative notes may lead to documented incompetence in the area of Interpersonal and Communication Skills if the resident does not respond in a timely fashion once he/she has been notified of the delinquency(ies). Timely completion will approximate resolution of the delinquent dictation within 72 hours of being notified by the attending surgeon or Program Director.

**HOSPITAL DISCHARGE SUMMARIES**

It is recommended that discharge summaries be dictated at the time of discharge. The summary must be concise and reflect the thinking of the service regarding care of the patient. A short and timely summary is more desirable than one that is detailed but delayed. Delinquent records reflect negatively on the evaluation of the resident’s communication skills and under extreme circumstances may lead to temporary suspension of hospital privileges of the supervising faculty.

Discharge summaries will be completed by the resident who operated upon the patient last. In the event that no operation was performed or if the operation was performed by the attending surgeon, the PGY-1, -2, or -3 who admitted the patient will be responsible for the dictation, assuming that a surgical resident admitted the patient and was actively involved in the management of the patient’s care (implying that the Chief Resident accepted responsibility for care of the patient).

Rotation to another service will not be an excuse for not carrying out an assigned chart completion task while on the academic surgery service. However, rotation off of the service by residents not in the General Surgery residency program will often require discharge summaries of unfamiliar cases to be dictated by a General Surgery resident rotating onto the academic surgery service if resident responsibility for dictation of the medical record is unclear. It is for this reason that the resident writing the discharge orders must indicate on the discharge orders to which the dictation summary is to be assigned. The most senior resident on the service will be responsible for making the assignment if any questions arise. Unfair or inappropriate assignments will not be acceptable or tolerated.

**PROCEDURE, CASE and COMPLICATIONS MONITORING POLICY**

Monitoring of a resident’s procedure and case management, requires the resident to document operative and procedural performance weekly into the web-based ACGME Case Log site. Timely upkeep of these
records is necessary for the Program Coordinator to generate regular reports to the Program Director. Based on this surveillance, the Program Director will adjust the clinical and operational experiences to assure a uniform, balanced and fair training experience for all residents.

Likewise, the timely completion and updating of the resident’s individual ACGME Case Log and/or the Procedure Log in New Innovations for bedside procedures not normally recorded in the ACGME Case Log system will be required for the satisfactory assignment of clinical privileges at the respective hospital. If a log book is not submitted completely filled out and up-to-date within a week of request, the responsible resident will be asked to remove him or herself from all clinical activities and report to the Program Director. At that time the resident will be required to complete their log book before returning to the clinical service. If more than two weeks is missed from an off-service rotation (not General Surgery), the resident may be required to make up the time missed before satisfactorily completing the rotation. This may require loss of vacation time or extended time in the residency training program.

A list of all morbidities and mortalities for the respective Green or White service must be submitted to the respective Program Coordinator, or his/her designee) by the Chief Residents on a weekly basis by 5:00 p.m. each Monday. This list must be inclusive of any and all morbidities and mortalities experienced by the respective service for the previous week. Morbidity is defined as any untoward or unexpected outcome in a patient especially when it requires care or prolongs the patient’s hospital stay. No exceptions to this practice will be acceptable. No morbidity and/or mortality should be presented without first notifying the respective attending surgeon of the time and place. If an attending wishes to delay a morbidity and/or mortality discussion until such time that he/she can be present, the Chief Resident can accommodate the attending such a request. The Chief Resident or his/her designee will be responsible for presenting all cases at M&M Conference. It is expected that any and all faculty participating in the program will make they available to be present during the discussion of their respective patient’s morbidity and/or mortality.

Tardy reporting of operative cases into the resident’s respective case logs will not be tolerated and will lead to suspension of operating room privileges/activities until completed. Any operative case that has not been recorded within a week of its completion in the operating room will be considered tardy.

**MISCELLANEOUS GUIDELINES, RULES AND POLICY**

**Formal Presentations by Resident**

*Case Presentations at Rounds/Conference*

The presentations should be short but formal. Do not skip any of the following, basic format items:

1. Patient sex.
2. Patient age.
   a. Give this clearly and with emphasis.
3. Primary complaint.
   a. Why did the patient come to see the doctor?
4. History of present illness.
   a. Especially the duration of the complaint.
5. Past history.
   a. Pertinent history only.
6. Physical examination.
   a. At time of presentation, report what was recorded, whether or not you performed the examination.
7. Initial work up.
8. Initial impression.
9. Initial plan.
11. Pertinent episodes since initial encounter.

Abbreviations and the use of slang or colloquial language is to be avoided during the presentation of information during rounds. For example, “blood urea nitrogen” should be used instead of “BUN”, “abdominal aortic aneurysm” instead of “AAA.” Presentations will be clear and specific as to the exact procedure and treatment prescribed. Interpersonal and communication skills are a basic tenet of successful completion of this program.

Residents are to be certain of facts, discussing the case (as needed) with the attending prior to the presentation to make sure of details that may be obscure or vague after reviewing the medical record.

Faculty are to be contacted and informed that their patient will be presented at M&M Conference at least 48 hours prior to the conference when possible. When a resident is involved with a case that results in morbidity or mortality he or she will be obligated to present it at this conference, with or without the approval of the supervising faculty. The hallmark of a morbidity and mortality presentation must be:

1. What could I have done better?
2. What did I learn from the case/experience?
3. Were there any systems issues or concerns that adversely impacted the care of the patient or compromised the patient's safety?

Case presentations at Grand Rounds or other teaching conferences are optional and should be presented only with concurrence of the supervising faculty.

**Solicitation**

Residents will not be allowed to solicit any funds or “gifts” from pharmaceutical representatives on their own personal behalf. Such solicitation will be considered unprofessional behavior. A resident may, however, refer an interested pharmaceutical representative to the program coordinator, faculty or Program Director for the purpose of providing voluntary, appropriate support for an approved educational activity of the program.

**Vacations**

Vacation allowance (three weeks or 15 working days) is determined by the resident’s GMEI contract. Residents are advised to schedule their vacations for the upcoming year by July 31, or the preceding academic year to assure that the time requested will be available to them. Request for changes will be considered if submitted in a timely fashion and according to guidelines. Residents are further advised to avoid taking more than one week off on any rotation. Residents will not be allowed to take more than one week off on any off-service (any non-General Surgery) rotation. Vacation requests are to be submitted in the appropriate format by the 10th day of the month immediately prior to the anticipated vacation time being requested. There will be no exception to this requirement without permission of the Program Director. Failure to comply with these guidelines could lead to a resident missing their allotted time off. Requests will be honored on a first come, first served basis. Changes must be appropriately documented and approved by the Program Director or his/her designee. **The Program Director will not approve any vacation**
that results in inadequate patient coverage on an Academic Surgical Service at any one time (under normal circumstances).

Residents not make final plans and/or purchase any tickets or travel-related items that cannot be fully refunded before receiving notification of approval of your requested vacation time off.

Emergency leave must be approved by the Chief Resident and the Director or his/her designee. The resident need only to notify the Program Director in most cases to receive approval for any circumstance that the resident believes constitutes a family or personal emergency requiring them to leave their duties, the hospital, or the Lansing/Flint area on short notice.

Postgraduate Education

Requests to attend postgraduate programs outside of MSU Integrated Residency in General Surgery must be approved by the Program Director or his/her designee.

No one can make changes to the curriculum without the approval of the Program Director.

All residents are required to be current and certified in ATLS, ACLS, BLS, and to have satisfactorily completed USMLE Steps 1, 2, and 3, FLS and an ultrasound course with at least ASC basic ultrasound certification prior to completion of their surgical residency to be recommended for certification by the American Board of Surgery and graduation from the General Surgery training program by the Program Director. It is expected that the USMLE Step 3 examination will be taken and passed by the end of the pgy-2 year. It is recommended that the resident make arrangements to take the Step 3 exam at the end of their PGY-1 year.

Resident Research and Scholarly Activity

It is expected that each categorical resident will present at least one scientific paper worthy of publication at a local, regional and/or national meeting before completing their clinical training.

An appropriate topic for these papers will be chosen by the resident no later than the last month of the PGY-2 year with the consent of a designated faculty advisor. All residents must give a short outline of their project proposal to the Program Director and Chief of Surgical Research. Residents who do not submit and receive approval of a proposal will be assigned a project.

Travel requirements for a paper presentation must be preapproved on a special travel request form.

Counseling Services

Psychological and educational skill counseling may be arranged in a confidential manner at the request of the resident. Certain counseling services are available as an employee benefit for a limited number of visits and for a limited scope of care. It may be necessary for the resident to pay out-of-pocket for extended counseling services beyond contractually defined benefits and/or resources of the department.

Human Resources at GMEI is available to assist any resident who requires confidential counseling through contractual arrangements with GMEI.
Other

The respective Chief Resident may establish and other mechanism for assuring operative case assignments that must be distributed (at least by 7 p.m.) the evening prior to the day of surgery for all residents and medical students who are assigned to their academic surgical service.
APPENDIX A

GENERAL COMPETENCIES

EDUCATIONAL GOALS FOR RESIDENTS IN GENERAL SURGERY
(Learning Objectives)

A. Patient Care
General surgery residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. They must:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patient and their families in both pre- and postoperative situations.
2. Gather essential and accurate information about their patients through review and individual-specific feedback of history and physical examinations, clinic and progress notes, transcribed and written communications entered into the patient’s record.
3. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
4. Develop and carry out patient management plans while embracing a patient-centered approach.
5. Counsel and educate patients and their families.
6. Use information technology to support patient care decisions and patient education.
7. Perform competently all medical and invasive procedures considered essential for the scope and practice of General Surgery.
8. Demonstrate manual dexterity appropriate for their level of training.
9. Be able to develop and execute patient care plans appropriate for the respective resident’s level of training.
10. Work effectively and cooperatively with each patient’s primary care physician, specialists, and other health care professionals, including those from other disciplines, to provide patient-focused care and develop individualized plans for pre- and postoperative care of the surgical patient.
11. Provide health care services aimed at preventing health problems, maintaining health, and encouraging recovery following operative procedures and nonoperative surgical care

B. Medical Knowledge
General surgery residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. General surgery residents are expected to:

8. Demonstrate an investigatory and analytic thinking approach to clinical situations.
9. Critically evaluate and demonstrate knowledge of pertinent scientific information.
10. Know and apply the basic and clinically supportive sciences, which are appropriate to General Surgery as outlined in their published curriculum.
C. Practice-based Learning and Quality Improvement

General surgery residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

11. Analyze practice experience and perform practice-based improvement activities using a systematic methodology (i.e., critically evaluate personal practice outcomes).
12. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems.
13. Obtain and use information about their population of patients and the larger population from which their patients are drawn.
14. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
15. Use information technology to manage information, access on-line medical information such as laboratory and imaging study results; and both further and support their education.
16. Demonstrate a recognition of the importance of lifelong learning in surgical practice by evaluating patient outcomes in the context of available and current surgical literature and recommended practices; and share that information and experience with medical students under their tutelage.

D. Interpersonal and Communication Skills

General surgery residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming (and forming partnerships) with patients, their patients’ families, and professional associates. Residents are expected to:

17. Create or develop and sustain a therapeutic and ethically sound relationship with patients.
18. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills (for example, as manifested in written and dictated clinical progress notes and operative reports); and, thereby effectively communicate with other health care professionals and effectively document practice activities.
19. Work effectively with others as a member or leader of a health care team or other professional group.

E. Professionalism

General surgery residents must demonstrate a commitment to carry out professional responsibilities, adhere to ethical principles, and show sensitivity to a diverse patient population. Residents are expected to:

20. Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development. As such, they must aspire to maintain a high standard of ethical behavior.
21. Demonstrate a commitment to ethical principles pertaining to the provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices that foster patient-centered care.
22. Demonstrate sensitivity and responsiveness to the culture, age, gender, and disabilities of patients and other health care professionals.
23. Demonstrate a commitment to the continuity of patient care via ongoing postoperative clinical care and continuing communication with the patient’s primary care provider and the patient as needed.

F. Systems-based Practice
General surgery residents must demonstrate an awareness of, and responsiveness to, the larger context and system of health care and exhibit an ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

24. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society, and how these elements of the system affect their own personal practice.
25. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
26. Practice cost-effective health care and resource allocation that does not compromise quality of care.
27. Advocate for quality patient care and assist patients in dealing with system complexities as such complexities impact their health and ability to take care of themselves.
28. Know how to partner with health care managers and health care providers to assess, coordinate, and improve surgical outcomes specifically and health care in general; and know how these activities can affect surgical health care delivery and surgical system performance.
RESIDENT DISCIPLINARY ACTION, CONFLICT RESOLUTION & DUE PROCESS

Policy

MSU Integrated Residency in General Surgery will provide residents with an opportunity to and method of resolving conflicts, and, assures residents an environment in which conflicts can be addressed without fear of intimidation, retaliation, or discrimination. MSU Integrated Residency in General Surgery will not tolerate intimidation, retaliation, or discrimination and any individual who exhibits these behaviors will be subject to disciplinary action up to and including termination. A resident who believes they have been subjected to these behaviors should report the alleged act immediately to their supervisor or to the Director of GMEI.

Every effort will be made to solve conflicts within the resident’s own department by following that program’s conflict resolution process. Issues that cannot be resolved at the department level, will be governed by the policies and guidelines of MSU Health, GME and/or GMEI depending on the issue at hand.

Guidelines for Disciplinary Action

Program Directors have the authority to summarily suspend a resident if there is a serious violation of the rules and regulations of the residency program or a participating hospital/institution, OR whenever such action, in the Program Director’s estimation, must be taken in the best interest of patient care. Such suspension is effective immediately upon written notification to the affected resident, and a copy of such notice must be provided to the Assistant Dean/Institutional DIO. Disciplinary procedures apply to residents who have been summarily suspended. Residents have the right to use the appeal process as described in this document.

Disciplinary action may be instituted for academic deficiencies, administrative deficiencies (e.g., failure to adhere to administrative or record keeping policies/practices), or professional misconduct (e.g., failure to follow the rules and regulations of the residency program or hospital, or any inappropriate or unprofessional behavior including that which jeopardizes patient welfare). Faculty, residents, or staff should direct their concerns about a resident to the appropriate Program Director.
When a Program Director is made aware of a concern, he/she will investigate all issues raised regarding the resident and may then take one of the following actions:

1. Clear the resident if the charges are found to be without merit
2. Issue a letter of warning to the resident
3. Place the resident on probation for a specified period subject to a prescribed remediation plan and evaluation procedure. After the specified probationary period, the Program Director and two departmental faculty members will evaluate the resident’s remedial efforts and either continue the resident in the program in good standing, extend the probationary period, or use actions A-E below on such terms and conditions as deemed appropriate.

The Program Director must notify the resident, the Assistant Dean/Institutional DIO, and the Director of Medical Education in writing of a decision to use options A-E below.

Residents may appeal Adverse Actions A-E below, in accordance with the “Appeal Procedure of the Guidelines for Resident Grievance/Due Process” which is contained in this policy.

Adverse Actions A-E:
- A. Hold the resident over at the same training level for a finite period of time, not to exceed one year
- B. Suspend the resident for a specified period of time.
- C. Not renew the resident’s contract. The Program Director must provide written notice to the resident of the intent not to renew the resident’s contract. If the primary reason(s) for non-renewal of contract occur during the last four months of a contract period, the Program Director must provide the resident with as much notice as possible.
- D. Not recommend the resident to sit for the designated Specialty board examination in his/her specialty
- E. Terminate the resident from the program

Guidelines for Resident Grievance/Due Process
Conflicts regarding Adverse Actions A-E as listed above are subject to the Appeal Procedure that follows, if the resident cannot resolve the problem at the program level.

Appeal Procedure
Only Adverse Actions A-E as listed above are eligible for review under the appeal process. All other conflicts will be handled using the “Guidelines for Conflict Resolution”

Residents have five (5) working days from the date the resident is informed by the Program Director that an adverse action (Adverse Actions A-E) will be taken, to submit to the Program Director and the Assistant Dean/Institutional DIO a letter stating an intent to appeal the adverse action. If no appeal is sought within five (5) working days, the adverse action is final.

The Assistant Dean/Institutional DIO, or a designee, will within five (5) working days following receipt of a letter requesting an appeal, appoint a subcommittee of the Graduate Medical Education Committee composed of the following individuals to conduct a hearing (the subcommittee may also include a Vice President of Medical Affairs from one of the member hospitals). The Assistant Dean/Institutional DIO will name the subcommittee chair. Other members will include:
• Two faculty members from another program
• An MSU Integrated Residency in General Surgery administrator
• One Program Director from another program
• One Resident from another program
• McLaren Hospital or Sparrow Hospital Vice President of Medical Affairs

The subcommittee will schedule a hearing within 10 working days of its appointment. The subcommittee will receive such information and hear such testimony as it deems necessary to decide the appeal. The resident has the right to be present at the hearing and provide relevant information and witnesses to the subcommittee. No attorney may be present for either party. After testimony and review of information is completed, a secret ballot vote on recommended action will be taken.

Within two (2) working days after the conclusion of the hearing, the committee chair will notify the following individuals, in writing, of the subcommittee’s decision:

• Resident
• Resident’s Program Director
• Assistant Dean/Institutional DIO
• Department Chair

If the resident is dissatisfied with the subcommittee’s decision, he/she has five (5) working days to deliver written notice to the Assistant Dean/Institutional DIO that he/she is appealing the Hearing Subcommittee’s decision. If the Assistant Dean/Institutional DIO is not so notified within the required time limit, the Subcommittee’s decision will be final and binding. Written notice must contain the specific reasons for the appeal and only the process followed by the subcommittee will be reviewed.

The Assistant Dean/Institutional DIO has five (5) working days from receipt of the resident’s appeal letter to review the process followed by the Subcommittee to determine whether the appeal process was handled in accordance with stated policy. If the Assistant Dean/Institutional DIO determines that the appeal process was handled in accordance with stated policy, the matter is concluded and the decision of the Subcommittee will stand. If the Assistant Dean/Institutional DIO determines that the process has not been properly followed, he/she will provide a written explanation of the areas of deficiency to the Subcommittee and direct the Chair of that subcommittee to reconvene the process following stated policy.

Arbitration

Any controversy or claim arising out of the Residency Agreement or termination of the Agreement (including any claim of discrimination) shall be settled solely by arbitration in the Ingham County, State of Michigan, in accordance with the rules of the American Arbitration Association. The decision of the arbitrator shall be final and binding and neither party shall have any right of appeal thereafter. Judgment upon the award rendered by the arbitrator may be entered in the Circuit Court for Ingham County. The demand for arbitration must be submitted, in writing, to both the other party and the American Arbitration Association at P.O. Box 5105, Southfield, MI 48086-5105. The demand must be received by the American Arbitration Association within sixty (60) days after the alleged violation, misconduct, or incident occurred which gives rise to the request for arbitration. Failure to file the demand with the American Arbitration Association within the said sixty (60) day
time period will constitute a full and complete waiver of the claim, and a complete waiver of any right to compensation, benefits, or damages. If the written demand for arbitration is not filled within the said sixty (60) day period, it is forever barred.

The party seeking arbitration of the dispute shall bear all of the fees and expenses for filing the claim with the American Arbitration Association. The parties shall bear their own costs and attorney fees for preparing for and attending the arbitration proceedings, except that the parties shall share equally in the costs of the arbitrator’s fees and expenses, if any.

**Guidelines for Conflict Resolution**

The “Guidelines for Conflict Resolution” are used for conflicts other than those arising out of Adverse Actions A-E as previously listed. Residents are required to initially attempt to resolve conflicts with their Program Director and/or faculty. If the conflict cannot be resolved in this manner, the resident may use the following process:

1. The resident will present the conflict to the Assistant Dean/Institutional DIO
2. The Assistant Dean/Institutional DIO will acknowledge the conflict in writing and discuss it with the resident’s Program Director to assure that applicable departmental policies have been followed
3. The Assistant Dean/Institutional DIO will appoint a subcommittee of the Graduate Medical Education Committee to investigate the conflict and prepare a response for review of the following four members: a Program Director from another residency program, a resident from another residency program, a faculty member from another residency program, and the Director of Human Resources.
4. The Assistant Dean/Institutional DIO will review the subcommittee’s recommendation and make a decision which will be final and cannot be carried forward to the grievance/arbitration level.
This is to verify that I have received and read the General Surgery Guidelines, Rules and Policy Regulations for Residents.

____________________________ 
Faculty Signature

____________________________ 
Date

____________________________ 
Faculty Name (Printed)
This is to verify that I have received and read the General Surgery Guidelines, Rules and Policy Regulations for Residents.

__________________________________________________________
Resident Signature                                                      Date

__________________________________________________________
Resident Name (Printed)
SPARROW GME RED RULES

Time Out Prior to Invasive Procedure

SPARROW RED RULES MEMORANDUM OF UNDERSTANDING

Include signature page