COLLEGE OF MEDICINE

Department of Surgery

Division of Pediatric Surgery

Pediatric Surgery Residency Program
Policy Manual

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Introduction

The *Pediatric Surgery Residency Policy Manual* is designed to provide information about the Pediatric Surgery Residency at the University of Florida. It provides contact information, policies, guidelines, curriculum, and goals and objectives of the program. Changes and updates will be made periodically to keep it current. The program director will meet with each resident to review the contents of this manual at the beginning of the year.

Mission Statement

The fundamental mission of the Pediatric Surgery Residency at the University of Florida is to offer a two-year educational curriculum that provides the trainee with the knowledge and expertise to care for infants and children with pediatric surgical disorders as outlined by the ACGME. Upon completion of this training program, the trainee is expected to be competent independent practitioners in pediatric surgery capable of providing the highest quality care. The faculty hopes to foster a lifelong commitment to the promotion of children's health care and is firmly committed to helping each trainee recognize their full academic, clinical and personal potential within an intellectually stimulating, supportive, and learner-centered educational environment.

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Pediatric Surgery David W. Kays, M.D., Associate Professor and Chief	392-3718
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Thoracic and Cardiovascular Surgery Curtis G. Tribble, M.D., Professor and Vice Chair	273-5501
Transplantation and Hepatopancreatobiliary Surgery Alan W. Hemming, M.D., M.Sc., Professor and Chief	265-0606
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F. Jay Fricker, M.D., Gerold L. Schiebler Eminent Scholar and Chief

Critical Care 265-0462
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Endocrinology 334-1390
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Gastroenterology 392-6410
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General Pediatrics 392-2877
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PEDIATRIC SURGERY RESIDENCY

OVERVIEW

The Program

The Division of Pediatric Surgery at the University of Florida offers a 2-year residency (fellowship) in pediatric surgery. One new resident is selected each year through the National Resident Matching Program (NRMP). The principle goal of the pediatric surgery residency training program is to provide an educational experience leading to the acquisition of advance knowledge and skills in the care of infants and children with surgical disorders. The division performs approximately 1800 operations annually and the trainees will gain extensive experience in managing a wide spectrum of pediatric surgical problems. Upon completion of the two year education, the pediatric surgery resident should be capable and competent pediatric surgeons. Upon completing the two year training, the graduate is expected to take the American Board of Surgery's qualifying and certifying exam for Pediatric Surgery.

HIGHLIGHTS:

Clinical Programs:

- Level I Trauma Center
- Burn ICU (8 beds)
- Renowned Congenital Diaphragmatic Program
- ECMO Program
- Neonatal ICU (20 level III-IV; 30 level II at SUF and 9 level II at SAGH)
- PICU (14 beds @ SUF and 13 beds @ SAGH)
- Collaborative and productive Department of Pediatrics
- New faculty member to establish a robust and innovative minimal access program
- Multiple pediatric surgical subspecialists (pathology, radiology, anesthesiology, neurosurgery, orthopedic surgery, ophthalmology, otolaryngology)

Research Programs:

- Bench research on neuroblastoma and tumor biology
- New faculty member with a degree in Masters in Public Health

Applicant Qualifications

The applicant will have completed training in general surgery in a program accredited by the Accreditation Council for Graduate Medical Education

(ACGME) or the Royal College of Physicians and Surgeons of Canada. The applicant must be admissible to examination by the American Board of Surgery or be certified by that board.

Applicants will be critically evaluated for a variety of attributes including a professional attitude, dedication to patient care, the ability to make sound ethical and scientific judgments in the care of infants and children, a scholarly mind set and pursuit of life long learning, the ability to work well with others and to become part of a team, and the capacity for hard work with a positive attitude. Trainees are expected to teach and share knowledge with colleagues, students, and other health care providers. A competent surgeon must be able to think critically based on investigation of the literature. He/she must have respect for other cultures, religions, and individual preferences. Upon completion, the trainee will have the skills to be leaders and valued members of the pediatric surgery community with the ability to contribute to societal needs.

Hospitals

The care of pediatric patients is done at Shands at UF (SUF) and Shands at AGH (SAGH). These two integrated institutions are in close proximity. Most of the pediatric inpatient care is at the new children's tower at SAGH whereas most inpatient surgical services remain at SUF. This is the first phase in a move toward the building of a free-standing children's hospital. All faculty members who care for infants and children at SUF and SAGH work at both places and are members of the faculty at the University of Florida College of Medicine. Pediatric surgery trainees will see patients and operate at both SUF and SAGH.

Pediatric services comprise the majority of patients at SAGH and trainees as well as the faculty see patients there primarily as consultants. There are occasional surgical inpatients at SAGH and there is an eventual plan to have a full surgical service there. Currently, most pediatric surgical services are at SUF. Trauma, burn and the neonatal services will remain primarily at SUF due to the infrastructure.

SUF has 14 PICU beds, 20 level III-IV NICU and 30 level II NICU beds, 26 ward beds, and 9 IMC beds. In addition, there is a bone marrow transplant unit and a burn ICU at SUF.

SAGH has 13 PICU beds which may also serve as IMC beds. There are 9 level II NICU beds, and 60 ward beds.

Faculty

The Division of Pediatric Surgery consists of 4 pediatric surgeons all of whom are board certified in general surgery as well as pediatric surgery. The program director appoints the teaching staff and all faculty members are qualified, competent, and committed to support the educational program. The principal

missions of this division are to provide the best possible care for infants and children with surgical disorders and to establish a comprehensive educational experience for the pediatric surgery residents. The faculty is committed to establishing an outstanding education experience for the trainees and their support of the training program cannot be overstated.

In addition to the pediatric surgery faculty, other faculty involved in the training program includes the chief of neonatology and the chief of critical care. They have joint appointments in the department of surgery and are intimately involved in the education of the trainees.

Curriculum

The program length is 2 years with one resident in each year. Residents will spend 3 months on elective rotations in their first year which includes neonatology, critical care, and thoracic and cardiovascular surgery. More time may be requested for electives but no more than 6 months may be spent on elective rotations. The remainder of the time in the first year will be on the clinical pediatric surgery service. The entire second year (Chief Resident year) will be on the clinical pediatric surgery service.

The 2-year curriculum is structured to maximize the learning experience which includes elective rotations, didactic lectures, daily rounds, and multiple educational conferences. Residents will be expected to gain progressive independence and responsibility over the 2-year training program. Residents will develop a program of self-study, engage in scholarly pursuits, teach medical students and junior residents, and gain expertise in clinical analysis and surgical judgment. Faculty will provide guidance and supervision throughout the residency.

Basic and clinical conferences will include topics on the following:

- embryology
- genetics
- wound healing
- hemostasis and hematologic disorders
- immunology and transplantation
- physiology and pathology of the circulatory, respiratory, gastrointestinal, genitourinary, and endocrine systems
- fluid and electrolyte balance
- infection
- metabolic response to injury
- anesthesiology

The trainees will be given progressive responsibility in managing the patients. He/she will demonstrate competence and attain detailed knowledge and

experience in the following clinical conditions:

- congenital, neoplastic, infectious, and other acquired conditions of the gastrointestinal system and other abdominal organs; the blood and vascular system; the integument; the diaphragm and thorax (exclusive of the heart); the endocrine glands; the gonads and reproductive organs; and the head and neck
- traumatic conditions of the abdomen, chest, head and neck, and extremities with sufficient experience in the management of children with multiorgan injuries
- nonoperative management of surgical patients
- endoscopy of the airway and gastrointestinal tract including laryngoscopy, bronchoscopy, esophagoscopy, and gastroduodenoscopy; lower intestinal endoscopy, laparoscopy and cystoscopy; and the study and performance of new and evolving endoscopic techniques
- the complete care of the critically ill infant or child, including: (a) cardiopulmonary resuscitation, (b) the management of patients on respirators, (c) invasive monitoring techniques and interpretation, (d) nutritional assessment and management, and (e) the recognition and management of clotting and coagulation disorders.

Expertise in other pediatric surgical discipline is present at the University of Florida. There is a close working relationship among all specialties and the residents' education is enhanced by the multidisciplinary approach to patient care. Residents will have opportunities to gain knowledge of the basic principles of cardiothoracic surgery through an elective rotation month during the first year of training. Residents will gain extensive experience in the care of infants and children with burns. Ample opportunities to learn basic principles of gynecology, neurosurgery, orthopedic surgery, otolaryngology, anesthesia, vascular surgery, and transplantation will be available as there are pediatric surgical subspecialists in each of these disciplines. A structured curriculum emphasizing these surgical areas will add to the trainee's knowledge base.

The Division of Pediatric Surgery performs approximately 1800 operations per year. Residents are expected to participate in a majority of these procedures to gain appropriate breadth, volume and balance of operative experience. Pediatric surgery residents will attend at least one outpatient clinic per week. He/she will have ample opportunities to evaluate patients, make diagnoses, outline management plans, perform the operations, and follow-up the patients in the clinic. Residents will participate in the long-term evaluation and progress of children with major congenital anomalies, malignancies, and other chronic disorders. Under the supervision of the faculty, residents will be the primary consultants for the emergency department, the neonatal unit, the pediatric intensive care unit, as well as for other services.

Scholarly Pursuits

The faculty is also engaged in basic and clinical research and the resident is given opportunity to participate in these projects. One of the faculty members (EAB) is active engaged in basic research on neuroblastoma. Another faculty member (SI) has a degree in Masters in Public Health and will be involved in clinical trials as well as working with our divisional database. The resident is expected to engage in self-directed learning and independent study in addition to the structured curriculum. Access to clinical databases, library resources and journals will be readily available. Scholarly pursuit is required as demonstrated by submission of a project for national presentation and preparation of a manuscript for publication in peer-reviewed journals.

Learning Objectives

Year 1

During the first year of the program, the resident spends 9 months on the pediatric surgery service and 3 months on mandatory elective rotations (NICU, PICU, TCV). Requests for electives may be made but will be limited to 6 months in the first year. The resident will receive comprehensive clinical education in pediatric surgical problems and acquire a broad based knowledge.

More specifically, the resident will:

- Gain experience and increasing expertise in the care of infants and children with congenital and acquired disorders.
- Have a broad knowledge of the underlying pathophysiology, hereditary conditions, and environmental factors contributing to these disorders.
- Gain expertise in the resuscitation, evaluation and management of the sick or injured child.
- Understand the anatomic and physiologic principles that guide successful operative repair of pediatric diseases and develop technical proficiency in performing surgical procedures on infants and children.
- Learn the principles of perioperative evaluation and preparation of infants and children for surgery.
- Become proficient in the care critically ill infants and children with surgical disorders and diseases.
- Gain an understanding of the relevant embryology of surgical disorders.
- Be proficient in providing nutritional and pharmacological support of ill infants and children.
- Gain expertise in the management of infants and children on extracorporeal membrane oxygenation (ECMO).
- Participate in the education of medical students and residents rotating through the pediatric surgery service.
- Gain progressive responsibility in the clinical care of pediatric surgical patients.

While rotating on the pediatric critical care service, the pediatric surgery resident will:

- Become proficient in the ventilator management of critically ill infants and children.
- Gain expertise in the pharmacologic management of critically ill infants and children.
- Learn the systems issues in the care of critically ill infants and children.
- Gain a better understanding of the team effort in the PICU.

During the neonatology rotation, the pediatric surgery resident will:

- Gain expertise in fluid management of the sick term and preterm infant.
- Gain proficiency in the management of ventilators and ventilation strategies of the ill term and preterm infant.
- Learn concepts of infant nutrition.
- Gain competence in neonatal intubation.
- Be introduced to principles of pharmacokinetics in the preterm and term neonatal patient.
- Understand the systems issues in the care of a sick term and preterm neonate.

During the thoracic and cardiovascular rotation, the pediatric surgery resident will:

- Learn basic principles of cardiothoracic surgery.
- Gain experience in the care of infants and children with congenital cardiac anomalies.
- Learn the relevant embryology of cardiac and pulmonary development.
- Gain operative skills in complex cardiac and thoracic procedures.
- Gain experience in the perioperative management of ill infants and children with cardiac anomalies.

The resident will spend 1 day per week in the outpatient clinic setting staffed by the faculty. The resident will be responsible for evaluating new patients, create a management plan, participate in the surgery if needed, and provide follow-up care. The resident will also participate in the long-term management of complex and chronic problems or congenital anomalies.

First year residents will be expected to complete a clinical project that results in presentation at a national pediatric surgery forum and publication in a peer-reviewed journal. Faculty mentoring will be provided to assist in this academic endeavor.

Upon completion and mastery of the appropriate clinical, educational and administrative skills, he/she can be promoted to year 2 as the Chief Resident.

Year 2

The Chief Resident is the clinical and administrative team leader of the pediatric surgery service. The Chief Resident coordinates all educational programs of the division in collaboration with the program director. He/she performs more independently in the preoperative preparation, intraoperative care, and

postoperative management of infants and children with pediatric surgical disorders.

More specifically, the Chief Resident will:

- Maintain complete responsibility for managing the pediatric surgery service.
- Coordinate conferences and the educational programs.
- Be responsible for teaching residents and medical students on the pediatric surgery service.
- Perform at least 800 operative procedures upon completion of the 2 year training.
- Begin performing procedures in a semi-independent fashion with faculty supervision.
- Gain progressive responsibility in the care of the infants and children so that upon completion of year 2, he/she is read and competent to practice as a pediatric surgeon.

The Chief Resident will spend one day a week in the clinic seeing patients with the faculty. He/she will help organize the operative schedule and progress towards making independent decisions in the management and follow-up care of the patients.

RESIDENT ROTATION SCHEDULE

	July-August	September	October	November-February	March	April-June
YEAR 1	**Pediatric Surgery at SUF and SAGH**	**Pediatric Critical Care**	**Neonatology**	**Pediatric Surgery at SUF and SAGH**	**Thoracic and Cardiovascular Surgery**	**Pediatric Surgery at SUF and SAGH**
YEAR 2	Pediatric Surgery at SUF and SAGH					

MONTHLY CONFERENCE SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
Core Clinical and Basic Science Conference 7-8A, M603		Surgery M&M 7-7:45A Surgery Grand Rounds 7:45-8:30A	**Fellow's Conference** 7-8A, N6-01 **Path Conference** 5-6P, N6-01	**Patient Care Conference and M&M** 7-8A, M603 Pediatrics Grand Rounds, 8-9A
Core Clinical and Basic Science Conference 7-8A, M603	Trauma M&M and Multispecialty Conference 7-8:30A	Surgery M&M 7-7:45A Surgery Grand Rounds 7:45-8:30A	**Tumor Board** 4:30-6P	**Patient Care and Preop Conference** 7-8A, Woodward Pediatrics Grand Rounds, 8-9A
Core Clinical and Basic Science Conference 7-8A, M603	Burn M&M 7-8A	Surgery M&M 7-7:45A Surgery Grand Rounds 7:45-8:30A	**Fellow's Conference** 7-8A, N6-01	**Patient Care Conference and M&M** 7-8A, Woodward Pediatrics Grand Rounds, 8-9A
Core Clinical and Basic Science Conference 7-8A, M603		Surgery M&M 7-7:45A Surgery Grand Rounds 7:45-8:30A	**Tumor Board** 4:30-6P	**Patient Care and Radiology Conference** 7-8A, M603 Pediatrics Grand Rounds, 8-9A

CONFERENCE ORGANIZATION

Conference	Frequency (weekly, monthly, etc.)	Person(s) Responsible for Conducting Conference
Pediatric Surgery Clinical and Basic Science Conference	Weekly	Pediatric Surgery Chief Resident
Fellows' Conference	Biweekly	Mike Chen, M.D. Program Director
Tumor Board	Biweekly	William B. Slayton, M.D. Assistant Professor of Pediatrics Elizabeth Beierle, M.D. Associate Professor of Surgery
Surgery Morbidity and Mortality Conference	Weekly	Kevin E. Behrns, M.D. Professor of Surgery
Surgery Grand Rounds	Weekly	Kevin E. Behrns, M.D. Professor of Surgery Chair, Department of Surgery
Pediatrics Grand Rounds	Weekly	Richard Bucciarelli, M.D. Chairman, Department of Pediatrics
Trauma Multispecialty Conference	Monthly	Elizabeth Beierle, M.D. Director of Pediatric Trauma
Burn Morbidity and Mortality Conference	Monthly	David Mozingo, M.D. Professor of Surgery Director of Burn Unit Elizabeth Beierle, M.D. Associate Professor of Surgery Associate Director of the Burn Unit
Trauma Morbidity and Mortality Conference	Monthly	Lawrence Lottenberg, M.D. Clinical Associate Professor of Surgery Chief of Trauma Service Elizabeth Beierle, M.D. Associate Professor of Surgery Director of Pediatric Trauma
Pediatric Surgery Morbidity and Mortality Conference	Biweekly	Pediatric Surgery Chief Resident
Pediatric Radiology/Pathology Conference	Biweekly	Mike Chen, M.D. Associate Professor of Surgery

Other Educational Programs

There are several formal courses and educational conferences/experiences which are available to the trainees throughout the year.

- Annual James L. Talbert Visiting Professor
    - A visiting professor in pediatric surgery is invited to the University of Florida to present Grand Rounds and lectures.
- Annual Woodward Visiting Professor
    - Two distinguished surgeons per year are invited to give Grand Rounds and provide formal teaching rounds. Afternoon sessions are dedicated to resident education.
- Annual Dragstedt Visiting Professor
    - One visiting surgeon is invited to give Grand Rounds and providing educational conference with the residents. In honor of Dr. Dragstedt's focus on basic research, this distinguished surgeon tends to be selected more for his/her basic science accomplishments.
- Annual Donald Eitzman Visiting Professor
    - A visiting professor in the field of neonatology is invited to the University of Florida to present lectures.
- ECMO Course
    - Offered the Division of Pediatric Surgery and Respiratory Therapy. All trainees are expected to take this course.
- Neonatal Resuscitation Program Course
    - Available to the trainee each year.
- Fundamental of Clinical Research Course
    - Two week course provided by the General Clinical Research Center available to the trainee each fall.
- Pediatric Science Day
    - A departmental program occurring each April where the pediatric fellows and residents present their research to a visiting professor.
- Prenatal Diagnosis Conference
    - Meets for one hour every Thursday morning to discuss prenatal diagnosis, fetal ultrasonography, genetics, amniocentesis and patient care.
- Neonatology Seminar Series
    - Meets Thursday for one hour to discuss chapters from pertinent textbooks, review current journals and receive didactic lectures by interdisciplinary faculty.
- PICU Clinical Conference
    - Meets every Wednesday at noon for didactic discussion of critical care topics.
- OB/GYN – Neonatology Conference
    - Meets for one hour every Wednesday morning to discuss OB/GYN patient care, fetal monitoring and neonatal outcome.
- Pediatric Gastroenterology Journal Club
    - Meets quarterly to discuss multidisciplinary issues with the division of Pediatric Surgery.

PEDIATRIC SURGERY CURRICULUM

Head and Neck

Demonstrate knowledge of, and the capacity to manage patients in relation to the different patterns of disease, natural history and responses to treatment of head and neck disease in children. This will include:

- congenital lesions: thyroglossal duct cyst, branchial cleft cysts/sinuses and other remnants, cystic hygromas, lymphangiomas, hemangiomas, duplication cysts, torticollis
- salivary glands : tumors, hemangiomas, inflammation, calculi, ranula
- neck masses: inflammatory lesions (acute and chronic); tumors (lymphoma, rhabdomyosarcoma, neuroblastoma, teratoma)
- trauma: cranial and cervical injury, diagnosis and emergency management, indications for ICP monitoring, burn care; injuries to the esophagus, trachea and blood vessels; airway management, tracheostomy, recognition and emergency management of cervical spine fractures

Non-Cardiac Thoracic Surgery

Demonstrate knowledge of, and the capacity to manage patients in relation to the different patterns of disease, natural history, and responses to treatment of non-cardiac chest conditions in children. This will include:

- congenital esophageal lesions: esophageal atresia and tracheoesophageal fistula, webs, stenosis (congenital and acquired), duplications
- acquired esophageal conditions: gastroesophageal reflux, Barrett's esophagus, hiatal hernia, strictures, perforations, foreign bodies, lye ingestion, achalasia
- congenital lung lesions: cystic adenomatoid malformation, pulmonary sequestration, lobar emphysema, blebs and spontaneous pneumothorax, hypoplastic lungs and pulmonary hypertension
- acquired lung lesions: emphysema, abscess, pneumatocele, empyema, chylothorax, pulmonary metastases, infiltrates in immunosuppressed patients, lung complications in cystic fibrosis, airway and lung injuries.
- congenital airway lesions: stenosis, broncho- and tracheomalacia
- acquired airway lesions: bronchial adenoma (carcinoids, etc.), foreign body aspiration
- mediastinal lesions: cysts, tumors according to location (anterior, middle, posterior)
- chest wall conditions: pectus excavatum and carinatum, tumors
- diaphragmatic conditions: congenital diaphragmatic hernia (Bochdalek, Morgagni), eventration, phrenic nerve palsy, trauma

Abdomen

Demonstrate knowledge of, and the capacity to manage patients in relation to the different patterns of disease, natural history, and responses to treatment of abdominal disease in children. This will include:

- physiologic issues: secretion, absorption, motility, blood supply; continence, defecation; short bowel syndrome, intestinal adaptation; physiologic testing (manometry, pH study)
- gastric conditions: pyloric stenosis, antral web, perforation, antral dysmotility, stress ulcer, gastritis, acid/peptic disease
- duodenal conditions: atresia, stenosis, webs, diverticula, duplications, peptic ulcer, perforation
- small intestinal conditions: malrotation, jejunoileal atresia/stenosis, meconium ileus and equivalent, Meckel's diverticulum and related vitelline duct anomalies, necrotizing enterocolitis, intussusception, duplications, mesenteric cysts, neoplasms, Crohn's disease, congenital bands, mesenteric defects, bowel obstruction
- colonic conditions: appendicitis, inflammatory bowel disease, typhlitis, meconium plug

syndrome, intestinal pseudo-obstruction, Hirschsprung's disease, neuronal intestinal dysplasia, colonic atresia, polyps
- anorectal conditions: imperforate anus, fissures, abscesses, fistulae, condylomata, rectal prolapse
- hepatic conditions: cysts, portal hypertension, abscess, transplantation
- biliary conditions: biliary atresia, biliary hypoplasia, bile duct perforation, choledochal cyst, gallstones, acute/chronic cholecystitis, physiologic jaundice, cholestatic syndromes
- splenic conditions: hereditary spherocytosis, thalassemia, sickle cell disease, other hemolytic anemias, idiopathic thrombocytopenic purpura (ITP), cyst, lymphangioma, abscess
- pancreatic conditions: cystic fibrosis, pancreas divisum, annular pancreas, pancreatitis (trauma, lipid, steroid, drug induced, gallstone induced, ductal anomaly), cysts, pseudocysts, tumors, hyperinsulinism, trauma
- abdominal wall conditions: gastroschisis, omphalocele and variants, hernias (umbilical, inguinal, epigastric, femoral, etc.), vitelline duct remnants, umbilical granuloma
- abdominal trauma: intestinal trauma, lap belt injury, pancreatic injury, hepatic trauma, splenic trauma

Genitourinary Tract Conditions

Demonstrate knowledge of, and the capacity to manage patients in relation to the different patterns of disease, natural history, and responses to treatment of genitourinary conditions in children. This will include:
- penis: phimosis, paraphimosis, balanitis, circumcision
- inguinoscrotal area: cryptorchidism, varicocele, hydrocele, acute scrotum (torsion, etc.)
- bladder: exstrophy (bladder, cloacal); urachal anomalies
- tumors: (see oncology section)
- trauma: kidney, ureter, bladder with adequate knowledge of pelvic fractures and urethral injuries

Gynecologic Conditions

Demonstrate knowledge of, and the capacity to manage patients in relation to the different patterns of disease, natural history, and responses to treatment of gynecologic conditions in children. This will include:
- congenital conditions: vaginal atresia, hemato/hydro(metro)colpos, bifid vagina, duplex uterus, urogenital sinus
- inflammatory conditions: pelvic inflammatory disease, vulvovaginitis, vulvar abscess, fusion labia minora
- traumatic/mechanical conditions: vaginal laceration, child abuse; torsion (normal ovary, cyst, tumor)
- neoplastic conditions: cysts (follicular, teratomatous, carcinomatous, serous, mucinous), solid tumors (yolk sac, teratoma, carcinoma, theca/lutein, arrhenoblastoma, dysgerminoma); vaginal and uterine tumors (yolk sac, rhabdomyosarcoma); vulvar lesions (cysts, nevi, hemangioma)

Intersex Anomalies

Pediatric surgeons will, in collaboration with other health professionals, care for children with intersex anomalies. They must therefore demonstrate knowledge of, and the capacity to manage patients with these conditions based on different patterns of disease, natural history, responses to treatment and ethical implications of gender assignment. This will include:
- adrenogenital syndrome, mixed gonadal dysgenesis, true- and pseudo- hermaphroditism, testicular feminization syndrome and its variants, and gonadal tumors that may develop in these patients.

Endocrine Anomalies

Pediatric surgeons will, in collaboration with other health professionals, care for children with endocrine anomalies. They must therefore demonstrate knowledge of, and the capacity to manage patients with these conditions based on different patterns of disease, natural history, and responses to treatment. This will include:

- thyroid conditions: hyperthyroidism (including medical therapy, management of thyroid storm, preparation for surgery), thyroiditis, tumors, multiple endocrine neoplasia, management of thyroid mass following neck irradiation
- parathyroid conditions: hypoparathyroidism; hyperparathyroidism
- breast conditions: neonatal hypertrophy, mastitis, gynecomastia, nipple discharge, fibroadenoma, fibrocystic disease, cystosarcoma phyllodes, premature thelarche
- gastrointestinal problems: gut hormones, hyperinsulinism, hormone-producing tumors
- adrenal conditions: adrenocortical tumors, virilizing tumors, pheochromocytoma
- testicular conditions: cryptorchidism; tumors

Oncology

Pediatric surgeons will, in collaboration with other health professionals, care for children with cancer. They must therefore demonstrate knowledge of, and the capacity to manage patients with these conditions based on the different patterns of disease, natural history, and responses to treatment. This will include:

- general principles: oncogenes, DNA-flow cytometry, paraneoplastic and tumor-associated syndromes, hyperthermia, immunotherapy, radiation biology, immunosuppression and opportunistic infections, cancer nutrition, chemotherapy and drug action, surgical complications of chemotherapy and bone marrow transplantation
- renal tumors: Wilms' tumor, mesoblastic nephroma, nephroblastomatosis, adenocarcinoma and rhabdoid tumor
- adrenal tumors: neuroblastoma, ganglioneuroblastoma, carcinoma
- liver tumors: benign (hemangioma, hemangiomatosis, hemangioendothelioma, hamartoma, adenoma, focal nodular hyperplasia [FNH]), malignant (hepatoblastoma, hepatocellular carcinoma)
- soft tissue sarcomas: rhabdomyosarcoma, fibrosarcoma, leiomyosarcoma, liposarcoma, neurofibromas
- teratomas: sacrococcygeal and gonadal tumors, familial teratomas, associated syndromes
- lymphoma: Hodgkin's Disease, Non-Hodgkin's Disease, post-transplant lymphoproliferative disease and AIDS
- bone tumors: osteogenic sarcoma and Ewing's sarcoma, PNET, etc. as they relate to pediatric surgical intervention (rib resection, lung metastases, etc.)
- gonadal tumors:
    - testicular: benign and malignant, including teratoma, other germ cell and non-germ cell tumors, paratesticular rhabdomyosarcoma, metastatic i.e. leukemia
    - ovarian: see gynecology section

Critical Care and Trauma

Pediatric surgeons will, in collaboration with other health professionals, care for critically ill and injured children. They must therefore demonstrate knowledge of, and the capacity to manage patients with these conditions based on the different patterns of disease, natural history, and responses to treatment. This will include:

- fluids and electrolytes: maintenance requirements, management of dehydration, third-space loss; renal output, acid-base equilibrium, correction of perioperative electrolyte disturbances
- shock: hypovolemic, cardiogenic, septic, neurogenic

- pulmonary physiology: normal lung function and volumes, ventilation/perfusion abnormalities, ventilators, respiratory distress syndrome
- nutrition: caloric requirements, nutritional assessment, enteral vs. parenteral nutrition, nutritional access, influence of disease on nutritional requirements, age dependent needs
- coagulation: normal coagulation cascade, hemophilia, von Willebrand's disease, diffuse intravascular and consumptive coagulopathy, fibrinolysis, sick platelet syndrome, idiopathic thrombocytopenia purpura, thrombosis, effects of heparin, anti-platelet agents, thrombolytics
- anesthesia: inhalation agents, muscle relaxants, malignant hyperthermia, differential diagnosis and treatment of cardiac arrest during surgery, management of postoperative pain in infants and children
- extra-corporeal membrane oxygenation (ECMO): indications, techniques of cannulation, monitoring, management, complications
- trauma: demographics, epidemiology; recognizable patterns of injury (i.e., seat belt syndrome, patterns of child abuse); initial priorities; principles of operative and non-operative management of head, neck, chest, abdomen, pelvis, genitourinary and extremity trauma
- burns: pathophysiology of severe burn injury, fluid resuscitation (initial and maintenance), nutritional management, burn wound debridement and grafting, rehabilitation

Neonatology

Pediatric surgeons will, in collaboration with other health professionals, care for premature and ill newborns. They must therefore demonstrate knowledge of and the capacity to manage patients with these conditions based on the different patterns of disease, natural history, and responses to treatment. This will include:

- physiology of the premature and the small for gestational age infants (fluid requirements, thermal regulation, renal function, hepatic immaturity, nutritional requirements, etc.); and problems associated with prematurity
- hyperbilirubinemia, exchange transfusion, hypoglycemia, hypocalcemia, intracranial hemorrhage
- newborn respiratory distress syndrome
- neonatal sepsis, immune status, diagnostic workup, bacteriology, treatment, pharmacokinetics

Skin and Subcutaneous Tissues

Demonstrate knowledge of and the capacity to manage patients in relation to the different patterns of disease, natural history, and responses to treatment of cutaneous and subcutaneous conditions in children. This will include:

- nevi, nevus sebaceous, pilomatrixoma, juvenile melanoma; hemangioma, lymphangioma, lipoma; dermoid and epidermoid cyst
- ingrown toenails and paronychia
- pilonidal sinus and abscess.

Transplantation

Demonstrate knowledge of the indications for pediatric liver, kidney, small bowel transplants, and of immunosuppressive agents (effects and complications). Understand potential problems of transplants including infections and secondary tumors.

Fetal Medicine

Pediatric surgeons are an integral part of the prenatal evaluation of parents and infants with a known surgical disease. Pediatric surgeons participate in a number of ways in this prenatal management.

- Prenatal counseling for: abdominal wall defects, congenital diaphragmatic hernia, cystic adenomatoid malformation, pulmonary sequestrations, congenital tumors (teratomas), ovarian and abdominal masses and cysts, esophageal atresia, and others
- Participate in conditions that require immediate intervention at birth: lesions that compromise the airway and breathing, abdominal wall defects, congenital diaphragmatic hernia, teratomas
- Although most fetal surgery is not the standard of care, the trainee must gain an understanding of the current state of fetal intervention, the rationale, options, and outcomes. Conditions include congenital diaphragmatic hernia, myelomeningocele, congenital hydrocephalus, hypoplastic left (and right) heart syndrome and aortic (pulmonary) stenosis, urinary tract obstruction and abdominal wall defects.

PRIMARY SKILLS OBJECTIVES

By the end of training, the resident should have acquired and demonstrated the following skills as they apply to a pediatric surgical practice.

Surgical Skills

The resident is expected to be able to perform independently the full spectrum of operative interventions related to the primary pediatric surgery conditions listed above.

Trauma

- Function as a trauma team leader
- Function as the operating surgeon for pediatric multiple trauma patients, and if required, as supervising surgeon when several specialty groups may be working simultaneously
- Provide for the non-operative care of the trauma and burn patients
- Be proficient in airway and vascular access management

Endoscopy

Be familiar with the indications, techniques and complications of:

- laryngoscopy, bronchoscopy, esophagoscopy
    - diagnostic and therapeutic
- cystoscopy (as it pertains to management of ambiguous genitalia and imperforate anus)
- proctosigmoidoscopy
- Minimal Invasive Surgery (MIS)
    - MIS has become an integral part of pediatric surgical practices, and is an increasingly important part of training programs. Training in common, intermediate and advanced procedures via laparoscopy and thoracoscopy is provided. Trainees will have MIS experience from general surgery training. A simulation center at the University of Florida may be utilized to bolster the basic skills of suturing, anastomoses, intracorporeal knot tying and tissue handling. At the time of graduation, trainees will be proficient in basic and advanced pediatric MIS. A Da Vinci surgical robot is available at the University of Florida and will be utilized in the training program. Formal training in the robotic courses will be provided during the first year and the graduating fellow will have the basic skill set necessary for robotic assisted MIS.
    - Examples of procedures performed at our institution in pediatric MIS:

- Anti reflux procedures, pyloromyotomy, gastric pacing, bariatric procedures, resection of intestine, cholecystectomy, exploration for biliary atresia, choledochal cyst resection and reconstruction, splenectomy, appendectomy, pull-thru procedures, imperforate anus repair, decortication, lung resections, esophageal reconstruction, chest wall reconstruction, removal of thoracic or abdominal tumors.

Other Procedures

Gain expertise in the indications, techniques and complications of:

- central line insertion or other vascular cannulation
- ECMO cannulation
- tracheostomy, gastrotomies and other enterostomies
- pleural and peritoneal based shunts
- intestinal and airway dilatation techniques

Conference/Lecture Topics

Pediatric surgery residents are expected to attend all core conferences. If attendance is less than 90%, the resident must meet with the program director to discuss the obstacles to attendance. The only excusable absence is medical emergencies where the trainee's assistance is needed by the faculty and no other faculty is available to assist.

Fluids and electrolytes
Neonatal metabolism and physiologic differences (2 sessions)
Nutritional assessment and feeding access
Wound healing
Transfusion and coagulation cascade
Anesthesia management
    Inhalation agents, local anesthetics, pain management
Airway management
    Bronchoscopy, foreign bodies, emergency airways and trachs
Trauma resuscitation and management of multi-system injuries
Head and spine trauma and management
Abdominal trauma (2 sessions)
    Bowel and bladder injuries, splenic, hepatic, and renal lacerations
Burn resuscitation and management
Child abuse
Antibiotics and vaccinations
Immune deficiency syndromes
Cardiac physiology
Pharmacology of hemodynamic support
Pulmonary physiology
Ventilator management strategies
Pulmonary hypertension and ECMO
Congenital diaphragmatic hernia
Esophageal atresia/TEF-embryology of the foregut development
Malrotation and small bowel atresias-embryology of the midgut development
Meconium diseases and cystic fibrosis
Imperforate anus
Hirschsprung's disease and neuronal intestinal dysplasia
Necrotizing enterocolitis
Congenital and inflammatory neck lesions
    Branchial clefts/sinuses, TGD, torticollis, lymphoma, adenitis
Sickle cell disease and other hematologic disorders
    Spherocytosis, ITP, HSP, thalassemia
Acute scrotum
    Hernias, hydroceles, undescended testes, testicular torsion
Breast lesions
Melanoma and other skin lesions
Caustic ingestions
GI and airway foreign bodies
Abdominal wall defects-embryology and management
Portal hypertension and liver failure
Lymphangiomas, hemangiomas, cystic hygromas
Neonatal jaundice
    Biliary atresia, hepatitis, cholestasis, choledochal cysts
Gastroesophageal reflux
Stomach disorders
    Peptic ulcer disease, perforation, volvulus, gastritis
Cholelithiasis and pancreatitis
Gut hormones

Nesidioblastosis
GI motility
Continence and constipation
Short bowel syndrome
Other diaphragmatic problems
Eventration, phrenic nerve palsy, traumatic injury
Inflammatory bowel diseases
Morbid obesity and bariatric surgery
Acquired abdominal problems
Appendicitis, intussusception, HPS
Congenital abdominal problems
Vitelline duct remnant, mesenteric cysts, duplication cysts
GI hemorrhage
Meckel's, polyps, vascular anomalies
Chest wall deformities
Tracheal and bronchial anomalies
Congenital pulmonary lesions
CCAM, sequestrations, lobar emphysema,
Acquired lung lesions
Pneumatocele, empyema, spontaneous pneumothorax, traumatic injuries
Mediastinal tumors
Lymphoma, teratoma, duplication cysts, bronchogenic cysts, neurogenic tumors
Transplantation
Indications, timing strategy and outcomes
Transplant immunology and infections
Genitourinary anomalies-upper tract
Genitourinary anomalies-lower tract
Prune belly syndrome
Oncogenes and other oncologic principles
Flow cytometry, chemotherapy
Radiation biology
Complications of chemotherapy and bone marrow transplantation
Neuroblastoma
Wilms and other renal tumors
Liver tumors
Other abdominal tumors
Pancreatic, Burkitt's, lymphoma, PTLD
Benign ovarian pathology
PID, cysts, torsion, tubo-ovarian abscess
Ovarian tumors
Testicular tumors
Sacrococcygeal teratoma
Rhabdomyosarcoma and other musculoskeletal tumors
Endocrine regulation of sexual development
Ambiguous genitalia
Cloacal anomalies
Thyroid and parathyroid disorders
MEN syndromes
Adrenal tumors
Fetal medicine and interventions
Vascular rings-embryology, presentation, and management
Cardiac anomalies
TOF, VSD, ASD, PDA
Bone injuries
Endoscopic surgery-principles and issues (2 sessions)

Evaluations and Competency Based Objectives

The purpose of performing evaluations is to create an effective mechanism for assessing performance and to use the results to improve performance. The faculty and program director provide formative evaluation to the trainees every three months. Assessment will be based on six competencies: professionalism, patient care, medical knowledge, practice based learning, interpersonal and communication skills, and system based practice. More frequent evaluations may be done if there are deficiencies that require closer monitoring. Semiannual formal written evaluation will be done by the faculty and the program director every six months. These evaluations (see form) will be focused on the progressive development of the residents. The formal evaluations will be discussed with the resident.

A final evaluation will be provided to the resident upon completion of the program. It will focus on the resident's ability to practice competently and independently. All evaluations will be appropriately maintained and accessible to the residents and kept as permanent record.

When appropriate the various components of the competencies may be assessed by the pediatric surgery faculty, faculty from other services, peers, junior residents, medical students, nurse practitioners, nurses, and patients.

Specific requirements as they pertain to each of the six competencies are listed below:

Professionalism

- Deliver the highest quality care with integrity, honesty and compassion.
- Exhibit appropriate personal and interpersonal professional behaviors.
- Practice medicine ethically consistent with one's obligations as a physician with responsiveness to the needs of patients that supersedes self-interest.
- Demonstrate sensitivity and responsiveness to disabilities, age, gender, culture and ethnicity.
- Commitment to ethical principles pertaining to ongoing or cessation of therapy, confidentiality, informed consent, participation in research, the need to intervene on the child's behalf, and business practices and social behavior.

This competency will be assessed by the faculty and through 360 degree assessment (self, residents, nurses, patients/families, and staff)

Patient Care

- Provide care that is compassionate, appropriate, and effective for the treatment of surgical problems of infants and children.
- Obtain and synthesize relevant history from patients, their families and the community.
- Establish rapport with patients and their family and discuss appropriate information with the health care team.
- Demonstrate an appreciation of the physiologic and anatomic differences in preterm and term infants and children.
- Able to perform operative procedures competently.
- Take into consideration the legal issues regarding consent, confidentiality and refusal of treatment.
- Learn to factor in the economic factors in the care of the patient and their family.

This competency will be assessed by the faculty and through 360 degree assessment (self, residents, nurses, and patients/families)

Medical Knowledge

- Develop, implement and monitor a personal continuing education strategy.
- Critically appraise sources of medical information to formulate evidence based practices.
- Facilitate learning of patients, house staff/students and other health care professionals through formal and informal teaching opportunities.
- Develop the beginning of a life long self-study program focused on knowledge acquisition and enhancing technical skills.
- Contribute to knowledge base and foster the academic growth of the specialty of Pediatric Surgery by participating in scholarly work.
- Take the American Board of Surgery In-Service Exam for Pediatric Surgery each year to quantitatively assess knowledge base as compared to peers.

This competency will be assessed by the faculty and through ABS in-service exam.

Practice-Based Learning and Improvement

- Analyzes practice experience, perform systematic evaluation, and assimilate scientific evidence to improve care.
- Work effectively and efficiently in a health care organization.
- Utilize health care technology to optimize patient care, life-long learning and other activities.
- Understand the principles and practice of quality assurance and improvement, and actively participate in hospital-based quality assurance and improvement programs.
- Recognize the importance of maintenance of competence and evaluation of outcomes.

This competency will be assessed by the faculty and through 360 degree assessment (self and residents)

Interpersonal and Communication Skills

- Communicate effectively with the faculty, other physicians, nurses, other health professionals and health-related agencies.
- Contribute to other interdisciplinary team activities.
- Able to act in a consultative role with other physicians and health professionals
- Effectively use the team approach in the management of critically and chronically ill patients with complex problems.
- Engenders confidence in one's ability.

This competency will be assessed by the faculty and through 360 degree assessment (self, residents, nurses, patients/families, and staff)

Systems-Based Practice

- Identify the larger context and system of health care with the ability to effectively call on system resources to provide optimal care.
- Gain an understanding of how their practice affects other health care professionals, organizations, and the society.
- Contribute effectively to improve health of patients and communities.
- Know how different medical practice and delivery systems affect the ability to provide care.
- Able to respond to issues where advocacy is appropriate.
- Allocate finite health care resources wisely.

This competency will be assessed by the faculty and through 360 degree assessment (self,

residents, nurses, and staff)

The evaluation form is noted in the next section. Formative, semiannual, and final evaluations will be done using the same form. At the quarterly formative evaluation, the trainees will be given feedback on their progress towards the stated objectives. Satisfactory evaluations constitute a score of 2 or higher as long as continued progress is made.

If significant deficiencies are identified, the following will occur:

- Program director will meet with the faculty and create a remediation program.
- Program director will meet with the resident every two weeks to assess progress.
- Remediation program may include operative training, a reading program, and/or professional counseling.
- Trainee may request time from clinical service to correct the deficiencies.
- If no significant progress is made after 2 months, the resident will be put on probation and given 2 more months to show progress.
- If the resident demonstrates significant improvement, he/she will be placed back in the program on regular status.
- If no improvements are noted after 4 months of remediation and depending on the deficiency, the resident may be notified that he/she will not be advanced to the next year or will not be allowed to complete the program

First year trainee may advance to the second year upon completion of the first twelve months of training in addition to making appropriate progress in the care of pediatric surgery patients. The evaluation forms will be used to assess progress (see the form for details). At the end of the second six months, the resident will not have any section in Level I and II that shows a score of 1 (inadequate progress towards attainment of goals). The Chief Resident will be assessed using the same form. At the end of the fourth 6 months, the Chief Resident shall have no score of 1 in any of the sections.

Policies and procedures for discipline, grievances, nonrenewal, suspension or dismissal of a resident are outlined in the contract offered by the College of Medicine. An example of the contract and the exact language are available at the end of this manual. See Table of Contents for specific page of the contract.

UNIVERSITY OF FLORIDA
PEDIATRIC SURGERY RESIDENT
EVALUATION FORM

Resident: ______________________ **Evaluator: ______________________**

Training Period: ______________________

Specific or general training goals are indicated for each 6 month interval of training. Successive progression is expected over the course of the 2 year curriculum. Upon completion of the training program, residents are expected to be proficient in all levels.

Scores: (4) Superior (resident exceeded expected or specific achievement norms)
(3) Successful accomplishment of goals
(2) Improving towards achievement of goals
(1) Inadequate progress towards attainment of goals

Professionalism – Assessed via faculty interactions, comments/evaluation by nursing staff, residents, families		1st 6 MO	2nd 6 MO	3rd 6 MO	4th 6 MO
Level I	Demeanor and behavior are courteous and appropriate as a physician. Dress is professional and appropriate for the occasion. Behavior engenders confidence. Responsive to administrative duties including medical record keeping and dictations. Interested in how practices are run. Considerate of other's time, constraints, and cultures.				
Level II	Assumes greater role in helping to organize the clinical service and educational conferences. Aware of obligations to in-service exam and general surgery board exams. Develops sensitivity to age, gender, culture and ethnicity in dealing with patients and their families.				
Level III	Actively involved in teaching conferences. Involved in projects for publication and beginning to plan for career after training. Has insight to improve deficient areas and to place emphasis on skills commensurate with practice goals. Maintains exemplary procedure log. Understands the ethical issues regarding the care of complex congenital abnormalities as applied to ongoing or cessation of therapy, participation in research, and the need to intervene on the child's behalf.				
Level IV	Mature professional with understanding of clinical and academic practice. A role model for others. Demonstrate respect for everyone including families, peers, faculty, residents, students, and other ancillary workers. Practice medicine ethically consistent with one's obligations as a physician.				

Comments:

Patient care – Faculty assess thoroughness of patient care in terms of preoperative preparation and postoperative management. Ability to assess and manage complications.		1st 6 MO	2nd 6 MO	3rd 6 MO	4th 6 MO
Level I	Can manage the perioperative care of common pediatric surgical diseases (pyloric, appy, intussusception). Can order and assess preoperative diagnostic studies and optimize patients for the OR. Understands nutritional needs of infants and children. Ability to make good decisions regarding the need for operative or observational care. Can assess and manage simple outpatient problems. Has good operative skills in the performance of common procedures (appendectomy, pyloric stenosis, child hernia, CVL < 5 years, etc.)				
Level II	Able to manage the critically ill injured or burned child. Can seek appropriate consultations in complex patients. Developing progressive independence in the management of infants with surgical problems. Uses all available data to make informed decisions. Thoroughly prepares for potential pitfalls in patient care. Developing comfort in the management of complex and chronic outpatient problems. Able to perform more complex procedures comfortably (rigid and flexible endoscopy, laparoscopic fundoplication/splenectomy, thoracoscopy for empyema or biopsy, infant hernia repair, ECMO cannulation).				
Level III	Can prepare infants preoperatively who have complex associated congenital and acquired conditions. Can manage ECMO patients. Involved in more complex preterm and term infant nutrition (i.e. SBS). Independently sees patients in outpatient setting. Demonstrate competence in complex procedures (PSARP, pull-through procedures, nephrectomy for tumor, congenital intestinal atresia, or Kasai operation, premature hernia repair, diaphragmatic hernia).				
Level IV	Has achieved comprehensive view of patient care that assures quality and timely care, focused on optimal patient results and parent satisfaction with all aspects of care. Has exhibited a high level of coordination during inpatient as well as outpatient care. Can function nearly independently with minimal faculty guidance in all aspects of pediatric surgical care. Competent in performance of the most complicated pediatric surgical procedures (complex adrenal, renal, and hepatic tumors, esophageal atresia, infant lung resection, chest wall reconstruction, cystic hygroma).				

Comments:

Medical knowledge – Assessment performed during patient specific discussions, topic presentations at conferences, operative dictations. Feedback is from faculty.		1st 6 MO	2nd 6 MO	3rd 6 MO	4th 6 MO
Level I	Knowledge and understanding of common childhood conditions (pyloric stenosis, GERD, malrotation, appendicitis, intussusception, hernias). Able to generate appropriate differential diagnosis, workup, and management plan. Command of acute trauma management.				
Level II	Expanded knowledge of congenital disorders and tumors of childhood. Able to generate plan for evaluation of congenital GI obstruction.				
Level III	Knowledgeable in broad spectrum of complex disorders (i.e., VACTERL, metastatic CA, pulmonary hypertension, ECMO, etc.). Capable of developing comprehensive evaluation and management plan.				
Level IV	Completely capable of discussing the diagnosis and implications of various childhood disorders and dealing with nuances in presentation. Exhibits competent decision making ability.				

Comments:

Practice based learning – Assessed via faculty interactions and comments/evaluation by nursing staff.		1st 6 MO	2nd 6 MO	3rd 6 MO	4th 6 MO
Level I	Open and receptive to feedback on clinical management. Can incorporate recommendations into practice. Seeks protocols for reinforcement. Develop and implement a personal continuing education strategy. Utilize health care technology to optimize patient care.				
Level II	Demonstrate ability to learn from clinical experiences. Frequency of errors in judgment, management and technique decreases. Is intellectually curious and researches the literature for management strategies. Has initiated a clinical project. Engaged in quality assurance and improvement.				
Level III	Incorporates clinical experience into a framework to generate hypothesis and investigative questions. Has evidence based approach in clinical discussions. Able to educate others. Able to allocate finite health care resources.				
Level IV	Mature, responsible and self motivated attitude towards ongoing learning. Understands the need for continual assessment of the practice. Comprehends the value of transfer of knowledge to others to enhance patient care. Recognize the importance of maintenance of competence and evaluation of outcomes.				

Comments:

Communication and interpersonal skills – Assessed via faculty interactions, comments/ evaluation by nursing staff, residents, and families.		1st 6 MO	2nd 6 MO	3rd 6 MO	4th 6 MO
Level I	Interpersonal relationships with faculty in all departments are professional at all times. Easily approachable and available. Parents, nursing staff, and residents express satisfaction with interactions.				
Level II	Has established rapport with all departments and is able to negotiate matters independently based on personal reputation. Develops personal style in conferences settings. Positive response to criticism/feedback.				
Level III	Maturing style when dealing with difficult clinical situations. Able to communicate concisely with an expressed plan for management. Actively seeks feedback to improve performance.				
Level IV	Mature ability to communicate with colleagues, patients, and their families on the appropriate level that generates trust and confidence in abilities.				

Comments:

System based practice – Assessed via faculty interactions, comments/evaluation by nursing staff, residents		1st 6 MO	2nd 6 MO	3rd 6 MO	4th 6 MO
Level I	Become familiar with systems available at the institution. Adaptable to new systems, i.e. working with nurse practitioner or clinical specialist.				
Level II	Shows mature ability to work with others in 'team setting', i.e. trauma evaluation with other services; collaborative care with NICU and PICU services. Participate in improving the health of patients and communities				
Level III	Understand limitations of some systems and finds ways to overcome limited resources/limitations of systems. Learn the role of advocacy in the care of infants and children.				
Level IV	Understand current practice and have developed system to improve patient care (better discharge instructions, better pain management protocol) based on available scientific data.				

Comments:

First Six Months: Resident Signature ___________________________

Second Six Months: Resident Signature ___________________________

Third Six Months: Resident Signature ___________________________

Final Six Months: Resident Signature ___________________________

360 Degree Evaluation Form

Return to Program Director

Date: ____________________________________

Resident evaluated: ___________________________________

Evaluator: ________________________________

Check one: ( ) self ( ) nurse ( ) resident ( ) patient/families ( ) staff

Please check NA (not applicable) for any section in which you cannot adequately assess.

	Unsatisfactory	Satisfactory	Superior	NA
Professional in interactions	1 2 3	4 5 6	7 8 9	
Respectful of disabilities, age, gender, culture and ethnicity	1 2 3	4 5 6	7 8 9	
Delivers high quality care with integrity, honesty and compassion	1 2 3	4 5 6	7 8 9	
Provides effective care	1 2 3	4 5 6	7 8 9	
Able to synthesize management plan in critically ill infants and children	1 2 3	4 5 6	7 8 9	
Can analyze experience, gather data, and identify ways to improve care	1 2 3	4 5 6	7 8 9	
Open to suggestions	1 2 3	4 5 6	7 8 9	
Communicates ideas and plans effectively	1 2 3	4 5 6	7 8 9	
Reacts to criticism appropriately	1 2 3	4 5 6	7 8 9	
Understands the effects of the systems on the delivery of health care	1 2 3	4 5 6	7 8 9	

Comments:

Faculty and Program Evaluations

Trainees in pediatric surgery evaluate the faculty and program on an annual basis. Due to low number of trainees at any given time (1 per year in a 2 year training program), the trainees may opt to fill out the evaluations and turn them in at the Graduate Medical Education office into the hands of the Associate Dean for Graduate Medical Education (Timothy Flynn, M.D.). Dr. Flynn can then provide the program director with the appropriate feedback.

Faculty meetings occur monthly to discuss issues regarding the service as well as all matter related to the training program. This occurs on the 4th Friday of each month.

Faculty Evaluation

Faculty is evaluated by the program director and trainees annually. Resident's evaluations are kept confidential, but the information is reviewed with the faculty by the program director. The evaluations focus on the following:

- Teaching ability
    - Teaching rounds are efficient and educational
    - Faculty allows the trainee to gain progressive independence as he/she gains competence
    - Faculty's inspires the trainee to learn
    - Faculty takes time to teach
- Commitment to the educational program
    - Faculty is committed to the growth of the trainee
    - Faculty endorses the duty hour regulations
    - Faculty takes time to participate in conferences
    - Faculty has a good understanding of the balance between education and service
- Clinical knowledge
    - Faculty has good knowledge of pediatric surgery
    - Faculty performs continuous learning
- Scholarly activities
    - Faculty is engaged in clinical research
    - Faculty is engaged in basic science research
    - Faculty enthusiastically endorses the resident's participation in research
    - Faculty is a good mentor for scholarly pursuit
    - Faculty participates in the advancement of knowledge

Program Evaluation

The educational program is evaluated annually through a meeting of the chief resident, the program director, and at least one other faculty. Program curriculum, goals and objectives, and evaluation process are all reviewed and assessed for effectiveness. The review group keeps a written documentation of the evaluation and takes into consideration comments from other faculty, resident evaluations, resident's performance on the in-service exam, graduate's performance on the certification exam, and issues and comments cited by the institution's Graduate Medical Education Committee. The graduate's performance on the certifying exam represents a significant measure of the program's educational effectiveness. If deficiencies are found in any aspect of the educational program, the group in conjunction with the faculty will prepare a plan of action to resolve the problems.

Faculty Evaluation Form

Return to Program Director or DIO (Tim Flynn, M.D.)

Date: ______________________________________

Faculty evaluated: _____________________________________

Do not place your name or other identifying marks on this evaluation.

Please rate the individual faculty in the following areas.

	Unsatisfactory	Satisfactory	Superior	NA
Rounds are efficient and educational	1 2 3	4 5 6	7 8 9	
Interest in teaching	1 2 3	4 5 6	7 8 9	
Trainee is allowed to gain progressive independence	1 2 3	4 5 6	7 8 9	
Leadership quality	1 2 3	4 5 6	7 8 9	
Punctuality and availability	1 2 3	4 5 6	7 8 9	
Faculty complies with duty hour regulations	1 2 3	4 5 6	7 8 9	
Conference participation	1 2 3	4 5 6	7 8 9	
Rapport with housestaff	1 2 3	4 5 6	7 8 9	
Basic pediatric surgery knowledge	1 2 3	4 5 6	7 8 9	
Guidance in academic and career goals	1 2 3	4 5 6	7 8 9	
Participation in the advancement of knowledge	1 2 3	4 5 6	7 8 9	
Comments:				

Program Evaluation Form

Return to Program Director or DIO (Tim Flynn, M.D.)

Date: ______________________________

Do not place your name or other identifying marks on this evaluation.

Please rate the residency program overall in the following areas.

	Unsatisfactory	Satisfactory	Superior	NA
Clinical volume and variety	1 2 3	4 5 6	7 8 9	
Quality and quantity of conferences	1 2 3	4 5 6	7 8 9	
Exposure to scholarly activities	1 2 3	4 5 6	7 8 9	
Faculty supervision and teaching	1 2 3	4 5 6	7 8 9	
Accessibility of faculty	1 2 3	4 5 6	7 8 9	
Administrative support of program	1 2 3	4 5 6	7 8 9	
Contribution of integrated institution and electives to education	1 2 3	4 5 6	7 8 9	
Adequate and appropriate feedback	1 2 3	4 5 6	7 8 9	
Expectations and objectives defined	1 2 3	4 5 6	7 8 9	
Program complies with duty hour regulations	1 2 3	4 5 6	7 8 9	
Program Director's role in administration of the program	1 2 3	4 5 6	7 8 9	
Comments:				

Resident Duty Hours and the Working Environment

The primary objective of the training program is to provide an educational experience that leads to the attainment of knowledge and skills appropriate for an independently practicing pediatric surgeon. Didactic and clinical education has priority in the allotment of resident time and energies. Faculty supervision and guidance is available at all time and residents will be encouraged to engage in open communication regarding their personal well-being. Excessive stress and anxiety is counterproductive for the learning environment. Residents will be carefully monitored for their adherence to the duty hour limitations and for their overall well-being.

Stress

The program director will monitor stress through frequent scheduled meetings with the residents. Residents will be encouraged to meet with faculty and the program director for all potential problems including stress and fatigue issues. Both faculty and residents will receive education on the signs and effects of fatigue and stress and how best to manage these issues. The University has counseling available through the Residency Assistance Program for more in-depth management. Residents may be encouraged or required to seek counseling if deemed necessary by the faculty and/or program director.

Residents are encouraged to notify the faculty if they feel that they are working without adequate rest. The faculty will either take direct responsibility of the care or assign another resident.

Supervision of Residents

A qualified faculty from the Division of Pediatric Surgery supervises all patient care. The program director ensures that direct and adequate supervision is provided at all times. Residents and faculty have pagers and cell phones for rapid and reliable communication. The faculty is available at all times for continuous supervision and consultation. The call schedule will never have a time period where there is no faculty available.

The attending physician has ultimate responsibility for the overall care of all patients and for supervision of residents. Although the chief resident will require progressively less direction than the first year resident, even the chief resident will be supervised. The chain of command begins at the faculty level and it is based on an emphasis on graded authority with increasing responsibility granted as experience is gained. Delegation of responsibility is determined by the attending surgeon and is based on direct observation and knowledge of the pediatric surgery resident's skill and ability.

Residents will discuss care of all new consults and admissions with the faculty. All operative procedures must have attending approval and no operative procedures will be done without an attending present. Chief resident in pediatric surgery may assist and teach junior residents. Chief resident in pediatric surgery may not share patients with a chief resident in general surgery.

Duty Hours

Duty hours are monitored closely by the faculty and the program director. A computerized time-card program is in place in the Department of Surgery. Both residents and faculty will receive written policies regarding duty hours. A detailed discussion regarding the expectations will be done when the trainee begins training in this program.

Graduate education in surgery requires a commitment to continuity of patient care. This takes precedence without regard to the time of day, day of the week, number of hours worked, or on-call schedules. Nevertheless, patients have a right to expect that the responsible physician is healthy, alert, and effective in the delivery of appropriate care. The program director will monitor the duty hours every 2 weeks to ensure that there is an appropriate balance between service and education and that there is strict adherence to the regulations. On average, residents will be on in hospital

call no more than every third night and will have 1 day in 7 free of duties.

ACGME Duty Hour Requirements

- 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 relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
- Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

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

The program director and faculty will monitor the demands of call and work hours and make adjustments as necessary to minimize excessive service demands and fatigue. A back-up system for this program is the availability of the faculty for all care provided. The attending surgeon will take over care if he/she deems that the patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

Residents are required to complete the electronic time card so that their duty hours are reported and monitored by the program. They should visit the on-line time card no less than every 3 days in order to keep the electronic timecard current and accurate. At the end of each 2-week time period, the resident submits the timecard electronically and if there is non-compliance with the duty hour requirements, the resident will be asked to justify the episode. It is the responsibility of

each resident, with the support of the Program Director and faculty, to commit to the practice on compliance with regard to duty hours. Any resident who does not submit a timecard on a regular basis, or who violates duty hour requirements without justification, will be put on academic suspension until they receive the required number of days off from duty, or until the beginning of a new time period.

No moonlighting is allowed. Exceptions may be made at the discretion of the program director.

Administration Policies and Fringe Benefits

Eligibility

All full-time housestaff members and clinical post-doctoral associates appointed through a department in the College of Medicine are eligible to receive the College-sponsored fringe benefit program. Benefit costs are employer-paid. If any leave of absence or unpaid leave is taken during the residency, insurance benefits will be covered by the department for up to two months; after two months, the resident will be responsible for payment of insurance premiums.

For more information access the College of Medicine web site on benefits:
http://housestaff.medinfo.ufl.edu/policy/benefits.shtml

Contact: Freddy Jones
352-273-5077

Comprehensive Group Health Plan

The following is a brief description of your health plan. A copy of your Plan Booklet is located on the Fringe Benefit web site at www.med.ufl.edu/benefits. Where discrepancies exist, the Master contract will apply. It is your responsibility to notify the Fringe Benefit office of any changes in your family status. Humana Insurance Company underwrites the College of Medicine group health plan. The plan provides coverage for the employee, the spouse of an eligible employee (unless legally separated or divorced), qualified domestic partner, unmarried children under age 19, unmarried children between ages 19 and 25 who are dependent upon the insured for support and are either full time or part time students or who reside in the insured's household. Each insured individual is initially covered for a lifetime maximum amount of $5,000,000. The calendar year deductible is $1,000 per person/$2,000 per family. Coinsurance and copays on covered expenses contribute toward the stop-loss maximum. You will pay 20% or $25.00 per visit to a maximum of $2,500 per calendar year if you visit a Humana/Choice Care network provider. If utilizing a non-network provider, the loss is stopped at $5,000 of covered expenses, meaning that you are responsible for the 40% and the plan will pay 60%. Charges are discounted according to agreements between the providers. No deductibles or coinsurance payments apply to covered inpatient stays at Shands hospital facilities. Deductibles are waived for inpatient stays at network provider hospitals and covered charges are paid at 80% coinsurance. The calendar year deductible applies to inpatient stays at all other non-network hospitals and covered charges are paid at 60% coinsurance. You will also be responsible for the discounted non-eligible expenses. Covered Lab and x-ray charges by all others are paid at 80% coinsurance. For visits to physician's offices at Shands/UF or Shands/Jax, the UF Faculty Group Practice physicians will waive the deductible and coinsurance payments for covered charges. Deductibles and coinsurance payments will not be waived for non-covered charges. Physician visits to Network Providers are subject to a $25 copayment for outpatient visits. Physician visits to all other providers are subject to the calendar year deductible and are paid at 60% coinsurance for eligible expenses. You are responsible for paying the non-eligible charges and those charges do not apply towards your total stop loss. Facility charges for Outpatient Surgery are not subject to the deductible and are paid at 100% at Shands Hospitals and 80% at Network Provider Hospitals. Facility charges for Outpatient Surgery performed at All Other Hospitals will be paid at 60% coinsurance. Emergency Room Visits at Shands Provider Hospitals are paid at 100%. Emergency Room Visits to all Hospitals and facilities including out of area emergency visits are paid at 80% coinsurance. Your benefits have cost containment features on mental illness and substance abuse, home health care, hospital preadmission tests, weekend hospital confinement, hospice care, birth center benefit, ambulatory surgical facility benefits, second surgical opinion. Outpatient Visits for Mental/Nervous Disorders and Substance Abuse are capped at 52 visits per calendar year. Visits are limited for Physical, Speech and Occupational Therapy; charges are paid according to the same schedule as Outpatient Visits. "Well Baby" and "Adult Well Person" care are included as a scheduled benefit and are payable, without deductible, at 80%. "Adult Well Care" is limited to

$250 per Calendar Year. Pre-Certification is mandatory for in-patient hospitalization. A prescription drug plan is included in the benefits. Brand name drugs will require a $35 copayment, Generic drugs will require a $20 copayment. Mail order drugs (90-day supply) will require a $35 copayment for brand name drugs and a $20 copayment for generic drugs. Prescriptions written by an insured for self or any family members will not be reimbursable through the drug card nor regular plan benefits.

C.O.B.R.A.

If a covered employee or dependents' medical insurance terminates due to a Qualifying event (employment termination, work hours reduction, divorce/legal separation, Medicare entitlement, and maximum age for child), they may continue their medical insurance under the Consolidated Omnibus Budget Reconciliation Act (C.O.B.R.A.). For additional information, contact Fringe Benefits/Gainesville at 352-273-5077 or Fringe Benefits/Jacksonville at 904-244-9530. The employee pays premiums.

Life Insurance

Level term group life insurance underwritten by Provident/UNUM Life Insurance Company provides $50,000 of life insurance for all eligible employees with an additional $10,000 in the event of accidental death and dismemberment.

Long Term Disability Insurance

All active full-time College of Medicine housestaff members working at least 30 hours a week are provided Long Term Disability insurance. The policy is underwritten by UNUM Insurance Company. The monthly benefit is equal to 60% of the first $3,333 monthly salary to a maximum monthly benefit of $2,000 reduced by benefit offsets. The benefits as set forth under this policy will begin after the insured's sixth month of total disability. The maximum benefit period due to sickness and accident is to age 65. A special Guaranteed Issue Conversion Feature is provided. For information pertaining to this special feature, please contact Holloway Financial, Inc. (352) 377-2078 or 800-330-4628.

FICA Alternative Program

Social Security payroll taxes are collected under authority of the Federal Insurance Contributions Act (FICA). Social Security is currently withheld at 6.2% of eligible wages and matched by the university. Participants in this plan will no longer contribute to the Social Security Administration nor will the amount contributed by the employee be matched by the university. Instead, employees will contribute 7.5% of their wages into an investment account in their name. Medicare contributions at 1.45% will continue to be withheld and matched by the employer. The plan is mandatory for eligible employees and employees will be automatically enrolled or un-enrolled based on their salary plan status during the affected pay period. There is no minimum age or service requirement. Once a contribution has been made to the plan, the employee will receive an Enrollment/Designation of Beneficiary form and an introduction letter from Bencor, the plan Administrator. They will also be available on the BENCOR web site. These forms will allow the employee to choose between a Guaranteed Pooled Fund (an interest bearing account) and a variable investment option. As a participant in the plan, you will have the option of investing in a mutual fund plan or a fixed account and will also be asked to identify a beneficiary. If an employee does not direct the investments of your funds, they will automatically be placed into the Guaranteed Pool fund which has a fixed rate of 3.75%, GUARANTEED THROUGH DECEMBER 31, 2006. For information pertaining to enrollment please visit the web site at www.bencor.com or contact BENCOR at (386) 755-9192 or WATS: 888-258-3422.

Professional Liability

Pursuant to Section 768.28, Florida Statutes, the University of Florida Board of Trustees is exclusively responsible for any civil claims or actions arising from the acts of its employees and agents. The UF BOT is protected for such liabilities by the J. Hillis Miller Health Center Self-Insurance Program (UF SIP), a self-insurance program managed by a governing council created by the Florida Board of Governors that is chaired by the Sr. Vice President for Health Affairs. As an employee of the University of Florida (UF), you are personally immune from civil liabilities which may arise from acts or omissions committed by you in the course of your employment. UF SIP affords you personal professional liability protection while you act as a Good Samaritan, while you are involved in community service work, which has been pre-approved by your college, or if you are on a job assignment outside of Florida. UF SIP also provides defense costs for certain licensure investigations by the Department of Health. If you have questions regarding professional liability, please contact the UF SIP Director at 352-273-7066.

Resident Travel

Each trainee may attend an academic meeting each year with the expenses covered by the division. Meeting expenditures require the approval of the program director and division chief.

Living Quarters

There are no departmental or divisional provisions for living quarters other than On Call quarters at Shands.

Shands Hospital Office of Housestaff Affairs

Contact: Sharon Wallace
352-265-0787

The Office of Housestaff Affairs offers support and a voice for housestaff and serves as a clearinghouse for information. The Shands Housestaff Lounge located in room 6-240 is stocked daily with snacks and drinks and is a comfortable area to interact with other residents and relax. The room is equipped with a television, a VCR, computers for online access to Medline, WordPerfect, Microsoft Word, Excel and the Hospital Information System.

The Housestaff Gym is located in room 6-236 and provided as a courtesy of Shands @ UF and the Housestaff Affairs Office.

Resident Annual Leave/Sick Leave Policy

1. All trainees will have 15 working days of vacation per year. Weekends are not included as working days. Leave slips must be filled out prior to vacation.

2. Trainees must submit a vacation request at least two months ahead of the requested date. If vacations are requested later than that they may not be approved because of difficulty rescheduling continuity care patients. All vacation requests must be approved by the program director.

3. Each trainee is allowed ten days of paid sick leave annually. The program director or division chief must be contacted when a trainee is sick and a leave slip must be filled out upon return.

Maternity/Paternity Leave Policy

1. The duration of maternity leave before and/or after delivery will be determined by the resident and her physician. Requests for leave in excess of three months must be approved by the program director and department chairman.

2. It is an option for the employee to use vacation time prior to the employee being placed on leave without pay. Any illness caused by or contributed to by pregnancy, miscarriage, abortion, childbirth, and recovery therefrom (including uncomplicated pregnancy), shall be treated as a temporary disability, and the house officer shall be allowed to use sick leave credits when certified by his/her physician.

3. Beyond available annual and sick leave, leave will be unpaid.

4. While on unpaid leave, the resident's insurance benefits will be maintained by the department for two months.

5. The total time allowed away from the program in any given year or for the duration of the training program is determined by the requirements of the American Board of Surgery. The current requirement is completion of a minimum of 48 weeks of full clinical training per year. Make-up training may be required by either the residency program or the ABS credentials committee.

6. The resident will be paid for make-up or extended time, and fringe benefits will be maintained during this period.

7. Paternity leave of two weeks can be granted with the same provisions as maternity leave.

8. Maternity and Paternity leave policies also apply to adoptions and foster care.

Medical Records

The medical record is an essential part of good medical care. Proper documentation, chart completion and respect for the medical record are expected of all trainees. You are referred to PHYSICIAN ORIENTATION TO HEALTH INFORMATION AND RECORD MANAGEMENT, SHANDS HOSPITAL, for a full description of medical record documentation and department services.

Key highlights are listed below:

Documentation

- Indicate patient's full name and medical record number on all forms.
- Write your note immediately after treating the patient and be specific.
- **Sign, date and time all entries.**
- Do not use abbreviations unless they are listed in the approved abbreviation list published by Health Information and Record Management.
- Abbreviations are not acceptable for diagnoses and are not to be used on informed consent forms.
- Choose your words carefully. The medical record is not the place to vehemently disagree with a policy or a colleague.
- Make alterations carefully; avoid obliteration or creating the appearance of tampering. Cross off errors with a single line, ensuring the entry is still legible. Date and initial the correction.
- Write legibly.

Chart Completion

- By law, the medical record must be complete within thirty days of a patient's discharge. *In order to accomplish this, all physicians need to complete their medical records while the patient is in house or visit the Physicians' Workroom minimally once per week. Residents should sign in to document compliance.*
- Residents are responsible for signing their own progress notes, verbal orders, and dictating operative reports and discharge summaries.
- Your attention to the completion of medical records is reported biweekly to the Department Chairman, the Chief of Staff, and the Department Representative to Health Information and Record Management.

<u>Failure To Complete Medical Records In A Timely Manner May Jeopardize Your Clinical Privileges</u>.

The Physicians' Workroom is open Sunday through Thursday from 8 a.m. to midnight and on Friday and Saturday from 8 a.m. to 4 p.m. Calling the Workroom (5-3124) two hours before your expected arrival will expedite the retrieval of records. When you enter the Workroom, sign in at the desk so your medical records can be retrieved.

Medical Transcription

Transcription is staffed 24 hours a day except Saturday and Sunday. "STAT" transcription is available for patient transfer during non-business hours and on holidays by calling 5-0131. Written instructions for using the dictation system are provided by Health Information and Record Management.

Discharge Summaries

Discharge summaries should be dictated ON THE DAY OF DISCHARGE. Timely dictation is an essential part of patient care. All medical records must have a handwritten or dictated discharge summary (under 48 hours, dictated summary is not required). A final progress note may be

substituted for a discharge summary in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization. A dictated discharge summary is required for any patient with hospital stay greater than 48 hours.

Operative Report

ALL OPERATIVE REPORTS MUST BE DICTATED IMMEDIATELY AFTER SURGERY. Operative reports not dictated by 7:00 a.m. the morning following surgery are considered delinquent and reported daily to the Operating Room scheduling office and the Chief of Staff.

Health Information and Record Management

A Shands Hospital Committee coordinates Health Information and Record Management activities and physician, patient and administrative needs. Do not hesitate to contact the department's representative if you have any questions or suggestions.

LETTER OF OFFER TO RESIDENTS
OF THE UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE

Date ___________________

Dear ___________________

The College of Medicine, University of Florida (hereinafter "the University") is pleased to offer you a position as a resident at the PGY ___ level in the graduate medical training program in the Department of Surgery. This letter describes various aspects of the graduate medical training programs for residents and fellows at the University. Trainees in such programs (residents and fellows) are hereinafter referred to as "residents." The University reserves the right to make changes in the future to any aspect of these programs.

Resident Responsibilities:
The position of resident involves a combination of supervised, progressively more complex and independent patient evaluation, management functions and formal educational activities. Among a resident's responsibilities in a training program of the University are the following: 1) to meet the qualifications for resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the AMA Graduate Medical Education Directory; 2) to develop a personal program of self-study and professional growth with guidance from the teaching staff; 3) to provide safe, effective, and compassionate patient care, commensurate with the resident's level of advancement, responsibility, and competence, under the general supervision of appropriately privileged attending teaching staff; 4) to participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students; 5) to participate in institutional orientation and educational programs and other activities involving the clinical staff; 6) to submit to the program director confidential written evaluations of the faculty and the educational experiences; 7) to participate on institutional committees and councils to which the resident is appointed or invited, especially those that relate to their education and/or patient care; 8) to adhere to established practices, procedures, and policies of the University and of affiliated institutions as applicable, including among others, state licensure requirements for physicians in training where these exist; 9) to develop an understanding of ethical, socioeconomic, medical/legal issues, communication skills and cost containment issues that affect graduate medical education and medical practice and to develop an understanding of research design, statistics, and critical review of the literature necessary for acquiring skills for lifelong learning.

Sample

Duration of Appointment and Conditions for Reappointment:
Your initial appointment will begin on _______ for a renewable period of _1_ total year(s). We anticipate you will remain in the prescribed course of your residency until completion of this time. However, it is understood that appointments are renewed annually and that continued retention in the training program depends on your satisfactory performance/training progress, including your adherence to acceptable professional behavior, as well as the continuation of requisite funding for the program. A resident's reappointment and progression to more advanced levels will be based on the results of periodic reviews of the resident's educational and professional achievement, competence and progress as determined by the program director and teaching faculty. The program maintains a confidential record of the evaluations.

The primary site of your graduate medical training will be the University of Florida Health Science Center-Gainesville with its major teaching hospital and affiliates, but the location of the training for any resident may occur at various additional sites. All assignments and call schedules are made at the discretion of the appropriate program director of the University. In addition should residency programs be closed or downsized, the University will inform the resident well in advance of such events. Every effort will be made to complete the resident's course of training or to find another site for the resident to complete training.

Policies and Procedures for Discipline, Grievances, Nonrenewal, Suspension or Dismissal of a Resident:

The position of the resident (for the purpose of this document, the term resident applies to interns, residents and fellows) presents the dual aspect of a student in graduate training while participating in the delivery of patient care. The University of Florida College of Medicine is committed to the maintenance of a supportive educational environment in which residents are given the opportunity to learn and grow. Inappropriate behavior in any form in this professional setting is not permissible. A resident's continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident's academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

Sample

Grievances: A grievance is defined as dissatisfaction when a resident believes that any decision, act or condition affecting his or her program of study is arbitrary, illegal, unjust or creates unnecessary hardship. Such grievance may concern, but is not limited to, the following: academic progress, mistreatment by any University employee or student, wrongful assessment of fees, records and registration errors, discipline (other than nonrenewal or dismissal) and discrimination because of race, national origin, sex, marital status, religion, age or disability, subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida and the College of Medicine (as contained in the Housestaff Policy & Procedure Manual).

Prior to invoking the grievance procedures described herein, the resident is strongly encouraged to discuss his or her grievance with the person(s) alleged to have caused the grievance. The discussion should be held as soon as the resident becomes aware of the act or condition that is the basis for the grievance. In addition, or alternatively, the resident may wish to present his or her grievance in writing to the person(s) alleged to have caused the grievance. In either situation, the person(s) alleged to have caused the grievance may respond orally or in writing to the resident. If a resident decides against discussing the grievance with the person(s) alleged to have caused such, or if the resident is not satisfied with the response, he or she may present the grievance to the Chair. If, after discussion, the grievances cannot be resolved, the resident may contact the Assistant Dean of Graduate Medical Education (ADGME). The ADGME will meet with the resident and will review the grievance. The decision of the ADGME will be communicated in writing to the resident and constitute the final action of the University.

Suspension: The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the Chair, or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be informed of the reasons for the suspension and will be given an opportunity to provide information in response.
The resident suspended from patient care may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident within thirty (30) days of the date of suspension. Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision-making or appeal process. The resident will be afforded due process and may appeal to the ADGME for resolution, as set forth below.

Nonrenewal: In the event that the Program Director decides not to renew a resident's appointment, the resident will be provided written notice which will include a statement specifying the reason(s) for nonrenewal. If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed nonrenewal decision. The resident may be accompanied by an advisor during any meeting held pursuant to these

procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that nonrenewal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

Dismissal: In the event the Program Director of a training program concludes a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair in writing of this decision and the reason(s) for the decision. The resident will be notified and provided a copy of the letter of proposed dismissal; and, upon request, will be provided previous evaluations, complaints, counseling, letters and other documents that relate to the decision to dismiss the resident.

Sample

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed dismissal. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that dismissal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

Appeal: If the resident appeals a decision for suspension, nonrenewal or dismissal, this appeal must be made in writing to the ADGME within 10 working days from the resident's receipt of the decision of the person suspending the resident or the Chair. Failure to file such an appeal within 10 working days will render the decision of the person suspending the resident or the Chair the final agency action of the University.

The ADGME will conduct a review of the action and may review documents or any other information relevant to the decision. The resident will be notified of the date of the meeting with the ADGME; it should occur within 15 working days of the ADGME's receipt of the appeal. The ADGME may conduct an investigation and uphold, modify or reverse the recommendation for suspension, nonrenewal or dismissal. The ADGME will notify the resident in writing of the ADGME's decision. If the decision is to uphold a suspension, the decision of the ADGME is the final agency action of the University. If the decision is to uphold the nonrenewal or dismissal, the resident may file within 10 working days a written appeal to the Dean of the College of Medicine. Failure to file such an appeal within 10 working days will render the decision of the ADGME the final action of the University.

The Dean will inform the ADGME of the appeal. The ADGME will provide the Dean a copy of the decision and accompanying documents and any other material submitted by the resident or considered in the appeal process. The Dean will use his or her best efforts to render a decision within 15 working days, but failure to do so is not grounds for reversal of the decision under appeal. The Dean will notify in writing the Chair, the ADGME, the Program Director and resident of the decision. The decision of the Dean will be the final agency action of the University. The resident will be informed of the steps necessary for the resident to further challenge the action of the University.

<u>Financial Support and Benefits:</u>
Stipend: Each resident is given a stipend to pursue the resident's graduate medical education in an amount appropriate to the resident's level in the program. Stipend levels are reviewed annually by the Graduate Medical Education Committee of the College of Medicine and recommendations for changes are subject to approval by the University's Dean of the College of Medicine. Stipend levels begin on July 1 of each contract year and are paid biweekly.
Living quarters, meals, laundry, and other such expenses are the resident's responsibilities. In some cases and at the discretion of the University, meal tickets may be issued to the resident when the resident is assigned in-house call on nights and weekends; similarly, living quarters may be provided during some rotations outside of the primary location of the program.
Health, Life and Disability Insurance; Worker's Compensation Insurance: Health, life and

disability insurance are provided to the resident. If a resident suffers a work-related injury, the resident is covered under the workers' compensation program of the University provided the resident complies with the requirements of the worker's compensation program. Confidential counseling and psychological support services are available through the Housestaff Affairs office. The Housestaff Policy and Procedure Manual provides details of coverage.

Professional Liability Coverage:
As a participant in a graduate medical education program of the University, a resident is an employee of the University of Florida, a subdivision of the Florida Board of Regents, a State of Florida agency. The resident is personally immune from civil liabilities which may arise from acts or omissions committed by the resident in the course of employment. Section 768.28, Fla. Statutes, outlines the protection against claims and/or judgments extended to employees of the University. The Florida Board of Regents is vicariously responsible for any civil claims or actions arising from the acts of its employees and agents. Pursuant to Section 240.213, Fla. Statutes, the University has created a program of self-insurance covering claims and actions against the University and/or the Florida Board of Regents which may arise from the actions or omissions of University healthcare faculty members and other professional employees or students of the University. A resident must identify himself or herself at all times as a University of Florida employee while participating in the graduate medical education program in order to assure this coverage.

Sample

Medical Requirements:
Screening of the resident for infectious diseases, prophylaxis/treatment for exposure to communicable disease, and immunizations will be provided by the University or through arrangements with other health providers. The resident will have documentation of immunity to measles, mumps, hepatitis B, rubella and varicella (chicken pox); the resident will be required to have periodic tuberculosis skin tests. The resident will comply with the infection control policies and procedures of the institutions where the resident is assigned.

The University of Florida conforms to the Florida Medical Practice Act (F.S. 458). The rule calls for all licensed practitioners to report to the appropriate authority any reasonable suspicion that a practitioner is impaired to practice. The legislation provides for therapeutic intervention through the Physicians Recovery Network (PRN). This organization works closely with the State Board of Medicine and is recognized as the primary method of dealing with physician impairment in the state. Faculty, staff, peers, family or other individuals who suspect that a member of the housestaff is suffering from a psychological or substance abuse problem are obliged to report such problems. Reporting can be directly to the PRN or to the program director, Chair, or Housestaff Affairs office. All referrals are confidential and there is early involvement of the PRN. If the PRN feels intervention is necessary, they handle the situation and provide for treatment and follow-up. Residents can only return to clinical duties with the approval of the PRN. The PRN maintains contact with the program directors about residents in the program of recovery.

Disclaimer or Resident Assertions; Invention and Copyright Agreement:
The resident agrees that unless approved by the University's Chair all materials compiled or published by the resident relative to training and experiences received at the University and its affiliated hospitals, or arising from participation in training, patient care, or research pursuant to this agreement, will clearly state that the opinions or assertions contained therein are those of the resident and not those of the University. Pursuant to the University's rules, the resident must execute the University's Invention and Copyright Agreement.

Institutional Leave Policy:
A comprehensive leave policy is outlined in the Housestaff Policy & Procedure Manual and includes uncompensated leave, temporary military duty, absences pertaining to education and training, and maternity/paternity leave. Subject to the approval of the program director and consistent with the guidelines of the appropriate specialty board, all residents accrue fifteen (15) days of annual leave. Residents may be permitted to carry over unused leave to a new year, as consistent with the academic departmental policy of the University; however, such carry-over

must be approved by the program director and annual leave accrued may not exceed twenty-five (25) workdays. Unused annual leave is considered non-reimbursable.

A resident will accrue ten (10) days of sick leave for each full year of employment. The resident will be entitled to utilize sick leave for death, or in special cases, severe illness in the immediate family (spouse, parents, brothers, sisters, children, grandparents, and grandchildren of both resident and spouse). The number of days of sick leave allowed per illness will be determined by the program director. Unused sick leave is considered non-reimbursable.

The total time allowed away from a graduate medical education program in any given year or for the duration of the graduate medical education program will be determined by the requirements of the specialty board involved. If leave time is taken beyond what is allowed by the University or the applicable specialty board, the resident is required to extend his or her period of activity in the graduate medical training program accordingly in order to fulfill the appropriate specialty board requirement for the particular discipline. The resident will be paid for makeup or extended time if funds are available at that time.

Sample

<u>Outside Professional Activities:</u>
All programs have established rules regarding outside and extracurricular activities that meet their RRC requirements and University's policy. There are two categories of such activity: Programmatic activities are initiated by departments to provide clinical experiences which often are not afforded within the standard curriculum and which usually occur at non-campus health care affiliates. Supplemental compensation is provided by the University to housestaff who participate in programmatic activities.

Nonprogrammatic activities are initiated by the resident and do not involve any agreement between the University and the outside employer. Individual programs have total authority to decide whether nonprogrammatic activities are allowed in keeping with their Residency Review Committee guidelines and curriculum.

The resident is referred to both the departmental addendum for details regarding departmental policy for Outside Professional Activities and the complete policy on Outside Professional Activities set forth in the Housestaff Policy & Procedure Manual.

<u>Certificate of Completion:</u>
A certificate of graduate medical training will be issued to a resident on the recommendation of the University's appropriate Chair only after satisfactory completion of service and educational requirements and fulfillment of all other obligations and debts, including completion of medical records and return by the resident of State of Florida property, as well as property of any affiliated institution.

Departmental Addendum:
Depending on the graduate medical training program to which the resident is appointed, an addendum entitled "Appendix A" may be attached to and incorporated in this letter of agreement containing program-specific information and regulations. The resident agrees to be further bound by the special requirements contained in such Appendix A if any.

“Your signature on this letter affirms you are not currently excluded, debarred or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs and that you have not been convicted of a criminal offense related to the provision of health care items or services. Your eligibility to participate in Federal health care programs is a condition of your employment with the University. If you are at any time excluded, debarred or otherwise declared ineligible to participate in Federal health care programs (other than through a College of Medicine- approved "private contracting" arrangement) or in Federal procurement or non-procurement programs or are convicted of a criminal offense related to the provision of Health care items or services, you employment may be terminated immediately.”

Please sign this letter indicating your acceptance of this position and return one copy to the Program Director as soon as possible. We look forward to welcoming you as a member of our housestaff.

With best regards,

Accepted:	Sincerely,
______________________________	______________________________
Resident	Program Director
______________________________	for ______________________________
Date	

Sample