# Department of Surgery Resident Handbook

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Section I: Introduction to the Program, Faculty & Staff:

The Program

Department of Surgery Mission Statement

“The Department of Surgery is committed to outstanding education, compassionate care of our patients and to further the knowledge of medicine through our research. We intend to accomplish these goals with the highest standards of professionalism, pride, and honor. We will treat no patient with less compassion than another. We will see all residents and students as our future. We will strive to answer the hard questions. We will do all of this because it is our responsibility and lifelong passion.”

A Mission Statement on Education, Loyola Department of Surgery

“We want our faculty members and staff to manage educational programs that we are proud of and committed to, where all interested faculty members and staff have an opportunity to contribute and grow as teachers, mentors, learners, educators, researchers and administrators. We want our faculty members, education staff, and learners to feel respected, treated fairly, listened to, and accountable for the quality of the educational programs. We aim to provide a positive and supportive learning environment where students and residents, regardless of level, are properly challenged to achieve their maximum potential, both personally and professionally. Above all, we want our students, residents and faculty members to be satisfied with their accomplishments.”

Loyola's program is designed to foster a young physician's development into a complete surgeon. We want to train surgeons who will become leaders in surgery either in an academic or community practice - the person who is called when your relative is truly ill. This individual will be skilled in all components of general surgery as defined by the American Board of Surgery.

The Department of Surgery Office of Education Faculty and Staff

The Surgery Education Office provides support for the residents and faculty of the General Surgery Residency Program. The main telephone number is 708.327.3436 and the fax number is 708.327.3489

Vice Chair of Education & Program Director
Constantine Godellas, MD
708-327-2391 (office)
cgodellas@lums.edu

Associate Program Director
Dana Hayden, MD
708-327-2820
dahayden@lumc.edu

Associate Program Director
Theodore Saclarides, MD
708-327-2820
thsaclarides@lumc.edu

Residency Coordinator
Adriana Ohl, MBA
708-327-3436
Adriana.ohl@luhs.org
Top Ten for Interns:

- Remember your reputation starts today
- Be proud
- Write everything down
- Be a sponge
- Expect the unexpected
- Be a doctor
- Know when a patient is sick
- Remember to care for yourself
- Use your resources
- Have fun

Words of Wisdom Selected from 101 Tips for a Chief Surgical Resident Devin Flaherty, DO, PhD

- First, do no harm. No changes here.
- Residency is like a family and now you are a parent.
- Always do your best.
- Continue to read before cases, even the routine ones.
- Be a team player on the wards; the nurses and hospital staff are your eyes and your ears.
- Exercise when possible, eat healthy when you can; don’t let the increase in good eats increase your waistline, especially during interviews.
- Attempt to do all presentations ahead of time. Make sure presentations are informative and will serve not only to present a topic but also to teach the junior residents and medical students.
- Take time closing the skin.
- When something goes wrong, try not to lecture, but rather take the opportunity to teach.
- Sometimes you will be cranky, just don’t say or do anything that will permanently affect your relationships.
- When talking with a patient, look him or her in the eye. Listen.
- Only keep in your white coat what you absolutely need.
- Keep up with your charts and dictations, don’t wait until June.
- Wash your hands.
- Learn when not to operate.
- Be on time
- Never argue or contradict another colleague in front of a patient.
- Find a good nonsurgical book and read it
- For the full list of 101 Tips for a Chief Surgical Resident by Devin Flaherty, DO, PhD please visit the department of surgery residency website at https://www.loyolamedicine.org/gme/general-surgery-residency/department-surgery-residency-materials

General Surgery Residency Program
Code of Professional Conduct

I. Preamble

The General Surgery Residency Program at Loyola University Medical Center strives to prepare resident physicians for practice in surgery and training the future leaders in American surgery. The program shall maintain focus on the development of clinical and professional competence, and acquisition of key knowledge through organized educational programs with faculty guidance and supervision. Professional competence requires that they manifest in
their lives exemplary ethical and professional attitudes. The resident physicians shall respect the sanctity of human life and uphold the dignity of individual patients. They shall retain a level of personal humility and an awareness of medicine's inherent limitations. They will exemplify maturity and practice balance in personal and professional lives. There shall be an understanding and respect for collegial teamwork in the provision of medical and surgical healthcare. All of this shall be accomplished through a commitment to the development and continued maintenance of clinical competence in our colleagues, students, and ourselves.

The Code of Professional Conduct for residents is not intended to dictate behavior. The intention of this document is to establish a set of minimum expectations providing a disciplinary framework for those who choose not to abide by these professional standards or conduct themselves in a manner not supported by the Department of Surgery or the medical profession.

II. The Code of Professional Conduct for Resident Physicians

All residents are expected to conduct themselves in a manner that exemplifies competence, honesty, compassion, absolute discretion and patient confidentiality. Residents are expected to respect the rights and dignity of all individuals and conduct themselves with honor and integrity.

III. Expectations for Professional Conduct

A. The resident physician shall always be dedicated and committed to providing competent and safe medical care to the patients for whom he or she shall be entrusted.

B. The resident physician shall have respect for all individuals in the community. Residents, students, faculty, and staff recognize the right of all individuals to be treated with respect without regard to position, race, age, gender, handicap, national origin, religion, or sexual orientation.

C. The resident physician shall uphold the standards of professionalism as demonstrated in the practice of medicine and thus conduct themselves with collegiality during interactions with other members of the healthcare team, including but not limited to medical students, residents, fellows, and nursing staff.

D. The resident physician shall respect the laws and standards of the hospital and the land. He or she shall be responsible to seek changes in those standards that are found to be contrary to the patients’ best interests.

E. The resident physician shall handle appropriately the information, records, or examination materials that are distributed to him or her. Any form of cheating or providing false information is a violation of the trust placed in physicians and is a serious infraction of the Code of Professional Conduct.

F. The resident physician shall have respect for patients' confidentiality and safety and shall safeguard those confidences within the restraints of the law. Patients' privacy, modesty, and confidentiality must always be honored. Patients must be treated with kindness, gentleness, dignity, empathy, and compassion.

G. The resident physician shall have a responsibility and be held accountable to complete all assigned regulatory administrative duties of a surgical resident including but not limited to timely completion of duty hour logs, surgical case logs, and attendance at conferences sponsored by the Loyola University Medical Department of Surgery.

H. The resident physician shall refrain from any conduct that may reflect poorly on the Department of Surgery or Loyola University Medical Center.
IV. Violations

A violation of the Code of Professional Conduct occurs when any resident physician acts contrary to the values and responsibilities expected of those engaged in the profession of medicine. Violations occur when any resident physician jeopardizes the welfare of a patient, disregards the rights or dignity of another individual, or allows or assists another in so doing. The Loyola University Medical Center Department of Surgery reserves the right to initiate action and impose sanctions for any conduct that is determined to be a violation of the Code according to the outlined procedures of the Office of Graduate Medical Education (GME), Program Evaluation Committee (PEC), the Resident Professionalism and Support Group (RPSG), and/or any ad hoc committee formed for such reasons.

Authored, reviewed and unanimously ratified by the LUMC Department of Surgery on January 11, 2017.

Training Sites

Loyola University Medical Center

The Loyola University Medical Center is a quaternary-care system with a 61-acre (250,000 m²) main medical center campus in the western suburbs of Chicago. The medical center campus is located in Maywood, 13 miles (21 km) west of the Chicago Loop and 8 miles (13 km) east of Oak Brook, Illinois. The heart of the medical center campus, Loyola University Hospital, is a 547-licensed-bed facility. It houses a Level 1 Trauma Center, ACS Burn Center and the Ronald McDonald Children's Hospital of Loyola University Medical Center. Also on campus are the Joseph Cardinal Bernardin Cancer Center, Loyola Outpatient Center, Center for Heart & Vascular Medicine and Loyola Oral Health Center as well as the Loyola University Chicago Stritch School of Medicine (named for Samuel Cardinal Stritch, a former Cardinal Archbishop of Chicago) Loyola University Chicago Marcella Niehoff School of Nursing and the Loyola Center for Fitness. Loyola University Health System has been a member of Trinity Health since July of 2011. The Neiswanger Institute for Bioethics and Health Policy is a part of the Stritch School of Medicine.
Hines Veterans Administration Hospital

Edward Hines, Jr. VA Hospital, located 13 miles west of downtown Chicago on a 147-acre campus, offers primary, extended and specialty care and serves as a tertiary care referral center for VISN 12. Specialized clinical programs include Blind Rehabilitation, Spinal Cord Injury, Neurosurgery, Radiation Therapy and Cardiovascular Surgery. The hospital also serves as the VISN 12 southern tier hub for pathology, radiology, radiation therapy, human resource management and fiscal services.

Hines VAH currently operates 471 beds and six community based outpatient clinics in Elgin, Kankakee, Oak Lawn, Aurora, LaSalle, and Joliet. Over 600,000 patient visits occurred in fiscal year 2010 providing care to over 54,000 veterans, primarily from Cook, DuPage and Will counties. In FY 2010 the budget for Hines was over $510 million.

Presence Resurrection Medical Center

Presence Resurrection Medical Center is an award-winning, 360-bed academic teaching hospital located on the northwest side of Chicago. As a full service medical center offering comprehensive health services, we are dedicated to providing quality, compassionate care to all we serve. Recently, we opened a new five-story Patient Care Addition with 120 private rooms. Guided by the latest research, every aspect of the new addition promotes healing.
Gottlieb Memorial Hospital
Gottlieb Memorial Hospital is a 254-licensed bed acute care hospital in Melrose Park. We offer emergency, inpatient and outpatient medical services. Gottlieb, which is part of Loyola University Health System, is home to a cancer care and research center, weight loss center, rehabilitation services and Gottlieb Center for Fitness.

General Surgery Overall Goals & Objectives

The program has developed goals and objectives for each of the rotations that residents will be rotating through as they go through their training. Each resident is required to read and familiarize themselves with the goals and objectives pertaining to their rotation.

Statement of Residency Program Educational Goals in Surgery

The overall goal of the residency program in Surgery is to train residents to become thoughtful, caring and technically outstanding surgeons who are leaders and role models. To accomplish this, we have structured a training program that emphasizes graduated authority and responsibility while faculty surgeons maintain optimal resident supervision.

We believe that the six core competencies described by the Accreditation Council for Graduate Medical Education are at the heart of our teaching goals, and that surgical residents in the program will embrace these competencies as core values in surgery. They are: And this.

Patient Care

Surgical residents will demonstrate sufficient knowledge of the general surgery discipline and will acquire sufficient technical skill to provide care that is appropriate and effective. Our residents will be advocates for the promotion of good health and preventive care. In addition, our residents will be trained to understand the human as well as the scientific aspects of medicine, and will exhibit compassion for their patients and their families. Residents will invest time to explain the plan of care and its risks and benefits. Finally, we will provide sound training in the basic skills of general surgery for all categorical and preliminary surgical residents.

Medical Knowledge

Our residents will demonstrate commitment to life-long learning in their studies of evolving information in the biomedical, clinical, epidemiological and social-behavioral sciences, and as they apply this knowledge to patient care.
Practice-Based Learning and Improvement

Our residents will be trained to investigate and evaluate the results of their own practice of surgery, incorporating new scientific evidence to improve their patient care activities as appropriate. They will understand their own limitations and will seek assistance from colleagues when necessary to improve surgical patient care and practice outcomes.

Interpersonal and Communication Skills

Our residents will be trained to render effective and respectful information exchange with patients and their families, and will be courteous in their relationships with other health care professionals.

Professionalism

Our residents will be committed to perform their patient care responsibilities with the highest priority. They will be taught to be respectful of the diverse characteristics and cultures of their patients. As professionals, they will adhere to ethical principles, above all else.

Systems-Based Practice

Our residents will be taught an awareness of the larger context and system of health care as they effectively use system resources to provide care that is of optimal value. They will invest themselves in continuous quality improvement of our health care system in its many evolving forms.

Statement of Research in Residency Training

As a university-based residency program, we also believe it is an important part of our mission to train residents who will ultimately discover new knowledge that will improve patient care. As such, we will provide opportunities for scholarly work in clinical, behavioral and basic research for all surgical residents.

Residents are strongly encouraged to engage in independent research during their residency. For those interested in basic research, two years of dedicated time is recommended. Basic research will be performed under the mentorship of accomplished investigators with a track record of extramural funding and known mentorship abilities. Research in clinical outcomes, education, health services, and other areas is compatible with the department’s educational goals and will be approved when an appropriate plan is developed by the resident and the proposed mentor.

Clinical Rotations

Our residents will have opportunities to participate in the pre-operative, operative, and post-operative care of patients in the principal components of general surgery: specifically, diseases of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, endocrine system, the comprehensive management of trauma and emergency operations, and surgical critical care. In addition, we will provide clinical experience in cardiothoracic surgery, pediatric surgery, plastic surgery, burn management, transplant surgery, endoscopy, urology, gynecology, neurosurgery, orthopedics, and anesthesiology.

On all clinical rotations, the care of patients is ultimately the responsibility of the attending surgeon. Nevertheless, responsibilities for patient care will be assigned to residents at the discretion of the attending surgeon. For residents in the junior years of the residency, such responsibilities may include observation of the preoperative treatment planning, participation in straightforward operations, monitoring of patients’ conditions following surgery, arrangement for discharge, and participating in follow-up care in the attending surgeon’s office or clinic. For residents in senior and chief years, responsibilities may include formulating a pre-operative plan of care for approval by the attending surgeon, participating in and performing operations of varying complexity, monitoring of patients’ conditions following surgery,
ordering appropriate tests, making recommendations for change in post-operative treatment as indicated, and participating in follow-up care in the attending surgeon’s office or clinic. I would put this section directly underneath the description of the training sites

Educational Conferences

The goal of the educational conferences of the residency is to provide the opportunity for residents to learn in depth the fundamentals of basic science as applied to clinical surgery. These include but are not limited to the elements of wound healing, hemostasis, hematologic disorders, oncology, shock, circulatory physiology, surgical microbiology, respiratory physiology, gastrointestinal physiology, genitourinary physiology, surgical endocrinology, surgical nutrition, fluid and electrolyte balance, metabolic response to injury including burns, musculoskeletal biomechanics and physiology, immunobiology and transplantation, applied surgical anatomy, surgical pathology and image interpretation.

Core conferences of the Department include Surgical Grand Rounds, Morbidity and Mortality Conference, and Resident’s Conference/Core Curriculum, and weekly skills sessions, all of which meet weekly and attendance is mandatory. (Surgical Grand Rounds and Residents’ Conference are suspended during the summer months of July and August). Additional required conferences include numerous service-specific and hospital-specific conferences and the Summer Resident Lecture series.

Annual Events

- Farewell & Welcome Dinner- mid June
- Resident Roast- early to mid-June
- Resident Retreat- August
- Resident Holiday Breakfast- December
- Softball Game- May
- Grand Rounds- Monthly/ Wednesday’s
- Mock Orals- Fall (Senior Residents) Spring (Junior Residents)
- M&M- Monthly/ Mondays
- Multidisciplinary Tumor Board- Monthly
- Start of New Academic Year- June 22, 2017

RESIDENT OPPORTUNITIES

a. Residents are able to request special assignments for consideration by program leadership - research, medical informatics, etc. These are considered on a case-by-case basis. Residents on probation will not be considered for these special assignments. Special assignments include but are not limited to representing the department on the Quality Committee and GMEC Committee

b. The faculty award for Intern of the Year recognizes outstanding performance of a first-year resident. This is open to all PGY1 level residents in the General Surgery residency program. This award is presented at the annual welcome/farewell celebration.

c. The John L. Keeley, MD Surgical Fellowship Award is an annual award of $5,000 to $8,000 provided to one or two selected General Surgery residents for educational travel during the Chief Resident year. Senior trainees in the other Department of Surgery training programs are also eligible for this award. Proposals are submitted mid-year and decisions are made in the late winter by a Committee comprised of the Vice Chairs and Director of Administration in the Department of Surgery.

d. The Jack Pickleman Award for Teaching is presented to the resident chosen by medical students as best exemplifying excellence in clinical teaching. These ratings are collected through the Stritch School of Medicine Student Evaluation System. This award is presented at the annual welcome/farewell celebration.
e. The Juan Angelats Service Award is open to faculty, staff, alumni, fellows, residents, and emeritus faculty that have demonstrated a patterned long-term behavior of service. Nominations are invited in early spring of each academic year. This award is presented at the annual welcome/farewell celebration.

f. The Robert J. Freeark Trauma Resident Award is presented to a PGY4 resident who demonstrates excellence in performance in trauma/surgical critical care. The selection committee for this award consists of the faculty members in the Division of Trauma, Critical Care and Burns, the trauma nurse coordinator, nurse practitioners, and the SICU pharmacist with input from nursing and other support staff dealing with the trauma service and trauma patients. This award is presented at the annual welcome/farewell celebration.

g. Resident Service Award is presented at the annual welcome/farewell celebration and provides a small amount of funds for a service project designed by a resident. This award is designed to help foster the desire for service and to give back to the community.

h. Opportunities to attend local surgical meetings (e.g. Chicago Surgical Society, Chicago Metropolitan Trauma Society, etc.) are provided to residents on an invitation basis. Announcements regarding these opportunities will be sent by email from the Department’s Education Office.

Resident Mentoring Program
Loyola University Medical Center
Department of Surgery

Mission Statement
• The focus of the Resident Mentoring Program is to promote personal and professional resident success on an individual level.

Program Design and Vision
• **Mentor Selection:** Ideally, each resident will select a mentor of their own preference and should directly ask the attending to be his/her mentor. New residents (PGY1 or otherwise) will be assigned a mentor at the onset of joining the department. This mentor can be changed at any given time at the discretion of the mentor or mentee. The mentee’s surgical area of interest does not necessarily need to be related to this selection.

• **Mentee Responsibilities:** The mentee will be responsible for setting up a meeting with their mentor within the first two weeks of their first academic year at Loyola. They will also be required to meet with their mentor on a bi-annual basis to review their Resident Self Evaluation form, prior to meeting with the Program Director. Additional meetings should be scheduled as needed.

• **Mentor Responsibilities:** The mentors will volunteer their time to meet with designated mentees and be available for professional and personal guidance as needed. Mentors should consider inviting mentees to group meetings with their department, dinners with guest speakers, groups meetings with all of their mentees, etc. Mentors should be aware of any personal or professional deficiencies that the mentee may be encountering, and be actively involved in helping the resident construct a plan for improvement.

• **Relationship Structure:** At the first meeting between the mentor and mentee, they should establish how they envision the relationship and anticipate what issues may need to be addressed. Other than the bi-annual resident evaluations, there will be no other meeting or paperwork requirements. This relationship should be developed with whatever structure the mentor and mentee select.
**Program Goals**

- The mentor will help address concerns in an unbiased and confidential manner by facilitating coaching sessions for residents in need.
- It will help provide residents with the structure, resources, and accountability necessary to develop personal success.
- This relationship will allow mentees to seek advice from experienced surgeons on how to organize, study, select a career, etc.
- Mentees should feel free to discuss personal work/life balance and issues the resident is facing in their day-to-day life of being a resident. It should be an open and honest relationship.
- Mentors will have access to their mentee’s profile and be able to review the mentee’s evaluations from recent rotations, in order to provide educated feedback for the mentees.
- Mentors will also have access to their mentee’s ABSITE scores and mock oral exam performance evaluations, in order to help the mentee continue to improve.
- Mentors should ask the mentees about their research involvement and encourage them to actively participate in at least one project each year.
- Mentees should discuss their career goals with their mentors and engage in conversations about how to pursue these goals. The mentee should be prepared to provide insight into how they plan to further their aspirations.

**RESIDENT MENTORS**

Each resident in the program is REQUIRED to have a mentor. Incoming residents will be assigned to a faculty or chief resident to serve as their mentor for the first year. The mentor does not necessarily need to be in their potential area of interest. All faculty members in the department of surgery are willing to serve as mentors. It is required that the resident meet with their mentor for the first time every academic year before July 31st and then at least quarterly, thereafter.

All in-coming residents are assigned a faculty mentor to serve as a teaching advisor, research mentor and as a role model. The mentors can contribute to the development of the residents teaching and clinical skills, career management, and networking.

All in coming residents are also assigned a peer mentor who will help the resident navigate the hospital culture, get them acclimated with specific computer systems, serve as a resource for questions regarding the institution and how things work on specific rotations. In addition to that, it provides the PGY1 resident the ability to foster a long term relationship as they go through the program.
Section II: General Surgery Selection, Advancement & Retention Criteria:

**SELECTION OF RESIDENTS**

Residents will be selected on the basis of their application. The applicant’s academic record, scores on standardized tests, letters of recommendation, and personal interview are used in the selection process. In General Surgery, Vascular Surgery, and Surgical Critical Care, residents and fellows are selected through the National Resident Matching Program. In Plastic Surgery, residents are selected through the San Francisco Matching Program.

Additional information regarding Resident Eligibility and Selection can be found in Section II.C. of the Loyola University Medical Center Resident Handbook found at the following site: https://www.loyolamedicine.org/gme/current-housestaff

**ADVANCEMENT OF RESIDENTS**

Residents are advanced from year to year based on their performance. Their performance evaluation will be derived from, but not limited to, written and oral evaluation by the faculty, nurses, and patients; written and oral evaluation by their fellow residents, written and oral evaluation by students, and scholarly achievement. Although the faculty may discuss a resident’s performance at any time, the performance is reviewed semi-annually with the Program Director or Assistant Program Director and at least once a year by the entire surgical faculty.

Additional information regarding policies pertaining to Advancement can be found in the Loyola University Medical Center Resident Handbook Section III.G. found at the following site: https://www.loyolamedicine.org/gme/current-housestaff

**CRITERIA FOR RETENTION**

Interns and residents who are enrolled in the General Surgery Training Program at Loyola University Medical Center are required to achieve a level of competence in several areas and demonstrate their ability to progress to a higher level of training. In general, all interns and residents are required to abide by all of the rules and regulations set forth in the Graduate Medical Educational Manual for the Loyola University Medical Center, and also abide by state and federal laws governing health care. Specifically, interns and residents are evaluated at least on a semiannual basis with regards to their clinical evaluations obtained on each rotation, attendance at conferences, and fulfillment of administrative duties. The academic performance evaluation is based on the raw and percentile score on the annual American Board of Surgery In-Training Examination held annually in January, as well as performance on the mock oral examinations, and any other written or oral examinations conducted during the academic year. In order for a resident to progress to a higher post-graduate level, he/she must demonstrate competence in the six core competencies, as outlined earlier in this handbook, and obtain a satisfactory evaluation. While a failing grade in any specific area or rotation does not constitute grounds for dismissal, failure to improve and failure to demonstrate adequate progression can be considered grounds for retention at the same postgraduate level for another year, or grounds for dismissal from the program. Similarly, individuals on academic or administrative probation who fail to improve their performance clinically and academically, and who fail to achieve the outlined goals set forth by the Program Director may be dismissed from the residency program.
Section III: Specific General Surgery Policies:

Research Residents

The purpose of this document is to clearly communicate the terms and conditions of the Surgical Research Resident.

Responsibilities: Research Residents report directly to their immediate laboratory supervisors, who will assign the Residents their responsibilities for this appointment. Any work requests from outside the assigned laboratory will require prior approval and signatures from both the immediate supervisor and PI. Surgical Research Residents are expected to attend all the Department of Surgery Conferences (M&M, Grand Rounds, Lecture & Skills Sessions) in addition to participating during Resident Recruitment Season. Research residents who leave the lab with unfinished manuscripts will devote the entirety of their PGY4 elective month to complete the work. The determination of uncompleted manuscripts and degree of completion is to be determined by mentor and trainee.

Moonlighting: Moonlighting must not interfere with regular laboratory research work hours, which are generally Monday – Friday, at a minimum of 40 hours per week. Therefore, Research Residents will be allowed to moonlight one shift per week, on weekends only.

Time Off: Research Residents receive 20 days of vacation time each fiscal year (July – June.) These days must be used within this time frame, and cannot be carried over. Any unused days are lost on June 22nd of each year. Research Residents also receive educational days at the discretion of the supervisor, on a case-by-case basis.

Moonlighting is requested by completing a Leave of Absence (LOA) form in advance. This form can be obtained from the front office. A signature from the immediate supervisor/faculty member is required, to indicate their approval of the time. The form is then given to Kristin Wojtulewicz, Division Administrator for Surgical Research, for processing. A fully-executed copy will be returned to the research resident.

Clinical Experience and Education

Compliance with the ACGME duty hours requirements is a responsibility shared by faculty, residents, and fellows. Duty hours are to be logged in a timely manner at least every two weeks. Infractions are to be reported to the Office of Education or to the Administrative Chief Resident so that corrective action can be taken.

Maximum Hours of Clinical and Educational Work per Week
Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

Mandatory Time Free of Clinical Work and Education
Residents should have 8 hours off between scheduled clinical work and education periods. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
Maximum Clinical Work and Education. Clinical and education work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing transitions of care, and/or resident education.

We encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. In unusual circumstances, residents, on their own initiative, may elect to remain or return to the clinical site to continue to provide care to a single severely ill or unstable patient, for the humanistic attention to the needs of a patient or family or to attend unique educational events. These additional hours of care or education will count toward the 80 hour weekly limit.

In-House Night Float
Night float must occur within the context of the 80-hour and one day off in seven requirements.

Maximum In-House On-Call Frequency
Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

At-Home Call
Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical work and education, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to provide care for new or established patients. These hours of inpatient care must be included in the 80-hour weekly maximum limit.

Additional information regarding Duty and On-Call Hours can be found in the Loyola University Medical Center Resident Handbook Section II.E. located at website: https://www.loyolamedicine.org/gme/current-housestaff

SUPERVISION

Whereas responsibility for residents is graduated so that with increasing experience the resident has increasing responsibilities, resident supervision is likewise graduated. Beginning residents are supervised by the faculty as well as their more senior residents. Intermediate residents are supervised by senior residents as well as faculty. Senior residents are supervised by the faculty. There is no “resident run service” that is independent of faculty supervision. The amount of supervision will depend upon the level of training and expertise of the individual resident.

a. Faculty surgeons are always in house at Loyola.

b. There are faculty call schedules that outline continuous supervision, consultation, and availability

c. If any faculty member or resident notices that a resident is fatigued and cannot perform their duties, that resident will be relieved immediately of their responsibility for patient care.

d. Operating Room Privileges:
   Limited Privileges: defined as licensed residents (beyond the first year) with operative experience who are qualified to begin and close independently. They perform the key portion of the operation under the supervision of the attending.
**Full Privileges:** limited to senior residents (PGY 4 and 5) who can operate in emergent circumstances without supervision. In these circumstances residents with full privileges can start surgery without the presence of an attending surgeon. For elective procedures, the attending should be present for the key portion of the operation.

d. Intensive Care Unit and Floor Procedures:

**Limited Privileges:** defined as licensed residents with bedside procedural experience who are qualified to begin a procedure independently. They perform the key portion of the procedure under the supervision of the attending and/or credentialed resident.

**Full Privileges:** limited to residents who have been credentialed in the performance of the procedure. Credentialing will be achieved by the supervised performance of the procedure by an attending or senior level credentialed resident, who will sign off on the credentialing following the successful completion of a set number of these procedures.

Senior level residents are defined as those who have completed at least 2 post-graduate years (PGY-3 and above). A Chief resident is defined as a PGY-5 or greater.

Procedures to be done independently by house staff only with the attending physician’s permission and instruction are:

<table>
<thead>
<tr>
<th>Procedure*</th>
<th>Limited/Supervised</th>
<th>Full/Unsupervised</th>
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<td>Arterial line placement</td>
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<tr>
<td>Tracheostomies</td>
<td>PGY 1,2 attending supervision</td>
<td>Senior resident, 10</td>
</tr>
</tbody>
</table>

*The supervising attending needs to be notified prior to performance of the procedure unless in emergent circumstances.

Additional information regarding Supervision of Residents can be found in the Loyola University Medical Center Resident Handbook Section II.L. Found at website: https://www.loyolamedicine.org/gme/current-housestaff

**TRANSITIONS OF CARE**
PURPOSE: To minimize number of transitions in patient care and to comply with the Institutional and specific program Residency Review Committee (RRC) accreditation requirements established by the Accreditation Council for Graduate Medical Education (ACGME).

POLICY:

- All patient hand offs should take place in a designated workplace, office, or conference room to ensure patient confidentiality and lack of distraction. Hand offs in public areas such as hallways, cafeterias, and elevators are prohibited. 
- It is acceptable to conduct hand-offs over the phone in the morning, as long as both parties are in an appropriate room, without other distractions. However, hand-offs in the evening should always occur in person in designated work area.
- Hand-offs should only occur with direct one-to-one communication between the resident responsible for the patients being released and the resident that will be taking over their care. No third party communication is allowed.
- The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:
  - Identification of patient, including name, medical record number, and age
  - Identification of admitting / primary / supervising physician and contact information
  - Diagnosis and current status / condition (level of acuity) of patient
  - Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
  - Outstanding tasks – what needs to be completed in immediate future
  - Outstanding laboratories / studies – what needs follow up during shift
  - Changes in patient condition that may occur requiring interventions or contingency plans
  - Contact information of senior resident on-call
- On-duty residents are required to follow up on pending diagnostic studies and update on-call senior residents and / or attending regarding results once they return.
- Hand-offs during the first month of residency should be conducted in the presence of a senior resident of attending physician to ensure that residents are competent in communicating with team members in the hand-over process.
- Always allow ample time for the resident receiving sign-out to ask questions.
- Exchange contact information in the event there are any additional questions.
- Always scrutinize and question data if “something does not make sense” or if you think it is wrong.
- Use the virtual pager for the service you are covering when on duty. Sign on when you start duty and sign out the pager to the appropriate person at the end of your shift. Use the virtual pager number for all communications with caregivers and written records.
- Current call schedules for all services that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care are posted on the surgery education website: https://www.loyolamedicine.org/gme/general-surgery-residency/department-surgery-residency-materials

MOONLIGHTING

Moonlighting (i.e., employment outside the Department of Surgery) is not permitted during clinical rotations for residents in the Department of Surgery. Moonlighting while on clinical rotations is grounds for immediate dismissal. For Surgery residents participating in research, approval must be obtained annually from the Program Director prior to starting any moonlighting arrangement. Please contact the Residency Program Coordinator for the appropriate forms to fill out. Failure to do this will negate that resident’s ability to moonlight for the remainder of the year.

VACATION
First-year General Surgery residents are currently granted leave for a one-month period, which includes three weeks of vacation and one week of self-directed educational leave. (This arrangement is subject to change at any time.) **Vacation requests for PGY1 residents must be received by the Office of Education by June 1st. The incoming residents will be contacted by the Department of Education to acquire these dates.** First-year General Surgery residents may take four weeks of paid time off per year equaling 20 days (not counting Saturdays and Sundays). These days include any education leave for conferences unless presenting at a conference for the Department of Surgery - in which case the days that the resident is attending a conference for presentation will count toward duty hours.

**Vacation requests for all other PGY levels MUST be received by the Chief Administrative Resident by July 15 (or the date decided by the Chief) for the upcoming academic year.** Vacations will be taken in one-week blocks, equaling 20 days (not routinely counting Saturdays and Sundays, including Educational Leave). These days include any education leave for conferences unless presenting at a conference for the Department of Surgery - in which case the days that the resident is attending a conference for presentation will count toward duty hours. Changes in vacation requests will be considered, but must be submitted no less than four weeks prior to the schedule change, unless there is an emergency or other extenuating circumstances arise.

**Vacation will not routinely be granted during the first two weeks in July, and the last two weeks in June or during the Winter Holidays.** I would say “not granted during the months June and July or during the Winter Holidays” Vacations will also not routinely be granted during rotations on the trauma service and burn service. All requests will be reviewed and approved by the Program Director, and the Administrative Chief Resident.

**Note:** The academic year begins June 22 and ends June 21. Chief residents and other outgoing trainees are expected to be available until June 21 unless a vacation or leave has been approved by the Program Director and Chief Administrative Resident.

Vacation leave requests are typically granted on seniority and a first-come, first-served basis. Considerations in approval of vacation requests will include:

a. No other resident on that service or call schedule has requested similar leave.

b. No more than one Chief Resident is away from the general surgery services at Loyola, or no more than one of two senior residents away at Resurrection, at any one time.

It is the responsibility of the Chief Resident of the service to arrange for backup of his or her junior resident staff during any periods of any leave. The backup Chief Resident is to be identified to the junior resident staff and attending staff in advance of the Chief Resident’s departure.

**LEAVE POLICIES:**

**EDUCATIONAL LEAVE**

Educational leave is offered to attend local, regional, or national scientific meetings, CME conferences or at-home study time for first year residents (included in the combination vacation/educational leave). Presentation of research work at such meetings is also considered in this category. All requests for educational leave, including presentations, should be submitted through the Office of Education and will be reviewed by the respective Program Director and Chief Administrative Resident. Approval will be based on the resident’s clinical performance, punctual medical record keeping, attendance at mandatory resident conferences, and current upkeep of surgical logs. If a resident is submitting an abstract, the educational leave is to be submitted with a proposed budget at the time of abstract submission. There is no guarantee that leaves will be granted, but every opportunity will be considered to try and allow the resident to present his/her work.

a. Educational leave for first-year residents is one week out of their one month off (in combination with their vacation leave).
b. Educational leave for all other residents will be considered if the resident is presenting a paper at a local, regional or national society meeting. Part of approving the leave will be based on whether the society accepts a written paper of the project for publication. Ultimately, it is at the discretion of the Program Director to approve this leave.

c. All residents may be eligible for $1,000 per year to attend a scientific or educational surgical program. This may include a research paper presentation. The ultimate decision for funding will be based on the resident’s educational benefit in attending the program (presenting original, scientific work, pursuing career interests, or assisting in preparation for ABSITE or Board exams) and will be made by the Program Director based upon availability of educational funds.

d. All leave requests must be accompanied by a projection of anticipated expenses and an itinerary of the educational activity, which should be submitted to the Office of Education in a timely manner.

- Reimbursement for standard rooms rates apply.
- Meals provided at a meeting should eliminate the need for some meal reimbursements.
- Per diem rates are paid according to the location of the educational activity.

e. Upon completion of an educational trip, the resident must submit complete documentation accompanied by original, itemized receipts for reimbursement to the Office of Education. The resident will be reimbursed within four to six weeks from the date the Employee Expense Reimbursement Form is submitted.

f. Educational Leaves may NOT be requested for:

- the first two weeks in July, except if presenting.
- the last two weeks in June, except if presenting.

g. All leaves must be approved at least four weeks in advance of the requested time.

- Documentation of the scientific society or educational meeting must accompany your request.
- Include a copy of the acceptance letter and/or a copy of the manuscript, if you are first author or presenting a paper.
- Copies of all abstracts and manuscripts generated as a result of presentations must be submitted.

h. Educational leave will be capped at seven days per year for all residents, which is included in the resident’s 20 days of vacation. The day of presentation is included in the resident’s duty hours, but any additional days spent at a conference will be subtracted from their vacation time. An exception is made for the recipient of the Keeley Award, which is considered above and beyond routine educational and vacation leave.

i. There is no carry-over of educational leave from year to year.

OTHER LEAVE

Trainees are eligible for up to twelve days of paid sick leave during one academic year. Individuals may request additional leave for grieving, maternity or paternity leave, or for other personal reasons. These requests must be approved by the Program Director, must comply with the general policies of the Loyola University Medical Center Graduate Medical Education Rules and Regulations, and also must comply with the requirements set forth by the American Board of Surgery. An individual may arrange for any amount of time of unpaid leave with specific approval from the Program Director. As a general rule, residents will not be granted any leave to perform off-site rotations or clinical or basic research. Information about types of leave permitted can be found at the Graduate Medical Education website: https://www.loyolamedicine.org/gme/current-housestaff

Requests for leave for interviews will be capped at five days per year for all residents. Beyond this limit, any additional time taken for interviews will be deducted as vacation leave.
MATERNITY/PATERNITY LEAVE

It is the policy of Loyola to grant residents maternity/paternity leave for the birth, adoption, or foster care placement of a child. In granting maternity/paternity leave, Loyola will follow the requirements of the Family Medical Leave Act of 1993. Please refer to the Graduate Medical Education website for further information: https://www.loyolamedicine.org/gme/current-housestaff

FAMILY LEAVE

A leave of absence may be granted when extenuating circumstances require an employee’s absence. A staff employee with six or more months of service is eligible for a general leave of absence in up to 12-week or three-month increments to a maximum period equal to one’s length of employment but for no longer than two years. Under the Family and Medical Leave Act (FMLA), an employee, after working 12 months (not necessarily consecutive) and 1,250 hours, is eligible for up to 12 weeks of unpaid leave unless circumstances allow paid-time-off banks to be used. Please see the Graduate Medical Education website for more information: https://www.loyolamedicine.org/gme/current-housestaff

PERSONAL LEAVE

A resident may request a personal leave of absence from the program director. A leave agreement must be formalized in writing between the resident and the program director prior to the beginning of the leave. Requests for leave of absence in the first twelve (12) months of training are limited to situations that would otherwise be covered by the Family Medical Leave Act (FMLA). Leave of absences for reasons other than this during the first twelve months of training are not allowed. To begin the process, the resident must submit a written request to the program director at least 30 days prior to the beginning of the leave (except in case of emergency). The Leave of Absence Form, obtainable from the Central Office of Graduate Medical Education, must contain the reason(s) for the leave, beginning and return dates, the resident’s signature, and the program director’s approval and signature. A leave of absence should not exceed eight weeks. Benefits coverage is continued during leave under the conditions specified by the Loyola personnel policy. A resident must first use available paid time off and sick time (where applicable). Once available paid time off and sick leave if applicable are exhausted, RESIDENT HANDBOOK Policies and Procedures subsequent leave will be unpaid at which point the resident will be responsible for maintaining benefits at their own expense. If a personal leave compromises a resident’s ability to satisfy specialty board training requirements, the written leave agreement should specify how these requirements will be made up. A resident member may be required to extend the training period for any dates of absence in excess of allowable paid time off. During the extension, the resident member will receive regular salary and benefits except for paid time off allowance.

LEAVE PROCEDURE

a. Residents are to fill out a LOA form for all vacations and leaves, including conferences and other educational activities, and submit it to the Office of Education in a timely manner.
b. For General or FMLA Leave you must also contact the FMLA Office no more than 30 days prior to your scheduled leave at 708-327-3652 or email LOY-7fmla@lumc.edu
c. A Leave of Absence Form will need to be completed by you and then forwarded to the proper offices for approval. The form can be obtained at the Office of Education.
d. Within two weeks, the Office of Education will notify you as to the disposition of your request.
e. Failure to submit LOA form and being away from campus is grounds for immediate dismissal from the program.

PROFESSIONALISM POLICY
In accordance with the ACGME Professionalism Competency, Residents must meet certain Milestones in 3 practice domains of Professionalism. Those are Care for Diseases and Conditions, Maintenance of Physical and Emotional Health, and Performance of Administrative Assignments and Administrative Tasks. (Surgery Milestones can be found at www.acgme.org/Portals/0/PDFs/Milestones/SurgeryMilestones.pdf)

In order to meet the Professionalism requirements, residents **must:**

- log in their operative cases on a weekly basis
- complete New Innovations evaluations on a timely manner (75% min requirement)
- respond promptly to requests from faculty & staff
- attend conferences, meetings promptly & on time (75% attendance min. requirement)
- effectively and efficiently manage time and assures fitness for duty
- monitor personal health and wellness
- appropriately mitigate fatigue and/or stress
- demonstrate commitment to continuity of care
- respond to pages and consultation promptly
- be honest and trustworthy
- respect patient confidentiality
- Timely and accurate logging of duty hours at least every 7 days
- Education of housestaff and medical students. (Students complete evaluations of residents on their services.)
- Medical records - quality and timeliness (refer to Medical Record Policy)
- Patient care
- Completion of Step 3 exam prior to the end of 3rd year of residency
- Completion of FLS by PGY3 year
- Completion of FES by PGY5 year

Residents must also meet the overall resident responsibilities of achieving acceptable performance on ABSITE and other in-training exams. There is a mandatory remediation for residents scoring less than 30th percentile on ABSITE.

If applicable an authorship or co-authorship of one paper and/or presentation of one abstract at a scientific meeting during each year of training.

Residents who are not meeting the professionalism requirements **will not** be able to access Book/Continuing Education Funds and can face corrective action.

**MEDICAL RECORD POLICY**

Comprehensive patient care documentation is a must, and record keeping must be done on a timely basis.

Residents are not to copy medical student notes or co-sign them, you must write the notes yourself.

Completion of medical records in a timely fashion will be monitored routinely and is considered as a component of the semi-annual resident performance evaluation. Failure to comply with these policies will lead to administrative probation.

The properly completed Admission Note should clearly identify:

- clinical justification for the admission
- an outline of the proposed treatment plan
- reason for patient transfer to LUMC (if applicable)
- reason for patient’s re-admission within seven days of prior discharge from any hospital (if applicable)
History and Physical, Progress Notes, Consultations, Operative Reports, etc. are to be recorded within a 24-hour period.

Procedure Notes: All invasive procedures must be documented with a dated and timed procedure note. Standardized forms or templates are available in the electronic record and can be used for this purpose.

All major clinical events such as cardiac arrest and transfers to the intensive care unit must be documented in the progress notes. These notes should be dated and timed, outlining the clinical situation, interventions, and disposition. The note should also indicate that the Chief Resident and/or Attending have been notified.

The Discharge Summary must be completed at the time of discharge. The principle diagnosis (the condition, which after study, is determined to be chiefly responsible for the admission of the patient to the hospital) should be clearly identified. The principle diagnosis must be supported by the various tests, procedures, and notes contained within the complete medical record. The principle procedure (the procedure most related to the principle diagnosis) must be clearly identified.

All secondary diagnoses and procedures must be recorded.

All brief operative notes must be entered into the medical record within 24 hours of surgery, preferably immediately following the procedure.

Discharge Summaries must be completed within 24 hours after discharge. It is strongly suggested that summaries be completed at the time of discharge.

Verbal orders are to be electronically signed within 24 hours.

**All Medical Students’ notes and orders must be countersigned by the Resident or Attending Physician.**

The medical records and recorded diagnoses and procedures will be reviewed and attested to by the Attending Physician within 72 hours of patient discharge. It is imperative that you complete your records within the aforementioned timetable.

**IMPORTANT NOTE: PATIENT CONFIDENTIALITY MUST BE MAINTAINED IN ACCORDANCE WITH HIPAA REGULATIONS.**

**BOOK/CONFERENCE FUNDS POLICY:**

The Department of Surgery will reimburse PGY1 residents up to $200 per year for the purchase of the following materials. For PGY2 level and higher, the eligible amount is $400 per year.

a) Basic Textbooks of Surgery
b) Subscriptions to Medical Journals
c) Purchase of Surgical Loupes
d) iPads or Tablets (as approved by administration)
e) Appropriate educational electronic media

The department will reimburse all residents PGY1-PGY5 up to $1,000 per year for travel to an educational conference. Airfare, Hotel, Meals and Registration can be reimbursed.

Trainees are encouraged to take advantage of the Department of Surgery’s interest in supporting continuing medical education and must meet the required conference attendance and evaluation completion requirement prior to accessing funds. **Please note that the deadline for submitting original receipts for reimbursement of these funds is June 1st.** With any questions, please contact Adriana Ohl at Extension 7-3436.
TRAVEL POLICY

The following procedure will be implemented regarding reimbursement of expenses for approved travel. A Leave of Absence form with projected expenses must be pre-approved by the Program Director before travel takes place. Residents must also meet the min. 75% requirement for conference attendance and completion of evaluations. Those who do not meet the requirement will not be allowed to access funds.

a. Complete an Employee Expense Reimbursement Form. These forms can be obtained at any of the Department of Surgery offices at Loyola

b. A copy of conference material or flyer detailing meeting dates, hotel information, registration fee, meals and banquet inclusions, etc., must be attached to the travel expense report.

c. Unusual circumstances require an explanation, i.e., extra overnight stay to reduce airfare.

d. There is a pre-set per diem permitted for expenses other than lodging, airfare, and meeting registration costs. The per diem is determined by the location of the educational event. The per diem for domestic and international sites can be found at: http://www.luc.edu/finance/policies.shtml. The figure to note is the M&IE (Meals and Incidental Expenses). Deducting meals already provided in the conference/event, this will be the limit of the funds available per day. For travel days, this amount decreases incrementally.

e. Attach original, itemized receipts and documentation. Receipts are required for all expenses and for all lodging, airfare and meeting registrations. The receipt must confirm that this amount has been paid. Receipts from on-line reservations (Conlin)/purchases are acceptable.

f. Forward material to Adriana Ohl, Education Coordinator, Department of Surgery, Bldg. 110, Room 3210, LUMC.

g. If the form or documentation is incomplete, the material will be returned to you, requesting additional information.

h. Reimbursement in the way of addition to your paycheck typically takes 3-4 weeks upon approval.

REIMBURSABLE EXPENSES

*AIR FARE
Reservations should be made as early as possible in advance of travel to obtain the lowest rates available.
Documentation: Original Passenger Receipt

*TAXI
To and from airport (home).
Documentation: Original Receipt.

*LIMO / BUS / SHUTTLE
To and from airport and meeting destination
Documentation: Original receipts.

*HOTEL
SINGLE ROOM ONLY - at moderate rate.
Documentation: Original ITEMIZED hotel bill
Do not do room service, if you do please pay separately, not on hotel bill

*MEALS
Included in the pre-set per diem M&IE (Meals and Incidental Expenses) rate for each location

*REGISTRATION FEE
If presenting, registration is frequently paid by the organization hosting the event. Residents and fellows should register at a discounted rate, if available.
Documentation: Original receipt or canceled check (front and back)

* BANQUET FEE
Documentation: Original receipt or canceled check (front and back)

* MILEAGE
Current reimbursement rates can be found at http://www.luc.edu/finance/milereim.shtml and should not exceed lowest possible airfare.

Reimbursement will be in accordance with Loyola University guidelines regarding airfare, taxi, hotel, meals, etc. The guidelines are available at the following website listed as Travel & Business Expense Policy: http://www.luc.edu/finance/policies.shtml. These policies are subject to change without notice. It is the trainee’s responsibility to inform themselves regarding these policies prior to incurring travel expenditures.

NOTE: Final approval for ALL Educational Leaves of Absence and Reimbursements will be at the discretion of the Program Director and Chairman of the Department of Surgery. Residents will not be allowed to take an educational leave without this advanced written approval.

Departmental Corrective Action Policy

a. Academic Warning - The resident is in jeopardy of being placed on academic probation based on troublesome clinical or educational performance. The resident will be counseled as to specific deficiencies and potential steps for remediation. This status will be reassessed at the subsequent semi-annual evaluation (or at the discretion of the Program Director) and will either be removed or changed to academic probation. An academic warning is not considered a disciplinary action.

b. Administrative Warning - The resident is in jeopardy of being placed on administrative probation based on concerns about performance of administrative duties such as medical record upkeep (resident must be up to date on charting at the end of every month), operative log maintenance (resident must log at least every 30 days), or compliance with logging duty hours (residents must log duty hours at least every 7 days). The resident will be counseled as to specific deficiencies and methods to remediate them. This status will be reassessed within 30 days of the date of warning. If the violation is not corrected within the 30 days given; the resident will be placed on full Administrative Probation for 3 months. In addition, the Service Chief of the surgical service the resident is currently rotating on will be notified to pull the resident from all operating privileges until the violation is corrected. An Administrative Warning is not considered a disciplinary action.

c. Academic Probation - Academic probation, either with or without prior academic warning, will be considered based on one or more of the following: clinical scores from performance evaluations significantly lower than peer group (average is 3.0), ranking below the 30th percentile of ABSITE participants, failure of the oral examination (either the departmental or the city-wide oral exam), substandard teaching of medical students, attendance rate of less than 75% at mandatory conferences.

Academic probation will entail a structured plan for remediation of identified deficiencies through a personalized tutorial program with a designated faculty member. A tutorial plan will be outlined by the Program Director and reviewed with the resident. Periodic progress meetings with documentation will
occur. All faculty members will be notified of residents on academic probation. Probationary status will be reassessed at the subsequent semi-annual evaluation or at the discretion of the Program Director and is either continued or rescinded.

c. Administrative Probation - Grounds for administrative probation include: a consistent pattern of medical record delinquency, propensity of unsigned verbal orders, failure to comply with operative log submission policies, failure to log duty hours, and failure to complete evaluations. Administrative probation may involve any or all of the following: suspension from clinical duties, delay in approval to qualify for examination by the American Board of Surgery, loss of educational leave time, or immediate use of vacation days to remediate deficiencies.

Administrative probation may result in prolongation of the resident training program or a decision to terminate or not renew the resident’s contract.

Section IV: RESIDENT REQUIREMENTS

ACLS/BLS/ATLS/ Medical Licensure
Residents are required to maintain the following certifications during their General Surgery residency training:
- ATLS (expires after 4 years)- www.facs.org/quality-programs/trauma/atls
- ACLS (expires after 2 years)- http://www.luhs.org/internal/depts/ess/training.htm
- BLS (expires after 2 years)- http://www.luhs.org/internal/depts/ess/training.htm
- Physician license (temporary or permanent)- https://www.idfpr.com/

Residents are expected to know the expiration dates of their certifications and should plan accordingly for renewals. The Office of Education will be available to assist with this process but the ultimate timing and responsibility will be on the individual resident.

Surgical Operative Log

It is important to keep accurate records and logs of all the operations and procedures performed during one’s residency. In general, a resident can be categorized as the surgeon, assistant, or teaching assistant on any procedure. Cases as a Chief Resident are kept in a separate category. It behooves every resident to keep track of all minor procedures performed, including placement of central lines, swan ganz catheters, arterial lines, chest tubes, angiograms, and rigid and flexible endoscopies. Keeping track of other procedures such as intubation, peritoneal lavage, and cut downs are also important. For Vascular Surgery, Plastic Surgery, Surgical Critical Care, and General Surgery, each trainee is able to enter his own operative cases on line. The ACGME Surgical Operative Log with detailed instructions can be found at: http://www.acgme.org/acgmeweb/tabid/161/DataCollectionSystems/ResidentCaseLogSystem.aspx

New residents will receive a log-in and password once entered into the Accreditation Data System by the Residency Coordinator or assistant.

It is imperative that the Surgical Operative Logs be kept current.

Reports will be generated from the Office of Education and reviewed at the Semi-Annual Resident reviews (or at the discretion of the Chiefs of Service). Compliance with this policy will be part of the resident's performance evaluation. Consistent delinquencies will be considered grounds for administrative corrective action and ultimately administrative probation if failure to comply.

Failure to submit surgical operative logs in a timely fashion will be grounds for revoking operating room privileges until logs are up to date.

So that there is no misunderstanding in regard to your case records, the following definitions are to be the basis of your operative log:
a. **SURGERY DURING CHIEF YEAR (SC)** = Cases performed during the final 12 months of your residency (chief year)

b. **SURGERY AS JUNIOR RESIDENT (SJ)** = All operations performed during the four years prior to your year as chief resident (1-4). (see list of categories as defined by RRC) e.g. transplant, trauma, endoscopy, etc.

**DOES NOT INCLUDE**

Cases in which you supervised junior residents (see Teaching Assistants)

c. **TEACHING ASSISTANT (TA)** = Cases during your 4th and 5th year in which you were the principal supervisor of operations performed by junior residents.

**DOES NOT INCLUDE**

Cases in which attending surgeon was "scrubbed" and supervised the majority of the operation.

d. **FIRST ASSISTANT (FA)** = Operations in which you served as first assistant to a more senior resident or attending surgeon.

**FLS/FES**

Residents are required to have their FLS certification completed by their PGY 3 year. FES certification must be completed by fall of the senior year. Both certifications are ABS requirements. The Department will pay for both certifications. Please contact Adriana Ohl for further information and vouchers.

**Section V: ROTATIONS & INFORMATION**

**First & Second Year**

Training during the first two years in the General Surgery residency program provides a sound background for increasing responsibility for patient care. Residents are assigned to surgical services at affiliated hospitals to include Hines VA and Resurrection, where they gain invaluable experience. They work directly with experienced surgical faculty in an environment where progressive, supervised operative experience is available. Rotations include many of the general surgical services as well as SICU, Burns, Colorectal, MIS, Thoracic, Vascular, Transplant, Surg-One, and Endo/Peds.

**Third Year**

At the PGY3 level, residents are provided with the opportunities to develop independent clinical judgement, sharpen clinical skills and begin learning more sophisticated operative skills. Residents in the Endo, Peds and Burns rotations are the senior chiefs.

**Fourth Year**

At the PGY4 level, the senior years are designed to build independence and leadership skills. PGY4 Residents are the senior chiefs of the Thoracic, Resurrection, Vascular, SICU Days & Nights and Transplant rotations. They are also afforded the opportunity of 1 elective rotation of their choice.

**Fifth Year**

During the final year of clinical training, the chief residents manage the individual rotations that they are rotating on. Their goal is to assume leadership of the junior residents and medical students on their rotations. In addition to becoming familiar with complex clinical problems.
Curriculum/ Resident Experience

Core Competencies
The program requires that each resident obtain competencies in the following areas to the level expected of a new practitioner according to the guidelines of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Surgery. The following information is an outline of the general expectations for the Loyola Department of Surgery Residents.

| Patient Care | Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. |
| Medical Knowledge | Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. |
| Practice Based Learning & Improvement | Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals: 1. Identify strengths, deficiencies, and limits in one’s knowledge and expertise; 2. Set learning and improvement goals; 3. Identify and perform appropriate learning activities; 4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; 5. Incorporate formative evaluation feedback into daily practice; 6. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; 7. Use information technology to optimize learning; and 8. Participate in the education of patients, families, students, residents and other health professionals. |
| Interpersonal Communication Skills | residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to: 1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; 2. Communicate effectively with physicians, other health professionals, and health related agencies; 3. Work effectively as a member or leader of a health care team or other professional group; 4. Act in a consultative role to other physicians and health professionals; and 5. Maintain comprehensive, timely, and legible medical records, as applicable. |
| Professionalism | residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate: 1. Compassion, integrity, and respect for others; 2. Responsiveness to patient needs that supersedes self-interest; 3. Respect for patient privacy and autonomy; 4. Accountability to patients, society and the profession; and 5. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. |
| Systems-Based Practice | residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to: 1. Work effectively in various health care delivery settings and systems relevant to their clinical specialty; 2. |
Coordinate patient care within the health care system relevant to their clinical specialty; 3. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; 4. Advocate for quality patient care and optimal patient care systems; 5. Work in interprofessional teams to enhance patient safety and improve patient care quality; and 6. Participate in identifying system errors and implementing potential systems solutions.

Residency Schedules: Annual rotation, call and vacation schedules can be located at the Department of Surgery Website [https://www.loyolamedicine.org/gme/general-surgery-residency/department-surgery-residency-materials](https://www.loyolamedicine.org/gme/general-surgery-residency/department-surgery-residency-materials)

Section VI: Evaluation Process

Residents will be evaluated based on their clinical, academic, and administrative performance. Parameters to be evaluated will include:

a. Performance as recorded by faculty in the 6 core competencies (Medical knowledge, Patient care, Interpersonal and Communication skills, Professionalism, Practice - based learning and Improvement and Systems – based practice)

b. Attendance and participation in Resident Core Curriculum Conferences, Tumor Board, Morbidity & Mortality, Grand Rounds, Journal Club, etc. 75% required.

c. Performance on the American Board of Surgery In-Training Examination (ABSITE).

d. Case Logs up to date

e. Performance on the Mock Oral Examination

f. Teaching effectiveness as rated by medical students

g. Completion of medical records

h. Publications and presentations

i. Self-assessment

j. Duty hours log compliance

k. Evaluation completion compliance

l. Technical skills evaluation by the faculty

m. Peer to peer evaluations

n. Healthcare professional evaluations (nurses, nurse managers, NP, APNs)

o. Patient/patient family evaluations

Residents will meet with the Program Director, Associate Director, or Assistant Program Director twice each year to discuss their performance and progress in the program, as well as future plans. Residents will have the opportunity to review their respective portfolios at this time.
Should clinical, academic, or administrative performance be judged by the faculty to be of concern, several potential actions will be entertained.

Section VII: Miscellaneous Residency Resources

Program Evaluation Committee

Mission Statement:

The Program Evaluation Committee (PEC) is a liaison and review committee between the surgical residents and the Loyola Department of Surgery. It is composed of peer-selected surgical resident representatives and selected faculty representatives with the primary goal of improvement and innovation in the Loyola Surgery Residency program. The committee shall evaluate the current status of the surgical residency program on a monthly basis and create an open forum in which to discuss challenges, present new ideas/changes, and resolve conflicts with the overall goal of improving the surgical residency experience. The committee shall collectively work with the Department of Surgery and the Accreditation Council for Graduate Medical Education (ACGME) to enhance surgical education. The committee shall create and optimize program initiatives to plan the future of the General Surgery Residency Program.

Committee Objectives:

1. Create an open forum where surgical resident and faculty representatives can bring forth ongoing challenges, changes, or conflicts, including but not limited to resident education curriculum, duty hours violations, surgical team structure and composition, and annual resident scheduling.
2. Create an environment where collective thought and open discussion will find resolution for the questions that arise, while maintaining focus on the educational and training benefit of the surgical residents.
3. Build a committee that can foresee future obstacles and plan accordingly to prepare and enhance the success of the Loyola Surgery Residency Program.

Committee Structure:

1. The Chairperson of the committee shall be the Program Director. If the Program Director is unable to be present, one of the associate program directors shall hold the chair in the interim.
2. The faculty representatives are chosen from the faculty of the Loyola Department of Surgery and include faculty interested in investing themselves for the benefit of the residency program and who wish to take an active role in the future direction of the Surgical Residency Program.
3. The surgical resident representatives shall be elected annually from those that express interest in surgical residency improvement and will consist of the following:
   a. Administrative Chief Resident
   b. Education Chief Resident
   c. Surgical Skills Chief Resident
   d. 2 representatives elected from each clinical year by their peers
   e. 2 representative from each research year by their peers
   *Per resident feedback, meetings are now open to all residents/faculty to attend should they desire to*

4. The meetings shall take place on the second Monday of each month.

Surgery Program Evaluation Committee
• The Program Evaluation Committee responsibilities include:
  - Attend the monthly PEC Meeting
  - Reviewing the program annually to include evaluating current curriculum
  - Addressing any areas of non-compliance with ACGME standards
  - Developing and implementing any activities pertaining to education for the program
  - Reviewing the previous year’s program evaluations, faculty evaluations, resident evaluations and all other evaluations to address any areas of non-compliance or areas with needed improvement
  - The committee will track both resident and faculty performance and development- to include performance of program graduates on the certification of examination
  - Any and all initiatives to improve resident, faculty and program performance must have plan of action documented to include a delineation of how the plan will be measured and tracked
  - Plan of action must be approved by teaching faculty and documented

III. Emphasis on the Core Competencies in the Assessment of the program.

The evaluation process of the fellowship program will take into account the core competencies outlined by the ACGME. These competencies include:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
6. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Resident Professionalism and Support Group (RPSG) Policies and Procedures

I. **Mission:**
The Resident Professionalism and Support Group (RPSG) is a peer-selected group of residents joined by a faculty and staff advisor with a common goal to promote personal and professional resident success. The group will address concerns in an unbiased, objective, and confidential manner by facilitating improvement sessions for residents in need with the assistance of their faculty mentor. We shall provide residents with the structure, resources, and accountability necessary to develop personal and professional success.

II. **Committee Objectives:**
   a. Create an forum where resident and faculty or staff concerns may be addressed confidentially and anonymously in order to improve the residency experience and facilitate improvement and professional standards amongst the members of the residency program
   b. Help residents be successful during their residency experience at Loyola University Medical Center by providing support, structure, accountability and access to knowledge of resources
   - This will be facilitated in a confidential manner through 1:1 interactions with residents
   c. Build trust and rapport as a group and individual members with residents and faculty to create credibility and enhance the group’s success
   d. Brainstorm and develop processes to proactively address resident issues
Example 1: a “Transition Orientation” for residents returning to the residency program from their research experience
Example 2: Retreats or workshops for each class highlighting things to expect in the coming year and providing tutorials on items specific to each class such as completing USMLE Step 3, fellowship application process, writing a CV and Personal Statement, recognizing and avoiding burnout, etc.

III. Membership
This group shall consist of one resident representative from the PGY-2, PGY-3, and PGY-4 resident cohorts. There shall be two chief resident representatives. The chairperson shall be a PGY-5 resident who has met the criteria for election.

All candidates for membership must meet the following criteria:
1. Successful completion of 1 year of general surgery residency training at Loyola University Medical Center
2. Currently in good standing academically and professionally within the Department of Surgery and the Loyola University Medical Center

All members shall be elected on an annual basis in April of each academic year to begin his or her elected term on the first day of July. Each PGY cohort shall elect one representative to membership of the RPSG. Any member may be re-elected by his or her peers. There shall be no term limits for any member’s re-election.

The chair of the committee shall be elected on an annual basis in April to begin his or her term on the first day of July. The chairperson shall be elected by ballot casting of active residents of the General Surgery Residency program at Loyola University Medical Center. The chair of the committee must meet the following criteria in addition to the requirements stated above:
1. Successful completion of 4 years of clinical general surgery residency training
2. At least 1 year of active membership to RPSG
3. No ongoing referrals to RPSG

IV. Meetings and structure
a. The committee shall meet on the third Tuesday of each month, or more frequently, if deemed necessary by the chairperson or faculty/staff advisors.

b. All members shall be required to attend each meeting. If the member is unable to attend, they shall provide written or verbal announcement to the chair or faculty/staff advisors.

c. The standard for facilitating discussions and decision-making shall abide by Robert’s Rules of Order. Deviation from this outline shall be utilized at the discretion of the chairperson or the faculty/staff advisors.

d. The order of business shall be as follows:
   1. Call to order
   2. Roll call and designation of proxy voters as deemed necessary
   3. Reading review of the minutes of the previous meeting
   4. Old Business
   5. New Business
   6. Adjourn

e. For any voting procedure, a voting quorum must be present, defined by 50%+1 votes of the elected members. If a member is unable to be present at the time of the scheduled meeting, they shall reserve the right to vote by proxy or supply the committee with a written vote prior to the initiation of the meeting. Any member electing to vote by proxy, must provide written consent for such actions.

V. Procedure for Referrals:
a. Points of Contact
Residents or faculty shall bring concerns to the attention of the group by contacting any of the resident members or faculty/staff advisors. For academic year 2017-2018, committee member information please visit the department of surgery website- https://www.loyolamedicine.org/gme/general-surgery-residency/department-surgery-residency-materials
This group of residents and advisors shall present issues and concerns in an anonymous and confidential manner for discussion during meetings.

b. Process for Resident Assistance, Intervention and Remediation:
   1. All concerns brought to the attention of one of the members of the committee shall be addressed at the monthly meeting. Concerns will be addressed only at the group’s monthly meeting unless assistance is needed sooner in order to address concerns in a timely manner to facilitate confidentiality among the members and the residency program.
   2. The committee shall listen to all concerns, deliberate, and provide a potential plan of improvement. Deliberation and improvement plans shall be created with objectivity and professional improvement in mind. The decisions shall be made on a case-by-case basis according to the needs of the individual resident and commensurate with the level of significance and urgency of the concern or issue presented. This date shall be referred to as the “decision date”.
   3. The improvement plan or intervention shall be presented to the resident-at-hand by a senior member or faculty advisor of the RPSG and the appropriate faculty mentor for accountability. The committee member shall send an email to the faculty and staff.
   4. The resident shall provide an email acknowledging the discussion. Any explanation of changes, improvements, or methods by which he or she will attempt to accomplish the plan may be discussed. The resident shall complete this task before the second meeting following the “decision date”. If additional resources are necessary they shall be arranged.
   5. If the concern or issue persists or worsens, if the resident does not follow through with the aforementioned schedule, or if the resident exemplifies blatant disregard for the actions and improvement attempts by the committee by the second meeting following the “decision date”, a formal letter shall be placed into the resident’s permanent file. Additionally, the issue or concern shall be discussed to determine the appropriate suggested course of action and shall be brought to the attention of the program director and/or chair of the department of surgery.
   6. All topics presented at RPSG shall be discussed with complete confidentiality while maintaining the identities of residents anonymous, if necessary. If a committee member compromises the confidentiality of the meeting or topics, the RPSG shall discuss the infraction and the committee member may be removed from their position at the discretion of the committee. The member will be replaced in a timely manner according to the voting procedures as discussed above.
   7. In the event that an RPSG member requires discussion regarding concerns brought to the attention of the committee, he or she will be excused from that portion of the committee meeting. All discussion topics shall remain anonymous and the process of assistance, intervention, or remediation shall be performed as outlined above.

Reviewed and unanimously approved by the members of RPSG on April 19, 2016

LABORATORY COATS

Two laboratory coats embroidered with resident’s name will be issued to each resident per training year as needed, excluding research years.

Coats may be obtained 24 hours a day, 7 days a week on the third floor in the EMS Building. Soiled lab coats may be dropped off to be cleaned in the same location. The laundry process takes 1 week.

PAGERS

Pagers will be assigned to residents and fellows at the beginning of their training. They are to be returned to the Office of Education (Room 3210) upon completion or termination of training.
If replacement batteries are needed, or if the resident experiences difficulties with his/her pager, they are to report this to the Office of Education at Extension 7-3436. Residents will be held responsible for lost or broken pagers and may be charged to replace the pager.

CONTINUING MEDICAL EDUCATION

The Department of Surgery feels strongly that continuing medical education should begin with the onset of residency. Therefore, the items listed below will be of interest to you.

b. American College of Surgeons - Candidacy Group
   General Surgery residents are strongly encouraged to become members of the Candidate Group of the American College of Surgeons. There is no cost for membership for first-year residents. For PGY2 level and higher, the Department of Surgery will reimburse the membership fee in full upon receipt of proof of payment. Membership information for the American College of Surgeons can be found at the following website: http://www.facs.org/memberservices/resident.html.

   Trainees in other programs are also encouraged to join their respective professional groups of this type and membership fees will be reimbursed upon receipt of proof of payment.

DEBITEK MEAL CARD

The Department of Surgery will provide residents with a per diem rate of $12 per scheduled overnight call. “In-house” excludes home-call or being called in from home, and moonlighting. Overnight call must be a scheduled call that is at least 12 hours and that spans two calendar days. Funds will be directly added to your Red Debitek Meal Card.

Section VIII: BENEFITS

Details provided in the LUMC Resident Handbook and is available at the Graduate Medical Education website: https://www.loyolamedicine.org/gme/current-housestaff
For a printed booklet, please contact Adriana Ohl @ 708-327-3436
By signing this document, I ________________ MD attest that I have read and understand the Department of Surgery Handbook, it's policies and the Resident Code of Conduct.

______________________________  ______________________
Signature                      Date