

RIVERSIDE UNIVERSITY HEALTH SYSTEM

GENERAL SURGERY RESIDENCY

HANDBOOK

2025-2026



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**Riverside University Health System
General Surgery Residency**

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

This residency program believes and promotes the philosophy of excellence in surgical education. We have specifically arranged every rotation to enrich the experience of our residents. We believe this approach is the most effective way of teaching the science and the art of medicine and surgery. Our goal is to train safe, confident, and competent surgeons who will be tomorrow's leaders in the specialty of surgery. Each of you has different long-term goals: some to serve as community surgeons, and some as academic surgical researchers and educators. There is ample opportunity; we have developed a residency program that will satisfy the development of any of these goals.

MISSION STATEMENT:

- To have a residency program which is amongst the leaders in the area of surgical education
- To educate residents and medical students in the art and science of surgery.
- To recruit, support and retain faculty with high academic standards, who are committed to surgical education and are excellent role models to younger generations of surgeons.
- To maintain and foster a research environment that contributes to medical knowledge and stimulates innovative thinking in our residents and faculty.
- To foster an educational environment in which the mission of RUHS, Kaiser Permanente, Children's Hospital Orange County (CHOC) and Loma Linda University Medical Center is emphasized not only in the care of the patient, but also by helping our residents to become excellent surgeons while they continue to cultivate their cultural, social and spiritual life.

GENERAL EDUCATIONAL OBJECTIVES:

- To acquire a comprehensive knowledge base, clinical decision-making ability, and technical skills in the principal components of general surgery. These goals are fostered in an environment of progressively graded clinical and operative experience and responsibility.
- To acquire a broad experience in the additional components of general surgery, including acquisition of the appropriate knowledge base, the development of specific technical skills, and an understanding of the principles of decision-making particular to the specialty.
- To acquire the ability to quickly and effectively assess, stabilize, and manage (operatively or non-operatively, as appropriate) the patient with severe multiple injuries, regardless of the organ systems involved.
- To demonstrate the intellectual curiosity and commitment required to participate fully in the didactic curriculum of the residency program and to develop personal, life-long habits of self-study and continuing education.
- To develop professional habits consistent with sound ethical medical practice, including:
 - Effective interpersonal relationships with peers and other health professionals.
 - A compassionate attitude toward patients and their families and friends.
 - Clarity and timeliness of written communication in medical records and elsewhere.
- To develop General Competencies in areas recommended by the ACGME (Milestones)
 - Patient care
 - Medical knowledge
 - Practice-Based learning and improvement
 - Interpersonal and communication skills
 - Professionalism
 - System-Based practice
- To secure an environment in which the residents can develop mature surgical judgment and technical skills and, at the same time, be able to cultivate their cultural, social and spiritual life.

YEARLY EDUCATIONAL GOALS:

PGY 1 Goals:

The first- year resident rotates on the General Surgical Services at Riverside University Health System (RUHS). In addition, the PGY-1 will rotate through the surgical subspecialties, surgical critical care, transplant surgery, acute care surgery, surgical oncology, colorectal surgery and vascular surgery. The primary goal of the first year is to develop entry-level skills, knowledge, and abilities while managing the surgical patient. The PGY-1 resident is responsible for the day-to-day care of surgical patients on the service to which they are assigned under the direct supervision of senior residents and faculty. These activities will provide experience in the principles of pre- and postoperative care, as well as experience as an assistant and operating surgeon working under direct supervision.

PGY-1 resident should demonstrate the ability to:

- Establish proficiency in the evaluation of patients under routine and emergency circumstances, recognize surgical emergencies, perform a history and physical examination, order appropriate ancillary studies, and effectively communicate findings to other physicians.
- Establish proficiency in providing pre-operative and post-operative care, including ensuring appropriate pre-op and post-op orders for floor patients, handle nursing calls appropriately, and manage most routine postoperative care with graduated autonomy.
- Develop a working knowledge of common problems in general surgery, surgical critical care, and all subsequent subspecialties exposed to with a passing grade on each rotation.
- Establish a working knowledge and familiarity with common procedures of the surgical specialties (achieves acceptable grade on rotation evaluation).
- Acquire basic operative skills necessary to prepare the patient in the operating room, perform less complex surgical procedures, such as hernia repair, central line procedures and minor outpatient surgery.
- Acquire basic skills to perform an endotracheal intubation and administer conscious sedation once the California Medical License is obtained.
 - MOODLE log in: <https://www.ruhstraining.org/login/index.php>
 - Search “Moderate/Deep Procedural Sedation Online Course for Residents”
 - Enroll and complete course
 - Send completion certificate to Jennifer Lugo
- Develop personal values and interpersonal skills appropriate for the surgical resident (ie. Availability, Affability and Ability) ensuring patient care needs are warranted the highest priority.
- Learn the basics of scientific methodology
- Complete interesting case report and submit for presentation at RUHS Research Symposium (Due in early March, present in May), local or national surgical meetings
- Develop outline for major research project with guidance from your mentor
- Develop open and laparoscopic skills through the SAGES curriculum:
<https://www.webassessor.com/sages>
- Develop a working knowledge of the core competencies and complete the assigned curriculum for each area.

- Develop lifelong habits of self-assessment, self-directed learning and reflection upon what has been learned to consciously change behaviors and practices that can improve patient care
- Improve the communication skills with different members of the health care team
- Develop a working knowledge of the responsibility in complying with the requirements of the Joint Commission in Hospital Accreditation and how this ultimately improves patient care
- Examine the ethical underpinnings of clinical practice and address the ethics issues faced every day caring for patients.

PGY-2 Goals:

The second-year resident rotates on General Surgery Services at both RUHS and Kaiser Permanente and the surgical sub-specialties of plastic surgery, pediatric surgery (at Children's Hospital Orange County-CHOC), and SICU. The PGY-2 resident is responsible for day-to-day care of surgical patients on their assigned service and will be supervised at all times by senior residents and faculty, in addition to being a mentor and guide for the PGY-1 residents. The major goal of the second year of residency is to introduce the resident to critical care, and to allow graded responsibility for patient care, including instruction in pre-operative care and postoperative care, with an emphasis on nutritional and metabolic management. The PGY-2 will gain additional valuable experience in the operating room both as an assistant and as the primary surgeon on uncomplicated or routine surgeries.

PGY-2 residents should demonstrate the ability to:

- Develop skill in the provision of pre-operative and post-operative care by managing pre-operative and post-operative care of complex patients independently under supervision.
- Establish a knowledge base and skill proficiency for the management of the critically ill surgical patient, place endotracheal tubes, arterial lines, and performs escharotomy proficiently. (achieves acceptable grade on rotation evaluation)
- Develop organizational and teaching skills necessary for management of a surgical service (attends to routine organizational duties of service such as organizing rounds and teaching sessions).
- Acquire basic skills to perform ultrasound evaluations of breast, thyroid and trauma.
- Develop a working knowledge of and familiarity with the management of common problems in Plastic Surgery, Pediatric Surgery, and SICU. Demonstrate skill in operative technique required for procedures of increasing surgical complexity, such as skin grafting, more complex hernia repairs and complex soft-tissue surgery (can perform these operations with minimal assistance).
- Continue developing a working knowledge of the core competencies and complete the assigned curriculum in each area.
- Outline key professionalism principles as presented in the American College of Surgeons "Code of Professional Conduct" and apply it to everyday caring for patients.
- Develop lifelong habits of self-assessment, self-directed learning and reflection upon what has been learned to consciously change behaviors and practices that can improve patient care
- Continue to improve the communication skills with different members of the health care team
- Develop an understanding of the process followed to monitor and improve quality by the hospital as a system of care as well as medical staff in particular

PGY-3 Goals:

The third-year resident rotates on General Surgery Services both at RUHS and Kaiser Permanente with clinical experience on the Otolaryngology and Surgical Oncology and Gastroenterology services. The PGY-3 resident will function under the direct supervision of senior residents and faculty. The principal goals for this year are to learn the direct management of patients, plan and execute surgical procedures, and provide postoperative care. During the operative phase, senior residents and faculty assist the junior resident. This diverse and enriched learning environment should permit the resident to grow and achieve limited independence understanding that assistance is immediately available.

PGY-3 residents should demonstrate the ability to:

- Continue to develop technical skills necessary for the performance of more complex surgical procedures in general surgery, and minimally invasive surgery, e.g., perform laparoscopic cholecystectomy, small bowel resection, and other procedures of similar complexity.
- Acquire proficiency in surgical endoscopy by successfully performing colonoscopy, EGD, and sigmoidoscopy.
- **Take and pass Fundamentals of Endoscopic Surgery exam through SAGES.**
- **Take and pass the Fundamentals of Laparoscopic Surgery exam through SAGES.**
- Establish a knowledge base, judgment and interpersonal skills necessary to function as a surgical consultant by successfully managing entry-level consults with minimal direct supervision.
- Continue developing a working knowledge of the core competencies and complete the assigned curriculum in each area.
- Develop enhanced skills in the management of a surgical service by managing service administrative duties assigned by the chief resident or faculty.
- Proficiency in the rational use of surgical literature and evidence-based medicine (defends discussions and recommendation with scientific evidence). Outline key professionalism principles as presented in the College's "Code of Professional Conduct" and apply it to everyday caring for patients.
- The ability to communicate and interact with patients in difficult situations
- Learn the role of medical staff committees and function as a committee member

PGY 4 Goals:

The fourth-year resident rotates on General Surgery Services at RUHS, including vascular surgery and thoracic surgery at Kaiser Permanente. The PGY-4 resident will function under the direct supervision faculty. The principal goal of this year is to develop a higher level of responsibility in the direct management of patients, planning and executing preoperative care, surgical procedures, and resolving postoperative complications. Consequently, the PGY-4 resident is provided with an environment of growth and semi-limited independence.

PGY-4 residents should demonstrate the ability to:

- Continue to develop knowledge and skills necessary for the complete management of common problems in general surgery, vascular surgery, thoracic surgery and surgical oncology while managing most common problems with minimal assistance.
- Take and pass the Fundamentals of Laparoscopic Surgery exam through SAGES.
- Final submission of research paper for presentation
- Continue developing a working knowledge of the core competencies and complete the assigned curriculum in each area.
- Develop knowledge and skills necessary to function as the trauma team leader for both adult and pediatric patients and successfully directs trauma resuscitation.
- Satisfactory performance as a teacher of junior residents and medical students (receives acceptable feedback from students and peers).
- Outline key professionalism principles as presented in the College's "Code of Professional Conduct" and apply it to everyday caring for patients.
- Understand system-based issues that will better prepare them to manage finances after residency
- Ability to effectively communicate with patients about surgical errors and adverse outcomes and incorporate the critical elements of a disclosure conversation in their practice to provide optimum patient care.
- Continue lifelong habits of self-assessment, self-directed learning and reflection upon what has been learned to consciously change behaviors and practices that can improve patient care

PGY-5 Goals:

The fifth-year resident will be assigned to the General Surgery Services at RUHS and Kaiser Permanente. At the conclusion of this year, the Chief resident should have acquired all the required cases in the Defined Categories established by the ACGME, acquired sufficient professional ability to practice competently and independently, and be qualified and eligible for American Board of Surgery Board certification. In addition to American Board of Surgery Requirements, the chief residents will be role models of professionalism and help guide junior residents in all and any aspect of their daily duties.

PGY-5 residents should demonstrate the ability to:

- Develop knowledge and skills necessary to assume complete responsibility for the management of the surgical patient, including mastery of the fundamental components of surgery as defined by the American Board of Surgery (achieves acceptable score on written and oral examinations and receives acceptable evaluations).
- Demonstrates proficiency in the management of complex problems in general surgery, vascular surgery, surgical oncology and trauma and treats complex problems in the discipline with minimal help.
- Continue developing a working knowledge of the core competencies and complete the assigned curriculum in each area.
- Demonstrates personal and professional responsibility, leadership skills and interpersonal skills necessary for independent practice as a specialist in surgery and successfully manages the chief resident services.
- Outline key professionalism principles as presented in the College's "Code of Professional Conduct" and apply it to everyday caring for patients.
- Continue lifelong habits of self-assessment, self-directed learning and reflection upon what has been learned to consciously change behaviors and practices that can improve patient care
- Incorporate good communication skills in their daily practice
- Develop skills to organize and manage a practice after residency

ACGME COMPETENCIES :

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

- **Patient care** that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;
- **Medical knowledge** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
- **Practice-based learning and improvement** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
- **Interpersonal and communication skills** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
- **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
- **Systems-based practice**, as manifested by actions that demonstrate an awareness of responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

CONTINUATION IN RESIDENCY:

Continuation in the residency program is determined by **clinical** and **academic** performance and the number of positions available. It is ultimately determined by the recommendation of the Program Director, the Residency Review and Clinical Competency Committees. **Clinical performance is based on the attending evaluation of the residents.** Evaluations are completed via New Innovations and the SIMPL EPA mobile application. These evaluations are completed in ongoing fashion after patient interactions, operative cases AND in summative fashion at the completions of each rotation. **Academic performance** is based on a combination of **conference participation, research**, conference attendance, **professional** behavior, and yearly in training examination (American Board of Surgery In Training Examination- ABSITE).

The residency contract is issued for one year only. Admittance to the program in the first year does not guarantee a full five years of residency training. Continuances are year by year based on overall performance. Those residents whose poor performance does not allow them to complete even a single year will be given consideration under the terms for due process.

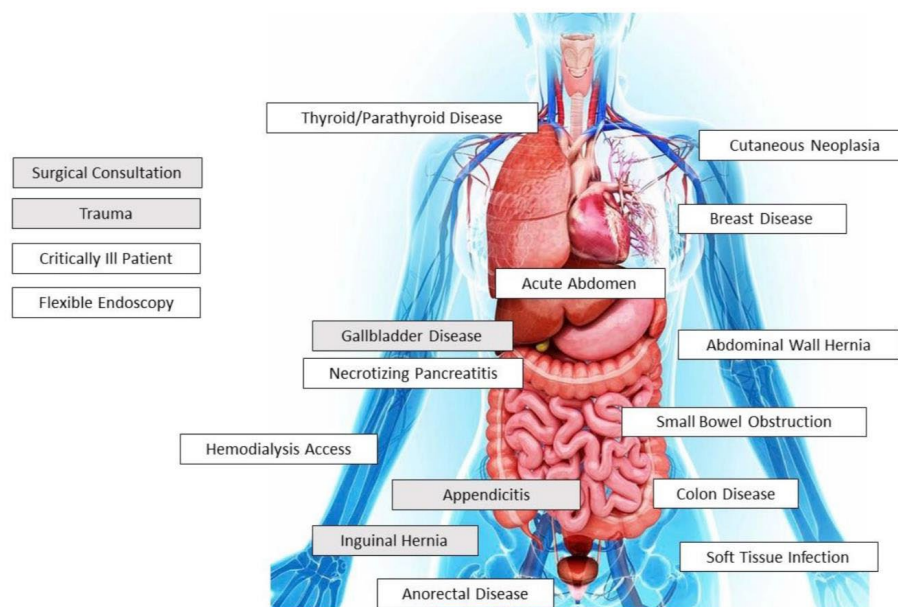
Resident Performance Evaluations:

An evaluation of resident performance is completed by their attending(s) at the end of each rotation. YOU ARE TO REVIEW YOUR ROTATION PERFORMANCE WITH YOUR ATTENDING STAFF MEMBER AT THIS TIME. PLEASE MAKE AN EXTRA EFFORT TO MEET WITH YOUR ATTENDING STAFF FOR THIS FINAL EVALUATION. THE EVALUATION MUST BE REVIEWED BY YOU AND THE ATTENDING STAFF.

All rotation evaluations can be reviewed on New Innovations. All rotation evaluations are reviewed by the Program Director or Associate Program Director and mentors; counseling is performed when indicated and at minimum on a biannual basis. The evaluations are kept in each resident's file and are available for review at any time.

The General Surgery Residency Program at Riverside University Health System recognizes informal resident assessment takes place in a variety of venues including the wards, clinics and operating room. To complete the program and be considered a candidate to the American Board of Surgery (ABS), residents must be **formally** evaluated in both the operating room and clinics. To successfully advance to each post graduate training level and to successfully complete the program and be recommended to the ABS, residents must adhere to the following:

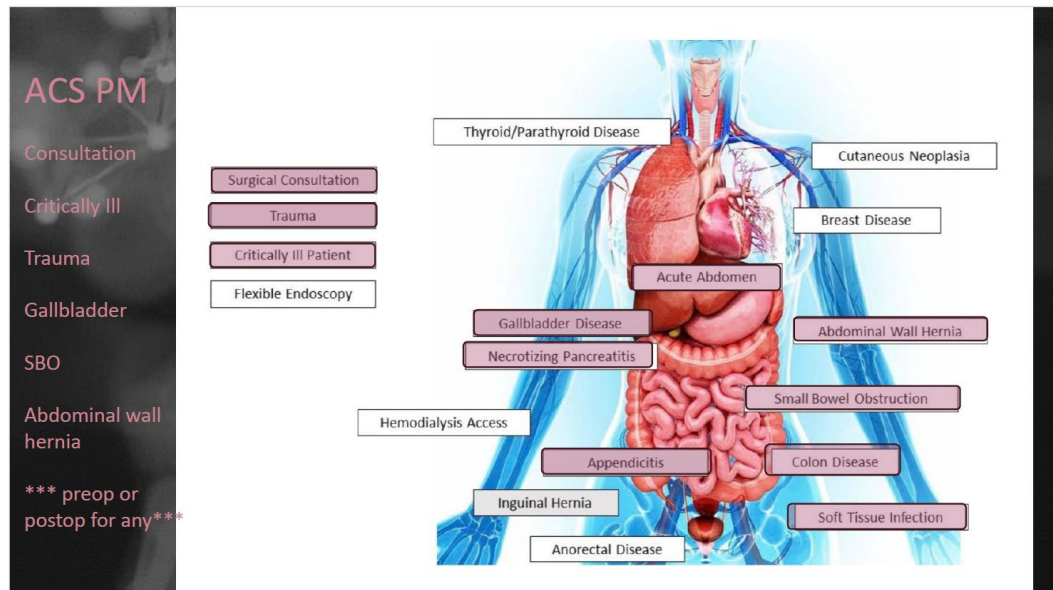
1. Be evaluated during **2 operative cases** each academic year (minimum 6 op evals are needed for ABS recommendation) on training level appropriate operative cases. **It is the resident's responsibility to ensure these are completed yearly. (Intra-op Evals)**
2. Be evaluated during **2 clinic patient assessment** (Clinic Assessment and Management Examination – CAMEO) examination each academic year. These evaluations will be scheduled by the program office anonymously.
3. **Entrustable Professional Activity (EPA)**- mandatory for all graduating classes after and including the graduating class of 2028.
 - a. Download SIMPL app ([SIMPL](#))
 - b. Check your RUHS email and activate your SIMPL account
 - c. Log in to SIMPL app
 - d. Request PREOP, INTRA-OP and POST OP evaluations from your faculty for all cases related to the 18 core General Surgery EPA's ([ABS EPA](#))
 - e. The 18 core General Surgery EPA's are depicted below:



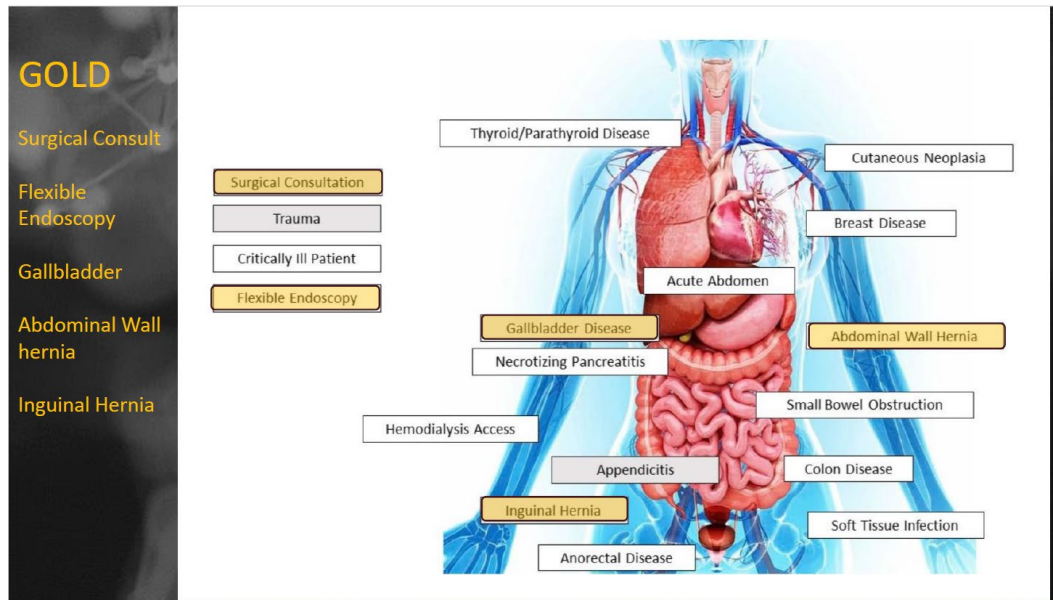
- i. _____
- f. YOU are required to obtain 10 EPA evaluations PER WEEK. You may request an EPA evaluation in any of the 18 core general surgery areas at any time from any

faculty. To assist in the completion of these tasks we recommend you focus the task as follows based on the rotation schedule.

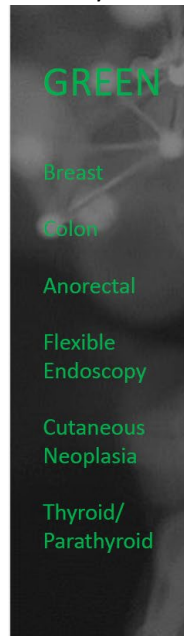
g. ACS PM:



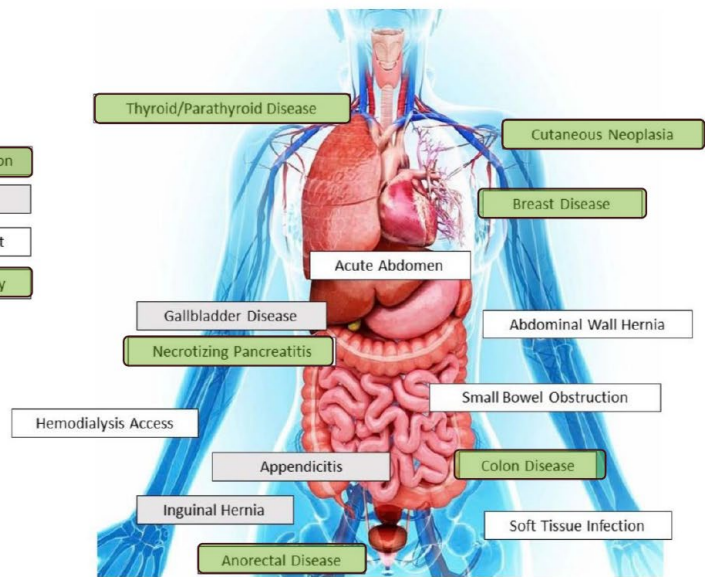
h. GOLD:



i. GREEN/GI:



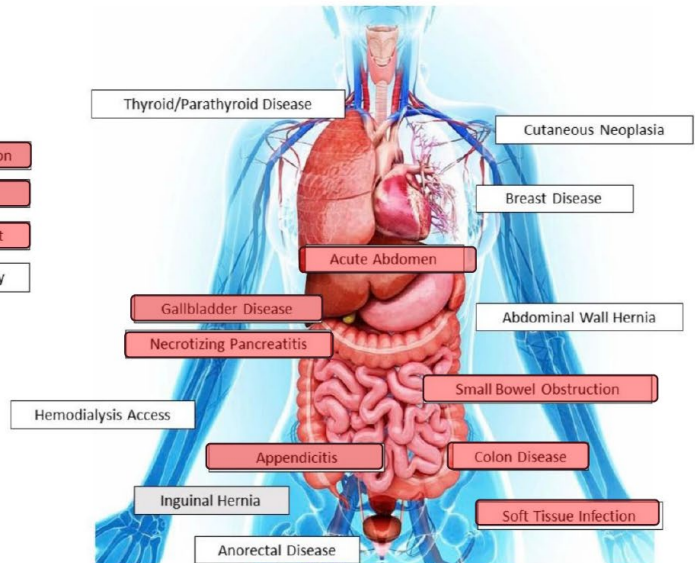
- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



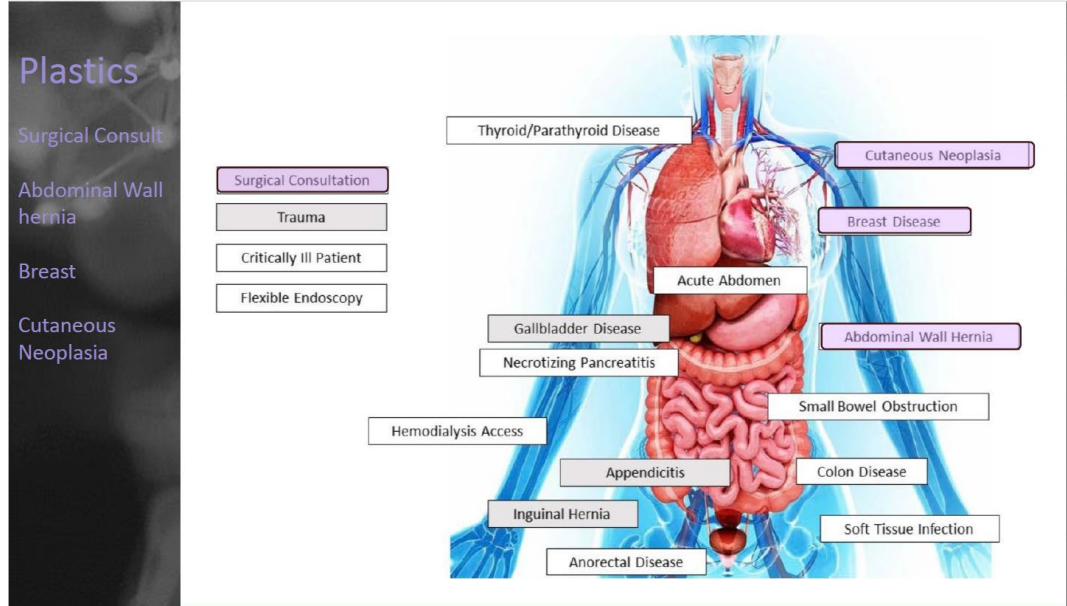
j. ACS (RED/ORNAGE):



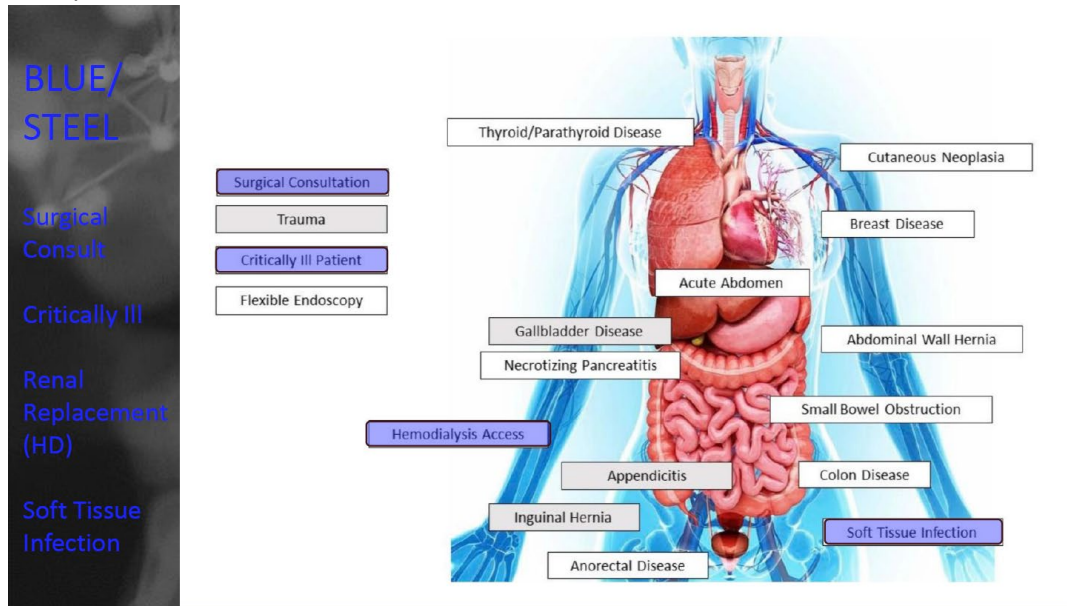
- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



k. Plastics:



l. BLUE/STEEL:



m. SICU:

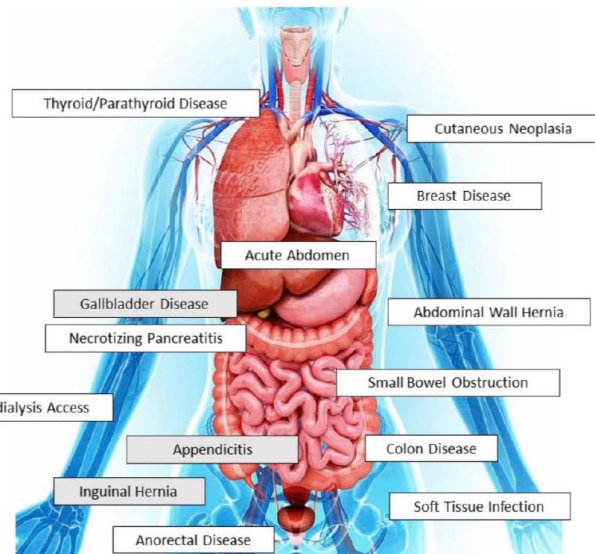
SICU

Critically Ill

Trauma

*** preop or postop care of ANY ***

- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



n. PURPLE:

PURPLE

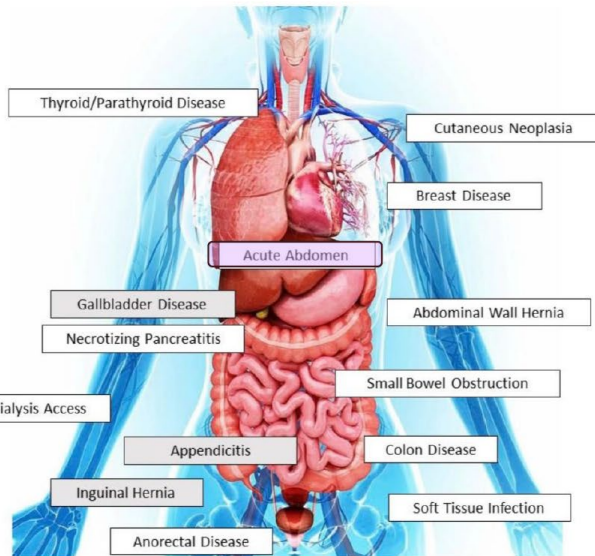
Surgical Consult

Critically Ill

Trauma

Acute Abdomen

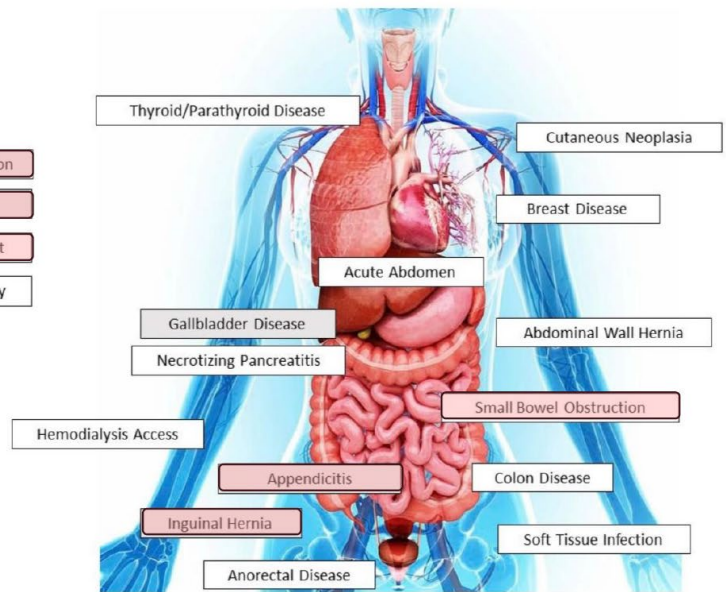
- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



o. CHOC:



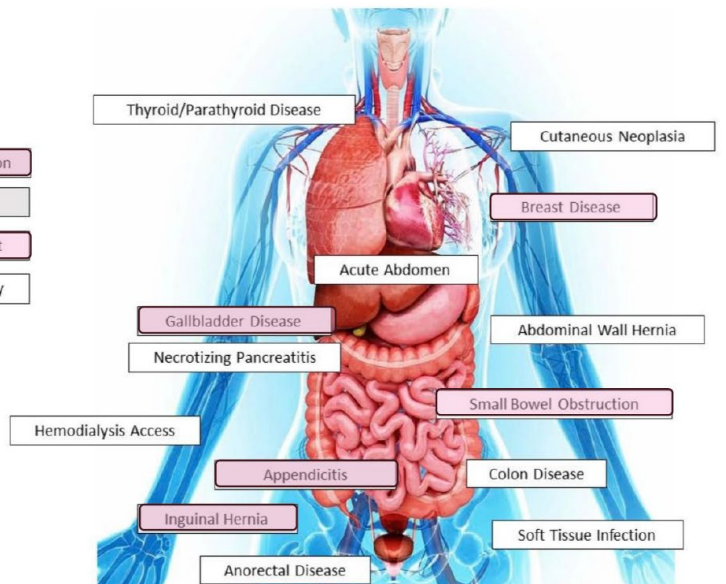
- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



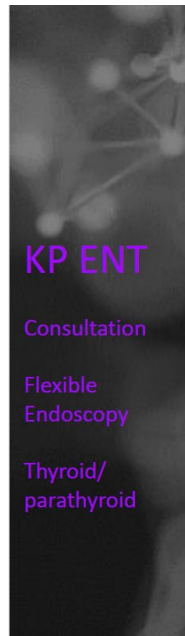
p. KP General Surgery:



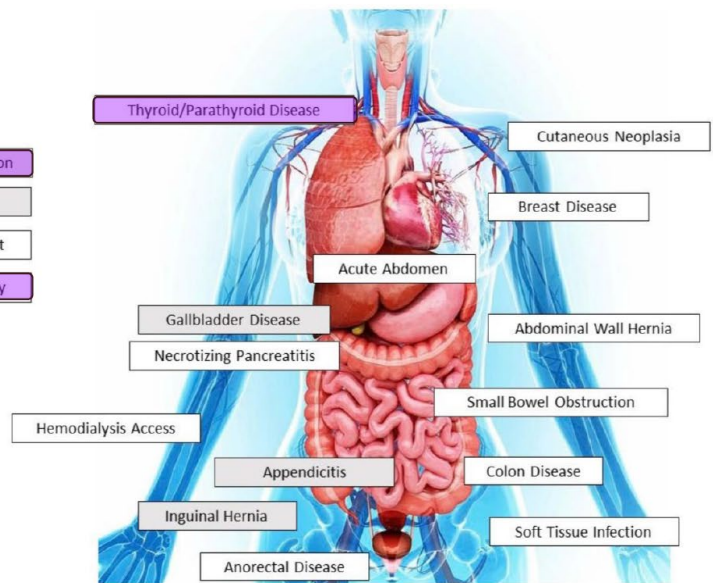
- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



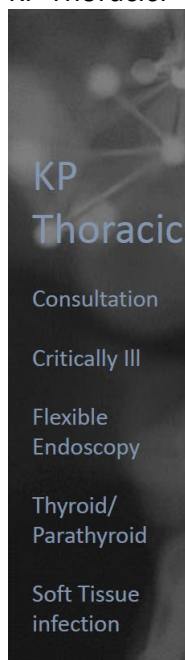
q. KP ENT:



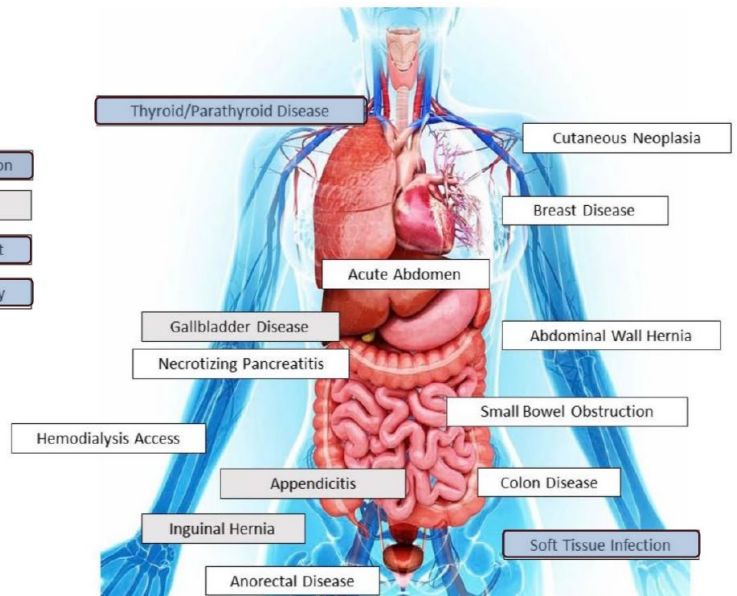
- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



r. KP Thoracic:



- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



s. KP Vascular:

KP
Vascular

Consultation

Critically Ill

Hemodialysis
access

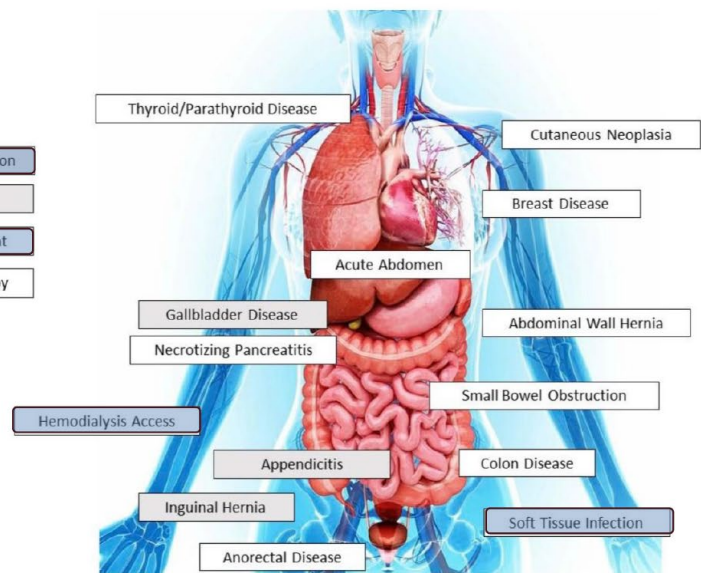
Soft Tissue
infection

Surgical Consultation

Trauma

Critically Ill Patient

Flexible Endoscopy



t. KP Colorectal:

KP
Colorectal

Consultation

Critically Ill

Hemodialysis
access

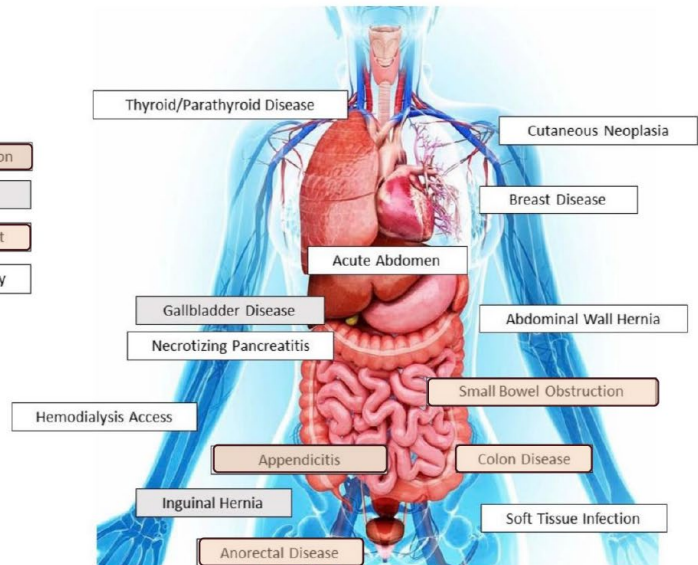
Soft Tissue
infection

Surgical Consultation

Trauma

Critically Ill Patient

Flexible Endoscopy



u. KP Surgical Oncology:

KP Surgical
Oncology

Consultation

Critically Ill

Thyroid/
Parathyroid

Cutaneous
Neoplasia

Breast Disease

Appendicitis

Colon Disease

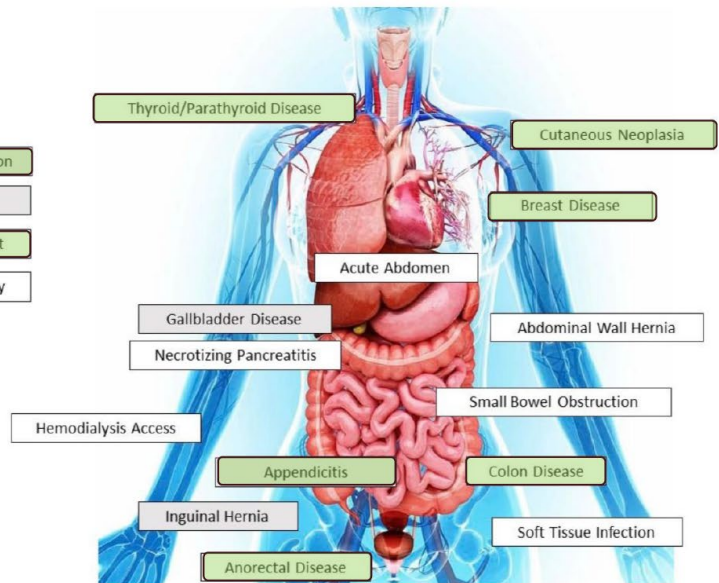
Anorectal disease

Surgical Consultation

Trauma

Critically Ill Patient

Flexible Endoscopy



v. KP Vascular:

KP
Vascular

Consultation

Critically Ill

Hemodialysis
access

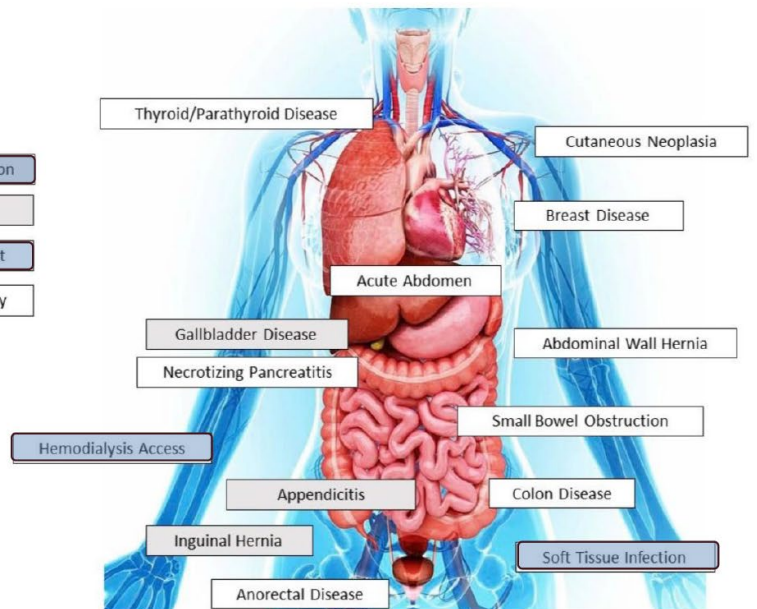
Soft Tissue
infection

Surgical Consultation

Trauma

Critically Ill Patient

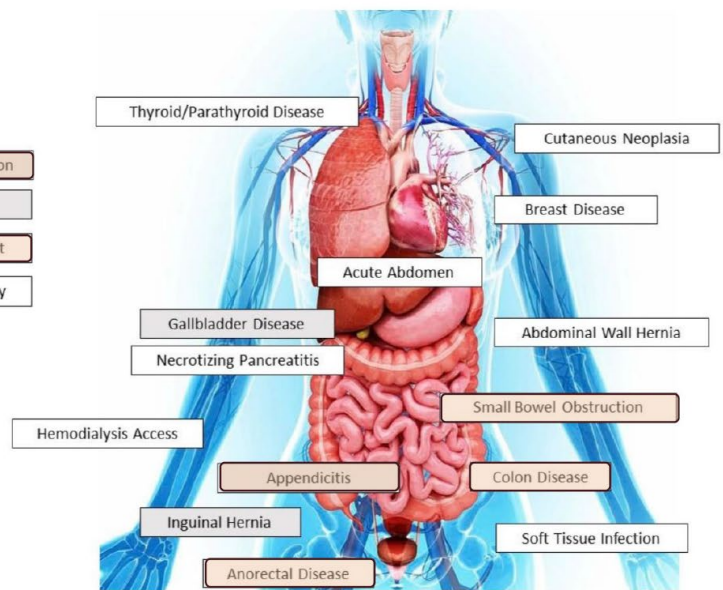
Flexible Endoscopy



w. KP Colorectal:

KP
Colorectal
Consultation
Critically Ill
Hemodialysis
access
Soft Tissue
infection

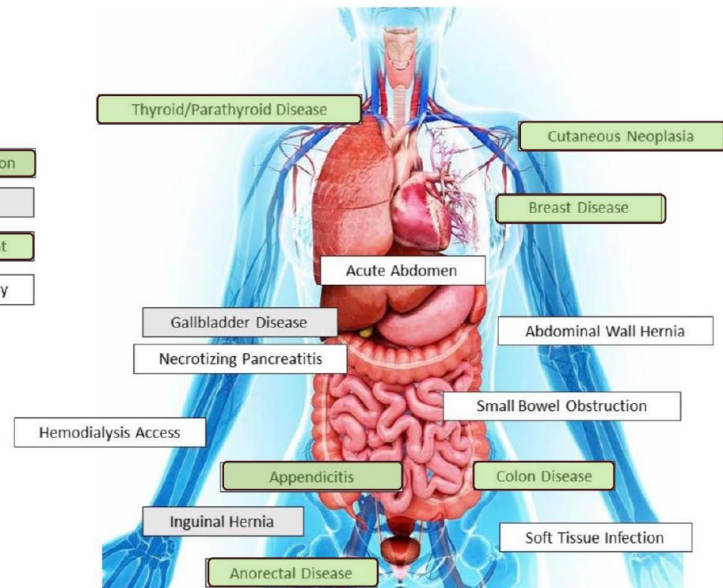
Surgical Consultation
Trauma
Critically Ill Patient
Flexible Endoscopy



x. KP Surgical Oncology:

KP Surgical
Oncology
Consultation
Critically Ill
Thyroid/
Parathyroid
Cutaneous
Neoplasia
Breast Disease
Appendicitis
Colon Disease
Anorectal disease

Surgical Consultation
Trauma
Critically Ill Patient
Flexible Endoscopy



Attending and Rotation Evaluations:

Each attending is interested in an evaluation of his/her performance. At the close of each rotation, you are **REQUIRED** to complete the faculty AND evaluation forms. Faculty/Rotation evaluation reminders will automatically be sent to you via e-mail when you complete the rotation. Reminders will continue to be sent to you through your e-mail address until you submit the evaluation. The feedback given will be compiled by the program coordinator and anonymous feedback will be given to the respective faculty and rotation directors to improve resident educational experience. These **evaluations are completely anonymous; this anonymity is guaranteed. The residency office does not have access to, nor can we obtain, your password.** These evaluations are reviewed by the Program Director, the Department Chairman, the appropriate section Chairman, and are used in Faculty Evaluations. These evaluations are used to improve the content and quality of the residency program.

FAILURE TO COMPLETE FACULTY AND ROTATION EVALUATIONS WILL BE REFLECTED IN YOUR PROFESSIONALISM EVALUATIONS.

Bi- Annual Evaluations:

The Program Director and/or Associate Program Directors of the Residency Training Program will conduct semi-annual interviews for each resident. For residents leaving the program the second interview will also be an “exit interview”. These interviews are meant to provide personal feedback regarding the resident's performance, future goals, and to identify areas of concern and need. We recognize residency can be a significant stress for not only the resident but also his/her spouse. We welcome the concerned spouse to the interview meetings.

Milestone Reporting:

Milestones are designed for programs to use in bi-annual review of resident performance and have been developed specifically for surgery by the American College of Graduate Medical Education (ACGME) Surgery Residency Review Committee. Milestones encompass knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. The department's Clinical Competency Committee will evaluate each resident using a variety of evaluation tools including direct observation, multi-source feedback, tests, and record reviews, etc. Your progress through the milestones will be reviewed during your Bi-annual evaluation.

Journal Club / Online Journal Club:

Residents are required to participate in Journal Club. The journal clubs are scheduled each month beginning in August through May on Thursdays during the Skills Lab Protected Curriculum. Journal club is moderated by both faculty and residents. If you are assigned to moderate, your name will be assigned on the Skills lab schedule, and you will be notified by the coordinator. Please be proactive and contact your paired faculty moderator to plan the journal club.

Oral Examinations:

Oral examinations are given to all fifth-year residents in May or June. These will be conducted in the same format as the American Board of Surgery Certifying (oral) Examination. Participation is required, as this simulates the Certifying Exam in Surgery, and will point out areas upon which the resident can concentrate study in preparation for this exam. In addition, residents at the PGY 3, 4 and 5 years, will be given an oral exams during each rotation by at least 1 faculty member and this will be noted on the rotation evaluation.

In-Training Examinations:

The American Board of Surgery In-Training Examination (ABSITE) is given each year on the last Friday/Saturday in January. This exam medical and surgical didactic knowledge and is graded according to level of training. It

is a good indicator of surgical knowledge and gives the resident exposure to the type of testing given by the American Board of Surgery. The following guidelines are used by the Residency Committee to evaluate test results:

- Residents with <50% correct (*percentiles are no longer reported after 2024*) will meet with the RUHS Academic Advisor, to develop an **Improvement plan**. The Improvement plan will involve reading, studying, and question back assignments. The plan will need to be approved by the program director and the plan will become part of the Resident's file. Quarterly Progress reports will be given by the RUHS Academic Advisor, to the Program Director and the Residency Review committee will use these items to determine progression.
- Residents with <25% correct (*percentiles are no longer reported after 2024*) will be placed in a **Remediation Plan**, consisting of formal schedule of reading assignments, in addition to self-study, quiz assignments and practice exams. The plan will need to be approved by the program director and the plan will become part of the Resident's file. Quarterly Progress reports will be given by the RUHS Academic Advisor, to the Program Director and the Residency Review committee will use these items to determine progression. Continued Poor performance may lead to formal academic probation.
- Residents with <20% correct (*percentiles are no longer reported after 2024*) will be immediately placed on **Academic Warning** and will also be placed on a Remediation plan, consisting of formal schedule of reading assignments, in addition to self-study, quiz assignments and practice exams. The plan will need to be approved by the program director and the plan will become part of the Resident's file. Quarterly Progress reports will be given by the RUHS Academic Advisor, to the Program Director and the Residency Review committee will use these items to determine progression. Continued Poor performance may lead to formal academic probation.

ABSITE Score (QE pass 95% CI)	100% pass CI >99	90% pass CI 89-91%	80% pass CI 78-84%	75% pass CI 70-79%	Improvement Plan (<50%)	Remediation Plan (<25%)	Academic Warning (<20%)
PGY 5	590	512	479	465	419	373	360
PGY 4	581	501	467	455	413	368	357
PGY 3	560	470	433	420	372	324	312
PGY 2	480	416	369	354	295	237	222
PGY 1	450	329	271	252	177	102	N/A

SOURCE: ABSURGERYDATA.shinyapps.io/relationqeabsite/

A resident that continues a pattern of poor academic performance may be discontinued from the program. Academic performance is based on a combination of conference participation, rotation evaluations, oral examinations and the ABSITE.

To be recommended to the **American Board of Surgery Qualifying Examination** the resident needs to consistently score high enough on the ABSITE to predict QE passing. The link above provides a detailed and dynamic relationship of ABSITE score to QE pass rates. The residency hopes that by holding residents to these standard not only will provide a motivation for studying, a monitoring process for evaluation of knowledge, and an avenue by which residents can prepare and ultimately pass the American Board of Surgery Qualifying and Certifying Examinations.

Operative Experience:

A RECORD OF YOUR OPERATIVE EXPERIENCE IS OF UTMOST IMPORTANCE. You should keep a personal record of all the operations you do, the date and whether you were surgeon, first assistant, second assistant or teaching assistant. Recording of operative cases is done through the ACGME Resident Case Log System website (<https://apps.acgme.org/connect/login>). You will receive your password and user name to enter your cases from the Surgery Residency office.

Residents are required to enter their operative cases on a daily basis. Failure to enter cases may result in suspension from your service. It is important that the dictating surgeon designates your position in the operation as you desire (i.e. 1st assistant, teaching assistant, etc) as this is how medical records will accumulate your experience. You may print your operative experience record at any time to verify correct data entry of cases. Also of importance are your critical care cases where no procedure is done but you are the primary physician during the patients hospital stay. It is important that these cases be tracked, as the board asks for a total number of these cases.

The final five-year record is a summation of your operative experience and must be turned in before June 30. This report will also be submitted to the American Board of Surgery once you have completed residency.

Lectures:

Important in the training of a surgeon is the acquisition of basic surgical facts. You are encouraged to develop your own study program of regular reading. To facilitate your learning, we have set up a lecture schedule.

All residents will be **required to attend the TUESDAY didactic session where the SCORE curriculum is used, IN PERSON.** This lecture is designed to review current surgical practice and serve as a forum for clinical case discussions. Oral examination-type discussion is encouraged.

The schedule is distributed in July and posted on the surgery website, as well as posted in the call room. Revisions are also posted there as necessary. Attendance is taken at each lecture, and residents must be present at, or have an excused absence for, all lectures. Excused absences include vacation, sick all day, etc. If you will be on vacation or are sick, please notify the residency office of this. *Any absence from these meetings must be explained.* Additionally, this lecture time is protected study time, please forward your phones to the appropriate person- ask your chiefs for assistance if you do not know what to do.

Research:

Residents are encouraged to join their attending staff in pursuing basic science and clinical research studies. Several physicians in the department conduct research projects and should be contacted months in advance to arrange research projects. Research time at institutions outside RUHS can be arranged. Specific areas of interest should be outlined as soon as possible, as these usually must be arranged more than a year in

advance. For residents interested in dedicated research time, it is suggested that one to two years be taken for this after the 2nd year. See the Program Director for further details and suggestions. Please point out areas of particular interest or previous work to the Program Director or attending so work in these areas can be encouraged.

Residents are required to be involved in scholarly activities during their residency. All residents must submit an abstract for publication and/or presentation to a recognized regional, state or national meeting prior to completing the program and being recommended to the American Board of Surgery.

The Comparative Effectiveness and Clinical Outcomes Research Center (CECORC) is the administrative office that supports clinical research at Riverside University Health System – Medical Center. CECORC is located in the CPC building on the first floor. For more information on their services, please visit their website via the hospital intranet under the Clinical Services tab.

Residents are allowed 5 days of Continuing Medical Education annually. These days may be used to make **presentations at regional, state or national meetings**. In addition, funding may be available through your annual education stipend.

Resident Travel for Professional Activities:

Criteria for approved travel:

The reason for traveling is to present the results of original investigative work conducted while at RUHS General Surgery Residency or for participation in educational activities approved by the Program Director.

- The traveler will be personally making the presentation of the investigative work.
- Time away from clinical duties is minimized. Residents presenting a paper or a poster at a scientific meeting can use their CME time.

The residency program may assist the resident with travel expenses when the resident has a poster or paper accepted at a scientific meeting. Expenses **will not be reimbursed** if the approval for travel was not obtained prior to the date of departure or if a Leave Request is not completed and submitted within the usual time frames. In addition, the manuscript for the presentation must be complete and reviewed by the Program Director prior to submission.

Allowable expenses include:

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

Additional funding for residents presenting papers is at the discretion of the section from which the paper originates, and each resident must apply to the Section Chief for funding prior to the meeting.

GRADUATE MEDICAL EDUCATION OFFICE:

The Graduate Medical Education Office (GME) is the hospital's representative to oversee that all residencies are approved and functioning appropriately. Dr. Daniel Kim is the Director of Graduate Medical Education at RUHS. Derilyn Clark is the Director of med staff Services in GME. Your GME medical director is Dr. Roger Garrison and Institutional Designated Institution officer (DIO) is Dr. Kim.

The GME office will assist you in obtaining your California Medical License and Drug Enforcement Administration Certificate (DEA) during your first and second years. Subsequently, each resident will then be responsible for providing an updated copy of his/her California Medical License, DEA Certificate, BLS and ACLS cards to both the GME AND the residency office. **No third-year resident will be employed without a California Medical License. It is important to apply for your license early in the second year to avoid unforeseen problems or delays.**

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

USMLE Step III:

USMLE Step 3 or COMLEX 3 must be taken in the **first three (July, August or September)** months of the PGY-1 year (no later than September 30). Residents are to notify the coordinator of their test date and complete a time off request. **Residents are to notify the coordinator prior to scheduling to ensure no other residents are off service during the requested time.** This early time span will allow you to adequately prepare for your MANDATORY in training EXAM that will occur in January, the score of which will determine your risk of academic probation.

California Medical License:

Residents are required to obtain and maintain a current non-restricted California Medical License within the time frame required by RUHS and the Medical Board of California (MBC). It is the resident's responsibility to obtain information concerning licensing requirements, examinations, and to meet established deadlines.

ACLS / BLS:

The Department of Surgery requires that all first-year residents complete an ACLS and BLS course prior to beginning their first year of training. Please present copies of these cards to the GME office and the residency coordinator prior to beginning residency. It is your responsibility to **renew** these courses and submit proof of renewal to your coordinator and to the GME and residency office.

ATLS:

Advanced Trauma Life Support is offered at the beginning of the **INTERN year** of residency during orientation. This course will assist in rotations where you are involved in running trauma encounters. The cost of the course is paid for by the residency program the first time. If you do not pass the course, you are responsible for the cost of retaking the course. You will be contacted by the residency office regarding dates for the course.

CLINICAL ROTATIONS:

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

The rotation schedule is created on a yearly basis prior to the start of the next academic year. Improvements in the residency may result in unexpected changes in the rotation schedule. If you have a specific request regarding your rotation schedule, please submit it in writing and schedule an appointment to discuss this request with the Program Director and coordinator.

Call schedules:

Requests for changes in the call schedule must be coordinated as early as possible with the administrative chief who is responsible for making the monthly call schedules. Requests are usually honored on a first come, first served basis. "On Call" days differ on each rotation and hospital:

Riverside University Health System: The administrative chief residents together with the program coordinator will work arrange a fair and complete call schedule, taking into account CME leave, and vacation that have already been approved. The coordinator may be contacted at 951-486-4381. All time-off requests must be received no less than **45 days** prior to the 1st day of the month you wish time off.

Loma Linda University Medical Center: Dr. DeVera and Jaime Adair coordinate the call schedule for the Department of Transplant Surgery and can be contacted at 909-558-3650.

Children's Hospital Orange County (CHOC): the Pediatric Surgery Team led by Dr. Peter You will determine call schedules and help approve or deny vacation during your rotation at CHOC, he can be reached at yup@choc.org

Kaiser Permanente Riverside: Dr. Tam and the chief resident coordinate the call schedule and may be contacted at 951-353-4422. All time off requests must be received no less than **45 days** prior to the month you wish time off in.

Consults:

Consults are an important part of surgical training and are to be completed (seen and staffed) in a timely manner. The resident "on call" or on the service is responsible for all consults received during that time frame.

Medical Records:

Chart completion is a vital and essential component of work as a physician. It reflects professional behavior. It is imperative that you complete all operative reports, discharge summaries, and signatures in a **TIMELY MANNER**

Operative reports must be completed on the same calendar day as the operation. In addition to this practice a **Brief Op Note must be completed prior to the patient** leaving the operating room. Failure to comply with this practice may result in OR privileges being revoked.

Discharge Summaries must be completed by the day of patient discharge, be thorough, yet concise and contain all pertinent diagnoses treated, operations and procedures performed, consultants and necessary follow up plans managed during the hospital stay.

Each hospital has its own specific guidelines, but these rules will avoid becoming delinquent and prevent you from falling behind on your work. If you do not complete the medical records per the hospital policy, you will be subject to suspension. During suspension, you are not permitted to participate in ANY aspect of patient care, including on-call or operative activities. IF A RESIDENT ACCUMULATES 45 DAYS ON SUSPENSION, HE/SHE IS REPORTED TO THE CALIFORNIA MEDICAL BOARD AND THIS CAN AFFECT LICENSE RENEWAL as well as jeopardize your ability to continue in good standing within the residency program. The Department of Surgery requires timely completion of all medical records. We keep track of timeliness and completeness of chart completion and include this in letters of recommendations to hospitals. Be cognizant of medical record clarification requests from health information management personnel. If you receive one of these requests, please address it as promptly and completely as possible.

Medical Student Teaching:

Medical student teaching is a very important part of the residency, as it encourages the resident to know the material about which we are teaching, and is a valuable resource for the students who have limited time on a given service. Our mission involved encouraging students to enter our specialty and provide excellent patient care to our community.

It is important to provide the students with supervised, graduated responsibility in patient care and documentation. Students that show interest and ability should be allowed to make decisions about patient care and should be given responsibility to follow and present their patients on rounds and in clinic etc. Students should be exposed to all things that typically occurs on a surgical service including: patient care, decisions to operate, and discussions with the patients and their families; as well as seeing consultations, being on the clinic to evaluate pre and post op patients and participating in the operating room. Junior and senior medical students are not required to work longer hours than the house staff (i.e., 80 hours per week). However, students may opt to work longer hours should they choose to do so to learn. Students are not required to stay for lectures or formal didactic activities if they have been on duty for more than 28 consecutive hours. However, students who have worked more than 28 hours may opt to attend lectures/didactic activities if they wish to do so to learn.

Common sense and the guidelines above will hopefully encourage the residents to be excellent teachers who are more knowledgeable about the subject of surgery and help make surgical rotations a fun and overall learning experience for all students as well.

LEAVES:**Authorized Absence:**

Resident Physicians are encouraged to apply for fellowship positions as they match their life goals. To support and encourage this process, the residency will allow **5 days** of authorized absence from the residents "CME bank" per academic year to interview for fellowships. Any additional days spent on interviews will come from the resident's "vacation bank". Additionally, if a resident has vacation scheduled and also schedules interviews during a particular rotation, the vacation dates may have to be adjusted. The level of care in the rotation cannot be allowed to suffer due to absences. A "Leave Request" must be completed for time off to interview for fellowships, even though the time off is not taken from the resident's vacation leave bank and even if the dates are not clearly known, this will allow the coordinator and administrative chiefs to plan accordingly when they are approving others' vacations ahead of time.

Vacation and Leave Policy:

Resident Physicians are granted the following vacation and leave time.

- PGY 1 - 5 Residents
 - **3 weeks (15 working days) per year**
 - **5 CME** days to be approved at the Program Director's discretion

Vacations are not allowed for the following:

- **June - last 2 weeks:** except for residents who are advancing to other programs and need to make arrangements for moving etc. Please ensure the program coordinator and Program Director are both well aware of arrangements you are making

- **July - first 2 weeks- no vacation allowed**, leaves for interviews are approved on a case-by-case basis (plan ahead and ensure the program director, coordinator, and admin chief knows your projected “interview” times)
- **January - for 3 weeks** immediately preceding the ABSITE Exam (ASBITE exam typically occurs the last Friday/Saturday of January)
- No vacation allowed for PGY 1 or PGY 4 resident on **Acute Care Surgery NIGHTS**
- No vacation allowed for RUHS PGY 2 on **SICU**
- No vacation allowed for PGY 3 residents on **Purple** rotation
- Residents need to use vacation time for program retreat.

Requests for leave must be submitted to the Residency Office **no later than 45 days** prior to the beginning of the month in which leave is requested (**including for Kaiser**). For example, if leave is desired during the month of September, the request must be in the Residency Office by July 1.

For rotations **longer than one month**: Maximum of **1 week (5 working days plus weekend)** may be taken per rotation. A resident desiring a longer vacation, e.g., two weeks, should arrange it around the transition time between two service rotations so that one week is taken off from each service.

For rotations **lasting one month**: Maximum **3 days (plus weekend)** may be taken per rotation.

Vacation requests must be spread out over the Academic Year, preferably one week in each quarter, and must not be allowed to accumulate to the end of the Academic Year. Please be mindful that residents leaving the program will HAVE to take vacation at this time and other’s vacations or leave will be denied). **All vacation requests for the entire academic year - except for one week - must be submitted to the residency office by September 1. (plan your whole year ahead of time). Residents may hold one week in abeyance for a later decision however, vacation requests submitted early in the year are more likely to be honored.**

Vacation requests may not be approved if 2 or more residents assigned to the same service request the same vacation time. In that case, the earliest request will have priority. All vacation requests go through the Residency Office.

Residents are encouraged to use a part of the vacation and leave time to attend regional and national scientific meetings and to present scientific papers at those meetings. Residents presenting a paper or a poster at a scientific meeting will be given an additional leave day for a local meeting and 3 additional leave days for an out-of-town meeting. (one day travel time to the meeting, one day for the presentation and one day for return travel at the discretion of the program director). Residents may utilize vacation or CME time to stay longer at a scientific meeting where they are presenting a paper.

Leave request forms may be obtained from the Residency Office. **A Leave Request must be completed for any time off other than regular days off during the month.** After completion, it is submitted to the Residency Coordinator, who will then give it to the Service from which vacation is being requested. A copy is returned to the resident and one kept on file in the office. If vacation plans change after the time has been approved, a new form is to be filled out. The resident does not take the Leave Request to faculty for signature. All approvals are handled by the residency office.

This vacation and leave policy will also apply to residents rotating on the surgical services from other residency programs in the Medical Center i.e. Orthopedics, Emergency Medicine, Family Practice, etc.

Sick Leave:

Residents are provided with ten (10) Monday-Friday days of paid sick leave.

- Resident must notify the assigned service they are currently rotating on, the Program Director, and the program coordinator if they are unable to work due to illness.
- Residents are responsible for keeping their residency/department aware of their status
- The Program Director will determine whether sick leave will have to be made up in compliance with program and Board requirements.

In the event of an extended leave, the GME Office must be notified if a resident is hospitalized or is ill/disabled on an outpatient basis for more than **seven days** so that disability benefits, if any, can be applied for. Application for State Disability is required by the Medical Center if either of these situations arises. It is imperative that a disability application be submitted as soon as possible in order to avoid interruption of pay. Application for benefits must be made no later than the 20th day after the first day for which benefits are payable.

No call / No show:

Residents are expected to report to work on time for each assigned work shift. Residents must notify, in advance, the attending in charge of their assigned service (attending, and team members), and the program director/program coordinator of unexpected tardiness or of their inability to report to work due to illness or emergency.

In the event that a resident fails to notify the above parties of their tardiness or absence, the following protocol will be used:

- The program director will be notified of the absence.
- The program coordinator will attempt to contact the resident as soon as the absence is noticed. Contact will be attempted via text message, phone calls to cell phone and home phone (if available), and email. Multiple attempts will be made to each contact method.
- If, after an **hour** of attempting to reach the resident, the program coordinator has not heard back from the resident regarding the absence, the program coordinator or program director will call the resident's **emergency contact(s)** to express concern that the resident has not arrived as expected for work. They may request that the emergency contact go to the resident's home to check on the resident.
- In the event the resident and emergency contact cannot be reached, the program director or program coordinator may contact the local Police Department to request a wellness check.
- If the program director or program coordinator have increased concern for the wellbeing of a resident, they may activate the above protocol immediately.

Discussion of resident absence or no-show for work will be limited to the program director, the program coordinator, the GME office, and others *only as needed* for resident safety. Preserving resident privacy will be prioritized to the extent possible except where there is concern for resident safety.

Residents are responsible for providing their **physical address** and at **least one emergency contact** (name, phone number, and relationship) to the program coordinator. Residents are required to update this

information annually, or sooner as appropriate. This information will be updated in New Innovations where it will be accessible to the program coordinator, the program director, and the GME office.

Maternity/Paternity Leave:

The American Board of Surgery requires that a resident be involved in the residency program at least 48 weeks out of a year. Thus, Leave will be limited to 4 weeks in a given academic year. The Program Director will determine whether time off for maternity leave will have to be made-up, in compliance with program and Board requirements. Resident must inform the Program Director of anticipated delivery within six (6) months prior to the expected delivery to allow the program to plan for the resident's absence, appropriately plan leave for the trainee and to minimize disruption to the program.

Funeral Leave:

Three (3) regularly scheduled work days off, with pay, for funeral leave are granted in the case of a death in the resident's immediate family. Immediate family includes spouse, children, stepchildren, parents, stepparents, father-in-law, mother-in-law, brothers, sisters, stepbrothers, stepsisters, only living relative, foster parents and legal guardians. The resident must notify the Program Director's office and GME office in the event funeral leave is required.

Jury Duty:

Residents will be compensated for days on jury duty provided court verification of jury duty served is provided to the program coordinator. The GME office, the residency office, and your current service team and attending must be notified of **both potential and actual jury duty**. Please be aware however, that to qualify for the American Board of Surgery, you are only allowed to miss **20 weekdays** MAXIMUM per without having time added to that academic year. It is advised you notify the court / judge of this if you are called in to serve for jury duty.

PROGRAM POLICIES:

Dress code:

YOUR DRESS and appearance IS A DEMONSTRATION OF THE QUALITY OF YOUR PROFESSIONAL SKILLS. It is expected that surgery residents appear well-groomed and professional at all times. White clinical coats and name tags are provided at all institutions. It is expected all personnel will dress in a professional way that represents the Department of Surgery. Soiled white coats can be placed in the dirty lab coat receptacle in the GME office for laundering. **When you are in clinic, you are expected to be in professional attire, not surgical scrubs with the exception of having to imminently return to the operating room. If you MUST wear scrubs in clinic, they must be clean and visually acceptable, devoid of any defects, holes, or stains.**

The Learning and Working Environment:

The General Surgery Residency Program recognizes that a sound academic and clinical education should be carefully planned and balanced with concerns for patient safety, quality of care, and resident well-being. Learning objectives of the program will not be compromised by excessive reliance on residents to fulfill service obligations. To prevent such negative outcomes, the Residency Program has adopted policies consistent with the Accreditation Council for Graduate Medical Education (ACGME) Learning and Working Environment requirements for residents.

Patient Safety/Quality Improvement:

The General Surgery Residency Program ensures a culture of patient safety and continuous quality improvement. Residents and faculty demonstrate an understanding and acceptance of their personal role in:

- Assurance of the safety and welfare of patients entrusted to their care
- System wide performance improvement and patient safety systems
- Promotion of safe, inter-professional and team-based care
- Reporting responsibilities and process for reporting patient safety events and near misses
- Disclosure of adverse patient safety events
- Quality improvement process and health care disparities, including review of data and quality metrics

All residents are required to complete on an annual-basis RUHS educational and GME competency modules as follows:

1. "Know Your Patient"
2. "Patient Safety- Further Steps to Prevent Harm"
3. "Patient Safety",
4. "Sleep Deprivation: Your Life and Your Work",
5. "Thriving through Residency: The Resilient Resident"
6. "Building the Patient-Physician Relationship"
7. "Resident Intimidation"

Residents will also participate in root cause analyses and performance improvement committees during the course of their residency. In addition, residents undergo experiential learning involving things such as inter-professional quality improvement activities which include reducing health care disparities.

Supervision and Accountability:

The General Surgery Residency Program has developed curriculum and rotation assignments where the clinical responsibilities must be based on PGY level, experience of the resident, patient safety, severity and complexity of patient illness/condition, and available support services. Patients must have an identifiable and appropriately-credentialed and privileged attending who is responsible and accountable for their care. Although the attending physician is ultimately responsible for the care of the patient, residents share in the responsibility and accountability for their efforts in the provision of care.

When providing direct patient care, residents and faculty must inform each patient of their respective roles in their care. Badges, including an attached badge buddy identification card, must be worn at all times.

Faculty provide supervision of residents in an educational setting which provides safe and effective care to patients while allowing residents to develop the skills, knowledge and attitudes necessary graduate and practice medicine unsupervised. Residents are supervised by faculty according to the Program Supervision Policy.

Supervision Policy:

The General Surgery Residency Program follows the principle that supervision is necessary at all resident levels but recognizes that a delicate balance exists in which graduated responsibility and opportunity to

make decisions is vital to the growth and development of surgical judgment by the resident. The principle of graduated responsibility under supervision begins in the PGY-1 year with resident credentialing in critical care skills and progression from specific to general supervision. The program director will evaluate each resident's abilities based on specific criteria, guided by the American College of Graduate Medical Education (ACGME) Milestones. As residents gain knowledge, proficiency in manual and problem-solving skills, and demonstrate acquisition of good judgment, the intensity of supervision decreases to foster independent decision-making. Resident capabilities are monitored on a regular basis through direct observation by faculty to ensure residents are working within their experience and documented ability.

Basic General Surgery Residency Supervision Policy:

The program promotes oversight of resident supervision based on the ACGME's three classifications or Levels of Supervision:

1. Direct Supervision: The supervising physician is physically present with the resident and patient.
2. Indirect Supervision:
 - a. With direct supervision immediately available: The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision
 - b. With direct supervision available: The supervising physician is not physically present within the confines of the site of the patient care, but is immediately available via phone and/or electronic modalities, and is available to provide Direct Supervision.
3. Oversight: The supervising physician is available to provide review of procedure/encounters with feedback provided after care is delivered.

The first year of residency emphasizes surgical diagnosis, pathophysiology and pre- and post- operative care. The PGY-1 resident, along with the more senior resident, is involved in the daily presentation of the patient to the attending surgeons where treatment decisions are finalized. The PGY-1 resident follows the patient to surgery, where he acts as one of the surgical assistants. In less complicated cases, such as hernia or appendectomy, the junior resident often performs the operation as directed by the attending surgeon.

PGY-1 residents require **Direct Supervision** until competency is demonstrated for:

1. Patient Management Competencies:
 - a. Initial evaluation and management
 - b. Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status and compartment syndromes.
 - c. Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing and other treatments.
 - d. Management of patients in cardiac or respiratory arrest (ACLS required)
2. Procedural Competencies:
 - a. Central venous access placement
 - b. Arterial catheterization
 - c. Temporary dialysis access management
 - d. Tube thoracostomy
 - e. I & D of simple abscess at bedside

PGY-1 residents require **Indirect Supervision** for:

1. Patient Management Competencies:

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

PGY 2 – 3 residents who demonstrate good performance may be given responsibility for independent judgment and surgical decision-making with continued attending supervision. By the third year, residents may be given more responsibility for evaluating surgical patients in the emergency room, initiating preoperative treatment and arranging for further surgical care. In addition, PGY 2-3 residents are more involved with the technical aspects of the surgery in the operating room.

PGY 4 residents are considered the senior/chief of the service and supervise junior residents and medical students. Senior residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while attending surgeons monitor their progress and continue to supervise the service. Senior residents are allowed and encouraged to exercise independent surgical judgment to the degree that is consistent with good patient care.

PGY 5 residents are considered the chief of the service and supervise junior residents and medical students. Chief residents are expected to exercise increasing degrees of independent responsibility for surgical decision-making and perform more advanced surgical procedures, while attending surgeons monitor their progress and continue to supervise the service. Chief residents are allowed and encouraged to exercise independent surgical judgment to the degree that is consistent with good patient care.

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

Only members of the Medical Staff who have been granted appropriate privileges and who have been selected by the Residency Program Director shall supervise residents.

Documentation of supervised order-writing shall be demonstrated by counter-signature of the resident's note or by referring to the resident's documentation in a separate attending note.

The supervising physician shall personally interview and examine the patient each day to confirm the resident's findings and to evaluate the resident's clinical care.

The supervising physician shall be physically present during the critical portion of each surgical procedure. This responsibility may be shared with a senior or chief resident who has been designated as being competent of performing a limited number of procedures without the direct presence of the supervising physician (i.e. chest tube placement, CVL, I&D of an abscess).

The supervising physician must approve any admission of a patient to the service. This will allow discussion of the resident's preliminary medical diagnosis and preliminary decision making.

The supervising physician shall be informed of transfer of a patient to another service or to another level of care e.g. ICU, intermediate, etc., or death of a patient.

The supervising physician must approve any recommendation to discharge a patient from the Emergency Room.

The resident shall order consultations and testing on behalf of the attending physician following discussion with the attending physician. This must be documented by the resident or by the attending in the order or in the physician's notes.

Any consultations requested by another service may be seen initially by the resident. The resident shall immediately discuss the consultation with the supervising physician for critically ill patients. The consulting physician shall personally evaluate the patient within one day of the request for consultation.

Residents in General Surgery will not operate independently. All cases taken to the operating room will be discussed with the attending physician and all operations will be performed under the supervision of the attending physician.

The GME office has instituted a system, e-Priv, which allows residents, faculty members, and other healthcare workers the ability to view resident procedures that have been designated by the program director as competent to perform without direct attending supervision, i.e. chest tube placement, CVL, I&D of an abscess.

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

Faculty Responsibilities for Supervision:

The supervisory faculty has accepted guidelines concerning supervisory expectations of faculty members as a condition of faculty appointment. The guidelines state that the faculty supervisor will:

1. Accept the responsibility for the surgical residents assigned to his/her patients.
2. Allow the residents to actively participate under his/her supervision and control in the care of their patients, including the performance of procedures, commensurate with the resident's level of training.
3. Recognize that the residents and learners are involved in a program designed to help them master the art and science of surgery. Realize that residents have not reached that point in their careers when they can function without supervision by the surgical faculty attending staff.
4. Recognize the responsibility of each surgical faculty member to assess the level of capability of each resident in each delegated task and to provide an appropriate level of supervision while delegating progressively increasing responsibility commensurate with increasing skill and judgment.

5. Recognize that all responsibilities which a surgical resident assumes are delegated responsibilities and that ultimately the attending surgeon is the physician responsible for the safety and welfare of the patients under their care and for the resident's participation in the management of those patients.

Professionalism:

Residents display professionalism through patient safety and personal responsibility. Acceptance of the personal role in support of the patients' safety, including accurate reporting of duty hours, patient outcomes, and clinical experience data. The program director will ensure a culture of professionalism that stresses the importance of awareness and accountability for fitness for duty.

The General Surgery Residency Program educates residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients and promotes patient safety and resident well-being in a supportive educational environment.

The General Surgery Program Director ensures a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty demonstrate an understanding and acceptance of their personal role in:

- Provision of patient and family-centered care
- Reporting of unsafe conditions and adverse events
- Assurance of their fitness for duty
- Management of their time before, during, and after clinical assignments
- Recognition of impairment, including illness and fatigue, in themselves and in their peers
- Commitment to lifelong learning
- Monitoring of patient care performance improvement indicators
- Honest and accurate reporting of duty hours, patient outcomes and clinical experience data

All residents and faculty members demonstrate responsiveness to patient needs that supersedes self-interest. Our physicians recognize that, under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

To ensure a professional and respectful work environment the residents will complete the GME Competency Education Program modules on "Building the Patient-Physician Relationship" and "Resident Intimidation", as well as other curriculum outlined in the program's professionalism curriculum.

Well-being:

Psychological, emotional, and physical well-being are critical in the development of competent, caring and resilient physicians and requires proactive attention to life inside and outside of medicine. The General Surgery Residency Program supports the well-being of the residents and faculty members by providing a learning and working environment that includes:

- Finding meaning in work by minimizing non-physician obligations, providing administrative support, allowing progressive autonomy and flexibility, and enhancing professional relationships
- Monitoring of work schedules
- Evaluating the safety of residents and faculty members in the learning and working environment
- Providing education on identification of burnout, depression, and substance abuse

Residents and faculty are encouraged to alert the program director or other designated personnel if signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence is displayed by another resident or faculty member.

All residents and faculty are provided confidential access to the Riverside County Employee Assistance Services (EAS). The EAS staff of licensed psychologists and licensed marriage and family therapists can offer professional, confidential, and knowledgeable help to residents with personal or work-related concerns. Residents may make a self-referral by calling the main Riverside office at (951) 778-3970. EAS resources may also be accessed at <http://eas.rc-hr.com/>. In addition, residents are also provided with supplemental EAS services 24/7 via the AMA/Standard Insurance (877) 851-1631. Residents have access to referrals for support groups, counselors, community resources and, if necessary, are connected to emergency services.

Residents and faculty also have access to the RUHS Physician Well-being Committee. This is a confidential resource for faculty and residents. The committee can provide access and resources for substance abuse, psychosocial stressors, physical illness and cognitive impairment. To set a confidential appointment with the committee, contact Dorinda Shaw at 951-486-4474 or via e-mail at d.shaw@ruhealth.org or Janice Reichardt, at 951-486-5015 or via e-mail at j.reichardt@ruhealth.org. If you are anxious about making an appointment, you can contact the Chair without disclosing names to Richard Prather, MD at 951-955-8000. Dr. Prather can also be contacted via e-mail at RDPrather@rcmhd.org.

The program will grant time for residents to attend medical, mental health, and dental care appointments. Residents are encouraged to notify the department of scheduled appointments as soon as possible to allow for sufficient time to make schedule adjustments.

Fatigue Mitigation:

Education is provided to all faculty physicians and residents to recognize the signs of fatigue and sleep deprivation. Residents are encouraged to stop and rest when fatigued. If sufficiently fatigued to potentially impair their ability to perform, the resident must transfer responsibility to another resident or to a faculty physician and notify the Program Director or designee of transfer needs. The department has developed the call schedule to include a back-up call resident and physician. Should the need for coverage for a fatigued resident take place during the night shift, residents should contact their in-house attending or senior resident. The attending or senior resident will work directly with the Administrative Chief resident to arrange for appropriate coverage.

At RUHS and/or participating sites, there are comfortable sleep facilities available for residents who are too fatigued to safely return home. Residents who recognize that they may be too fatigued to drive home are encouraged to utilize the sleeping facilities to rest before leaving the work site or utilize the safe ride home services provided by the Department and GME. Should a resident require a safe ride home, they can contact UBER or LYFT for the ride and submit receipt to the program coordinator for reimbursement. These ride home options are available to all residents regardless of the site rotation. Residents can also utilize these services the next day to return to work and retrieve their vehicle.

Residents must monitor themselves for signs suggestive of fatigue that usually occur after prolonged periods of sleeplessness such as:

- Sluggish thought patterns and inability to concentrate
- Impaired Recall
- Moodiness and Depression
- Inability to maintain a wakeful state in absence of external stimulation

- Micro-episodes of sleep
- Inflexible thinking or impairment of planning
- Intention tremors while performing delicate procedures
- Errors in judgment

The General Surgery program encourages residents to practice strategic napping after 16 hours of continuous duty.

Clinical Responsibilities:

The General Surgery Residency Program has developed curriculum and rotation assignments to ensure the clinical responsibilities of each resident are based on the physical status of the patient, the PGY level and experience of the resident, patient safety, severity and complexity of patient illness/condition, and available support services. Resident capabilities are monitored on a regular basis through direct observation by faculty to ensure residents are working within their experience and documented ability.

Teamwork:

Residents will care for patients in an environment that maximizes effective communication. The program provides the opportunity for residents to work as a member of inter-professional teams appropriate to the service to which a resident is assigned. Residents will collaborate on a regular basis with their attending, other residents, nursing staff, operating room staff, and other inter-professional and multidisciplinary teams to formulate treatment plans for our diverse patient population.

Transition of Care:

Residents will utilize the Department of Surgery Transition of Care policy to promote patient safety through accurate communication regarding patient care, treatment services, current condition, and any recent or anticipated changes. In addition to the departmental policy, residents should refer to the hospital-wide policy 621.1 “Hand-off Communication”. The Transition of Care policy should be utilized in the event that a resident is unable to perform their patient care responsibilities due to excessive fatigue, illness, or family emergency.

Residents will be evaluated by faculty at least once per year using the Hand-off evaluation Form available in New Innovations.

Clinical Experience and Educational Work Hours:

Initial education of the residents with respect to clinical and educational work hours is provided at GME and department orientation. However, education is ongoing throughout the entire program as hours are monitored and issues addressed. Residents are provided with education regarding fatigue and sleep deprivation at orientation utilizing an annual online module. The module is available to residents online on the RUHS website for their review at any time.

The program structure is configured to provide the residents with a balance between educational opportunities and opportunities for rest and personal well-being.

Situations in which residents work an excessive number of hours can lead to errors in judgment and clinical decision-making. These errors can impact patient safety, as well as the safety of the residents through increased motor vehicle accidents, stress, depression and illness related complications. RUHS, the DIO, and the Program Director must maintain a high degree of sensitivity to the physical and mental well-being of the residents and make every attempt to avoid scheduling excessive work hours leading to sleep deprivation, fatigue or inability to conduct personal activities. To prevent such negative outcomes, the General Surgery Residency Program has adopted the following clinical and educational work hours’ policies:

- Clinical and Educational Work Hours are defined as all clinical and academic activities related to the residency program (patient care, administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during clinical and educational activities, and clinical work done from home). Work hours do not include reading and preparation time spent away from the duty site.
- The resident shall not be assigned to work physically on duty in excess of 80 hours per week **averaged over a 4-week period**, inclusive of all in-house clinical and educational activities, and clinical work done from home.
- Adequate time for rest and personal activities must be provided between all daily duty periods. All residents should have 8 hours off between scheduled clinical work and education periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. These hours will be counted toward the 80-hour weekly limit. Should this occur, an e-mail must be sent to the program coordinator indicating the circumstances the resident is continuing to work, this must include the patient's name, date and additional time spent with patient.
- Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, **averaged over a 4-week period**. One day is defined as 1 continuous 24-hour period free from all clinical, educational and administrative activities. At-home call cannot be assigned on these duty-free days.
- PGY 2 – 5 resident work hours may not exceed 24-hours of continuous scheduled clinical assignments. Strategic napping after 16 hours between 10 pm and 8 am is strongly suggested. Residents may remain on duty for up to 4 additional hours (after a 24-hour shift) for activities related to patient safety, such as transfer care of patients, and maintain continuity of medical and surgical care, and/or resident education. No NEW patients may be accepted after 24 hours of continuous duty.
- In rare circumstances, after handling of all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
 - To continue to provide care to a single severely ill or unstable patient.
 - Humanistic attention to the needs of a patient or family.
 - To attend unique educational events.

These additional hours of care or education must be counted towards the 80-hour weekly limit and the one day off in seven requirements.
- Night float must occur within the context of the 80-hour, one day off in seven requirements.

- Night float must not exceed two months in duration continuously, and must not exceed four months per PGY level.
- Night float must not exceed 12 months total for the entire duration of a general Surgery residency.
- In-house call must occur no more frequently than every third night, averaged over a 4-week period.
- *At-home call* (or pager call) is defined as call taking call from outside the assigned institution. The frequency is not subject to every third night limitation. Residents must still be provided with 1 day in 7 completely free of clinical responsibilities, averaged over a 4-week period. Time spent on patient care activities while on at-home call (both at home and when called into the hospital from home) must be counted toward the 80-hour maximum limit.
- The Program Director and the faculty, monitor the demands of the at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- Residents are to be proactive in monitoring their clinical and educational work hours. Once call schedules are received, residents should review the schedule and immediately report any potential work hour violations program coordinator and/or Administrative Chief so that the call schedule can be revised in advance.
- Resident work hours will be checked weekly for compliance. Should violations occur, the resident will be required to complete a Work Hours Violation Report. These reports will be reviewed and signed off by the Program Director. All violations will be accessed to determine how these violations will be avoided in the future.

A report of work hours (for purposes of hours reporting, the work week runs Thursday through Wednesday) should be logged in New Innovations every Wednesday. Hours are considered delinquent as of Wednesday morning at 8 am. **Residents who are delinquent in reporting hours may be suspended from duty.** Chronic non-compliance (more than three times in a quarter) will require a meeting with program director where disciplinary action will be implemented.

Riverside University Health System requires all employees to submit a time card reflecting hours worked. Hours not recorded in New Innovations may result in a delay of pay. The purpose of reporting hours is for the residency office to monitor work hours, keep them within the ACGME guidelines, and to report to the RUHS Payroll Office for compensation.

The residency uses **New Innovations** to track work hours to verify residents are in compliance with ACGME guidelines as noted above. Residents are required to record work hours in **New Innovations** on a weekly basis. This includes hours worked at each facility/location. ***It is extremely important that hours are accurately reported.*** Under- and over-reporting of hours is not allowed; it is required that all residents accurately report work hours.

Monitoring of work hours is done by the program coordinator. Notifications of violations are sent first to the resident for verification and explanation/comment and then to the supervising physician and/or program director. Work Hours violations are reviewed monthly at the Graduate Medical Education Committee (GMEC) meeting.

Moonlighting:

Riverside University Health System Department of Surgery **prohibits** moonlighting during residency training.

Disciplinary, Remediation, and Appeal Process:

Riverside University Health System-Medical Center (RUHS-MC) strives to provide Residents with an environment conducive with academic and professional development. RUHS-MC understands that academic-related concerns or conflicts may arise during the term of the Resident's Graduate Medical Education Training Agreement (Agreement) with RUHS-MC. This policy and procedure is established to assist in clarifying and/or resolving academic-related disciplinary and/or remediation issues during the term of the Agreement.

Further, this policy and procedure is:

1. To establish guidelines for corrective action, remediation and/or disciplinary action relative to academic matters;
2. To assure careful consideration, reasoned action, and fair treatment with due consideration and regard for the facts and circumstances which lead to any corrective action, remediation and/or disciplinary action recommended or taken;
3. To provide an opportunity for Residents to address and resolve issues related to corrective actions, remediation and/or disciplinary action imposed due to academic matters.

These guidelines apply to General Surgery residents at each of the integrated institutions. Representatives from the appropriate hospitals will be involved in the decision-making process.

Guidelines and Procedures:**Academic-Related Disciplinary Action and Remediation:**

The residency program director is responsible for assessing and monitoring the academic and professional progress of each resident. The residency program director is also responsible for monitoring resident adherence to applicable policies and procedures governing the residency training program and RUHS-MC.

Academic-related disciplinary action and/or remediation is usually progressive in nature:

FORMATIVE FEEDBACK

- a. Formative feedback is appropriate for concerns that appear to be isolated and easily correctable.
- b. This will usually be verbal and is not considered remedial, but rather a formative assessment and part of the expected educational process.
- c. Documentation that a verbal discussion occurred may be required as determined by the program director.
- d. Formative assessments identifying strengths, weaknesses and targeted areas in need of improvement should be provided to the trainee.

LETTER OF NOTICE OF DEFICIENCY and FORMAL IMPROVEMENT PLAN

- a. A Letter of Notice of Deficiency and Formal Improvement Plan are appropriate for concerns that have not been adequately addressed by formative feedback or for concerns that appear to require more intentional effort on the part of the trainee to achieve competence and require additional monitoring by the program during the expected course of the residency program.

- b. The Formal Improvement Plan is appropriate for levels of performance that do not meet training expectations; however, it is still considered part of the educational process, and is not considered remediation.
- c. Written documentation will be provided to the trainee and retained. It will consist of:
 - i. a formal plan for improvement that is clearly related to the concern(s)
 - ii. the goal of the plan and what would demonstrate achievement of that goal
 - iii. a target time to demonstrate achievement of the goal
 - iv. consequences of not meeting goals/standards
 - v. notification that any extensions of the resident's training period, for academic or disciplinary causes, may lead to a delay in graduation and participation in fellowship training or private practice, and may also delay the resident's eligibility for board certification examinations. Extension of the resident's training period will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training.
 - vi. resident signature acknowledging receipt and review of the Formal Improvement Plan
- d. Trainees on a Formal Improvement Plan will receive face-to-face evaluations on a monthly to quarterly basis, as determined by the program director, from a faculty member that will include a review of the trainee's performance. A written summary of the face-to-face evaluation should be included in the trainee's file.
- e. Failure to correct the deficiencies within the timeline defined in the Letter of Notice of Deficiency and Formal Improvement Plan may result in further progressive disciplinary actions being taken including, but not limited to, possible placement on academic probation, extension of the training program, suspension or termination from the program.

REMEDIATION in One or More Competencies

- a. Remediation is appropriate for concerns that have not responded to a written improvement plan or to concerns of sufficient magnitude of deficiency that will likely require extension of the residency program in order to demonstrate competence.
- b. Record of remediation will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training.
- c. Written documentation will be provided to the trainee. It will consist of:
 - i) the fact that this action is remediation
 - ii) the specific reason for remediation
 - iii) a formal plan for improvement that is clearly related to the concern(s)

- iv) the goal of the plan and what would demonstrate achievement of that goal
 - v) a target time to demonstrate achievement of the goal
 - vi) the length of additional training, if any, anticipated for demonstration of the achievement of the goal
 - vii) the fact that academic-related actions may be appealed through Due Process for Academic-Related Disciplinary Action
 - viii) notification that any extensions of the resident's training period, for academic or disciplinary causes, may lead to a delay in graduation and participation in fellowship training or private practice, and may also delay the resident's eligibility for board certification examinations. Extension of the resident's training period will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training.
 - ix) resident signature acknowledging receipt and review of the written documentation
- d. Trainees in remediation will be monitored closely and will receive:
- i) feedback and/or evaluation of performance
 - ii) regular feedback sessions on a weekly to monthly basis, as determined by the program director, with an appropriate faculty member to support progress in achieving the goal
 - iii) formal, face-to-face evaluations on a monthly to quarterly basis, as determined by the program director, from a faculty member that will include a review of the trainee's performance. A written summary of the face-to-face evaluation should be included in the trainee's file.
- e. At the discretion of the Program Director, consultation may be obtained from the Office of County Counsel prior to implementing remediation.

PROBATION

- a. Is appropriate for concerns that have not responded to remediation or concerns of a nature such that failure to demonstrate sustained improvement would preclude continuation in the residency program.
- b. Probation will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training.
- c. Written documentation of probation will be provided to the trainee and retained.
Written documentation of probation will consist of:
 - i) the fact that this action is probation

- ii) the specific reason for probation
 - iii) the goal of the plan and what would demonstrate achievement of that goal
 - iv) a time period during which the trainee must demonstrate sustained achievement in meeting the goal
 - v) the fact that failure to demonstrate sustained achievement throughout the specified time period or recurrence after that time period will result in termination from the residency program
 - vi) the fact that academic-related disciplinary actions may be appealed through Due Process for Academic-Related Disciplinary Action
 - vii) notification that any extensions of the resident's training period, for academic or disciplinary causes, may lead to a delay in graduation and participation in fellowship training or private practice, and may also delay the resident's eligibility for board certification examinations. Extension of the resident's training period will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training.
 - viii) resident signature acknowledging receipt and review of the written documentation
- d. Trainees on probation will be monitored closely and receive:
- i) feedback and/or evaluation of any suboptimal performance
 - ii) regular feedback sessions on a weekly to monthly basis, as determined by the program director, with a faculty member to support progress in achieving the goal
 - iii) formal, face-to-face evaluations on a monthly to quarterly basis, as determined by the program director, from a faculty member that will include a review the trainee's performance. A written summary of the face-to-face evaluation should be included in the trainee's file.
- e. At the discretion of the Program Director, consultation may be obtained from the Office of County Counsel prior to implementing remediation.

SUSPENSION

- a. Investigatory suspension
 - i) Investigatory suspension is appropriate for a concern that poses immediate jeopardy to the safety of patients, the trainee or others, or represents a potential serious breach of professionalism
 - ii) The trainee may be placed on administrative leave

- iii) Investigatory suspension is not of itself considered a negative evaluation and may not be appealed. However, an action resulting from the investigation (i.e., remediation, probation or termination), may be appealed through Due Process for Academic-Related Disciplinary Action.
 - iv) Investigatory suspension may not be reportable to entities seeking verification of residency training if there are no adverse findings or action(s) taken against the Resident. Adverse findings or action(s) resulting from the investigation or extension of the Resident's training period may be reportable.
- b. Disciplinary suspension
 - i) Disciplinary suspension is appropriate for failure to complete or adhere to training program requirements, including, but not limited to, having an unacceptable number of medical record deficiencies, failing to maintain required certifications, failing to meet academic standards, demonstration of unprofessional behavior or misconduct of an egregious nature which necessitates removal from the residency training program.
 - ii) Disciplinary suspension for academic-related matters may be appealed through Due Process for Academic-Related Disciplinary Action
 - iii) The trainee may be placed on administrative leave
 - iv) Disciplinary suspension will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training
- c. Written documentation of investigatory or disciplinary suspension will be provided to the trainee and retained. It will consist of:
 - i) the fact that this is suspension and specification of the type of suspension
 - ii) the specific reason for suspension
 - iii) duration of the suspension
 - iv) in cases of investigatory suspension, the resident will be notified when the investigation has been completed and will be informed of the findings/actions of the investigation
 - v) in cases of disciplinary suspension, the resident must be notified of the requirements for removal of suspension and a time period during which those requirements must be met
 - vi) the fact that failure to satisfy the requirements set forth in the suspension documentation will result in termination from the residency program

vii) the fact that academic-related disciplinary suspension may be appealed through Due Process for Academic-Related Disciplinary Action

viii) notification that any extensions of the resident's training period, for investigatory or disciplinary suspension, may lead to a delay in graduation and participation in fellowship training or private practice, and may also delay the resident's eligibility for board certification examinations. Extension of the resident's training period will become part of the trainee's permanent record and be expected to be disclosed to entities seeking verification of residency training.

ix) resident signature acknowledging receipt and review of the written documentation

d. At the discretion of the Program Director, consultation may be obtained from the Office of County Counsel prior to implementing suspension.

NON-RENEWAL

a. Non-renewal of the resident training agreement is appropriate for:

i. Decision by the Resident to no longer participate in the residency training program

ii. OR negative actions that are not deemed cause for immediate termination which include, but are not limited to:

i. jeopardizing the safety of patients, co-workers or the public

ii. OR breach of professionalism

iii. OR substantial breach of the terms of the resident training Agreement

iv. OR failure to achieve the goals of remediation, probation or suspension in the required time

v. OR failure to satisfy the academic and/or clinical requirements of the training program

vi. OR serious neglect of duty or violation of RUHS-MC rules, regulations, or policies by the Resident

vii. OR conduct by the Resident seriously and clearly prejudicial to the best interest of RUHS-MC.

viii. OR misconduct of a nature which necessitates non-renewal of the resident's training agreement

- b. Written notification of the non-renewal will be provided to the trainee and retained. It will consist of:
 - i. The date of non-renewal notification. Notification must be given four months prior to the end of the training agreement unless the issue leading to non-renewal occurred at a time that made four months notification not possible
 - ii. The grounds on which the non-renewal of training agreement is based
 - iii. The fact that academic-related disciplinary actions may be appealed through Due Process for Academic-Related Disciplinary Action
 - iv. Notification that non-renewal of the resident's training agreement due to medical disciplinary cause(s) or reason(s) will be expected to be included in all future correspondence seeking verification of residency training.
 - v. The fact that the appropriate medical licensure board for the State of California will be notified of non-renewal of the resident's training agreement for medical disciplinary cause(s) or reason(s) after due process is completed.
 - vi. resident signature acknowledging receipt and review of the written documentation
- c. At the discretion of the Program Director, consultation may be obtained from the Office of County Counsel prior to implementing non-renewal of the training agreement.

TERMINATION

- a. Termination is appropriate for
 - i) jeopardizing the safety of patients, co-workers or the public
 - ii) OR a serious breach of professionalism including any criminal charges
 - iii) OR substantial breach of the terms of the resident training Agreement
 - iv) OR failure to achieve the goals of remediation, probation or suspension in the required time
 - v) OR failure to satisfy the academic and/or clinical requirements of the training program
 - vi) OR serious neglect of duty or violation of RUHS-MC rules, regulations, or policies by the Resident
 - vii) OR conduct by the Resident seriously and clearly prejudicial to the best interest of RUHS-MC
 - viii) OR unapproved absence of the Resident from the program

- ix) OR failure to fully cooperate with any investigation
 - x) OR incapacity of the resident due to illness or injury, at any time after the continuation of such incapacity for more than sixty (60) days, or upon exhaustion of any leave to which the resident is entitled during such incapacity under the Family Medical Leave Act, whichever occurs at a later time.
 - xi) OR misconduct of an egregious nature which necessitates removal from the residency training program
- b. Written notification of termination will be provided to the trainee and retained. It will consist of:
- i) The date of termination
 - ii) The grounds on which the termination is based
 - iii) The fact that academic-related disciplinary actions may be appealed through Due Process for Academic-Related Disciplinary Action
 - iv) Notification that termination will be expected to be included in all future correspondence seeking verification of residency training
 - v) The fact that the appropriate medical licensure board for the State of California will be notified of the termination after due process is completed
 - vi) resident signature acknowledging receipt and review of the written documentation
- c. At the discretion of the Program Director, consultation may be obtained from the Office of County Counsel prior to implementing termination.

Due Process for Academic-Related Disciplinary Action:

It is the intent of RUHS-MC that each resident successfully completes the residency training program and become eligible to proceed with further training or directly into practice. RUHS-MC does not anticipate the need to take corrective action or discipline against a resident; however, in the event corrective action or discipline is deemed appropriate, it is the intent of RUHS-MC to provide the resident with the opportunity to seek informal review and appeal the action imposed.

Informal Review of Corrective Action or Discipline:

Except when the Residency Program Director determines that a corrective action or discipline should be immediately imposed, the corrective action or discipline shall be reviewed with the resident before being implemented. The resident shall have the opportunity to seek informal review of a corrective action or discipline in accord with the following:

1. As stated above, the Residency Program Director shall provide the resident a Letter of Notice of Deficiency (hereafter "Notice") including a description of the deficiency, corrective action(s) to be taken and timeline in which action(s) should occur and any disciplinary action to be taken.

2. Within five (5) business days (excluding Riverside County holidays) of receipt of the Notice the resident may request, in writing, the opportunity to meet with the Residency Program Director to discuss, explain and/or refute the charges. In absence of the residents' request for an informal review, the Notice shall be the Residency Program Director's decision in the matter. At the discretion of the Program Director, the informal review may be conducted by an appropriate designee (i.e., Chair of the Clinical Competency Committee or Chair or Vice Chair of the respective department).
3. After the informal review with the resident, the Program Director may take such further action as may be appropriate, including, but not limited to, letting the charges and/or corrective action and discipline stand, or modifying the corrective and/or disciplinary actions. Within five (5) business days (excluding Riverside County holidays) after the review meeting with the resident, the Program Director shall provide the resident with written notice of his/her further decision in the matter. Said further decision shall be the Program Director's final decision in the matter.
4. Corrective action or discipline imposed shall be effective until otherwise modified upon the completion of the formal review process set forth below.

Formal Review After Imposition of Corrective Action or Discipline:

A resident shall have the right to have a corrective action or discipline imposed against him/her reviewed in accord with the following:

1. Within ten (10) business days (excluding Riverside County holidays) of receipt of the Program Director's decision, the resident may request, in writing, a formal review. The request for a formal review shall be directed to the Director of Graduate Medical Education (DGME) or the Osteopathic Director of Medical Education (ODME), whichever is applicable. If the resident fails to request a formal review as specified herein, he/she shall be deemed to have waived the right to said formal review and acquiesce to the corrective action or discipline imposed.
2. Upon receipt of the residents' request for a formal review of the corrective action or discipline taken against him/her, the DGME/ODME shall promptly set a date for convening a committee to review the action; but not later than fifteen (15) business days (excluding Riverside County holidays) after the committee is constituted. The committee's membership shall consist of the DGME/ODME or designee, Chief Medical Officer or designee, Human Resources Director or designee, a faculty member not associated with the resident's training program and a resident representative not associated with the resident's training program. The DGME/ODME or designee shall serve as Chair of the committee.
3. The DGME/ODME shall provide the resident, committee members and other appropriate persons with written notice of the time, place and date of the formal review.
4. The resident and the Program Director shall appear at the formal review. In cases of academic discipline, legal representation is not permitted for either party. Failure of the resident to appear at the formal review or to present his/her case at the formal review shall constitute a waiver of his/her right to a formal review and acceptance of the corrective action or discipline.
5. The formal review shall proceed and evidence taken in accord with the following:
 - a. Upon opening the formal review, the chair shall explain the review procedures and the rights of the parties as established hereunder;

- b. The formal review shall be limited to matters relevant to the committee's review of the action imposed against the resident;
 - c. The admission of relevant evidence will not be restricted by evidentiary rules applicable in a court of law;
 - d. Within reasonable limitations, both sides at the formal review may call and examine witnesses, cross-examine witnesses, and present exhibits or documents;
 - e. A recording of the proceeding will be effectuated by the use of a court reporter or an electronic recorder, or both, as appropriate;
 - f. Members of the committee may at any time ask questions of the parties or witnesses in order to gain a full understanding of the issues and facts. At the discretion of the chair, to aid the committee in its deliberations, the chair may request the production of any evidence not presented by the parties and seek the advice of legal counsel to address relevant issues of law;
 - g. At the discretion of the chair, closing arguments may be made by the parties; and,
 - h. Unless both parties agree to an open formal review, the review shall be closed and its proceedings deemed confidential. Witnesses other than the parties shall be excluded from the review except when providing testimony.
6. No later than fifteen (15) business days (excluding Riverside County holidays) after the close of the formal review, the committee shall prepare a decision and submit it to the Hospital Administrator or designee. The decision shall contain the committee's recommendation as to whether the action imposed should be sustained, modified, or rescinded, and the basis for the recommendation. The recommendation shall be supported by the preponderance of the evidence presented during the formal review. The parties shall promptly be provided a copy of the decision.
7. Within fifteen (15) business days (excluding Riverside County holidays) of receipt of the committee's decision, the Hospital Administrator or designee, upon consideration of the corrective action(s) or discipline taken and the review committee's report, shall issue a final decision as to the action taken against the resident. Upon issuance, the parties will be provided a copy of the decision.

Miscellaneous

- 1. The time requirements, with notice to the parties, provided hereunder may be extended or shortened as may be reasonable for the fair and timely resolution of a disputed corrective action or discipline.
- 2. At the discretion of the Chair of the Review Committee, a resident or faculty member, who is not involved in the corrective action or disciplinary measure under review, may be appointed to serve as a non-voting member of the committee to aid in the review process.
- 3. Notwithstanding a resident's informal review or appeal of a corrective action or discipline as provided hereunder, as approved by the Hospital Administrator or designee and Chief Medical Officer or designee, the resident may continue his/her clinical duties.

REFERENCES

1. ACGME Common Program, Institutional & RRC Program Requirements
2. AOA Basic Standards for Postgraduate Training & Specialty College Standards

Resident Representation:

When a resident has a particular problem/concern with the program, the resident has three avenues in which to discuss the problem/concern. First, the General Surgery **Residency Council** is an elected group of surgery residents who meet on a quarterly basis with the Program Director to discuss issues, concerns, and changes with the program. Residents at each level of training select one representative from their level to represent them on this council. Second, a senior resident represents the residents on the **Surgery Residency Review Committee**. This Committee is comprised of the Program Director, Associate Directors, and attending representatives from each hospital. Please contact your resident council representative or the senior resident representative if you have issues, you would like discussed at these forums. Third, the resident can bring the problem directly to the Program Director.

Personal Files:

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

Library:

The Department of Surgery currently maintains a core resident library in the RUHS library. No books are to be taken from the library. The library is available after hours by badge swipe access. In addition, residents are encouraged to utilize SCORE which offers a full cache of text books, videos, and journals.

American College of Surgeons (ACS):

This organization is the official representative of surgeons in the United States of America. A member of this organization is called a Fellow of the American College of Surgeons. This honor is granted to those who have completed a general surgery residency, have become board certified, have practiced in a local area for two years, and have satisfactorily completed the official interview, (which reviews personal and professional attitudes and standards). Residents can benefit from the privileges and opportunities of the ACS by becoming a member of the Resident and Associate Society of the American College of Surgeons (RAS-ACS).

Resident membership status:

The Resident Membership of the American College of Surgeons extends the educational and professional advantages of the college to surgical residents. The Candidate Group is composed of graduates from medical schools who are: A) Enrolled in approved surgical residency programs or, B) Fully trained surgeons who recently have entered into surgical practice and aspire to Fellowship in the American College of Surgeons. The Department of Surgery **requires** each resident to participate as a candidate member of the American Board of Surgery. The fee for filing an application is \$20.00; however, the fee is waived during the intern year and we have completed and filed your application. (Paired with the Fundamental of General Surgery course). You must however maintain your membership with ACS throughout your residency here at RUHS.

SESAP:

The Surgical Education and Self-Assessment Program presents current information that many surgical authorities consider important. The program provides a means of assessing your knowledge as you prepare for your board examinations (including the ABSITE). The Surgery Department strongly recommends your participation in SESAP.

Mail Boxes:

Mailboxes are located in the Surgery Residency call room. Please check them regularly for important program information and notices, **even if you are on an off-site rotation.**

RESIDENT HANDBOOK ACKNOWLEDGEMENT FORM – 2025-2026

- I have received the General Surgery Residency Program handbook for academic year 2025-2026 and I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it. The handbook describes important information about the General Surgery Residency Program, and I understand that this handbook replaces any previous understanding, practice, manual, handbook or workplace addenda, policy, or representation concerning the terms and conditions of the General Surgery Residency Program.
- I am aware of the residency program's disciplinary policy.
- I agree to abide by the policies and procedures contained within the handbook. I understand that the policies and benefits contained in this handbook may be changed, modified, or deleted at any time.
- I understand that it is my responsibility to retain a copy of this handbook and to request a new copy if mine is lost or damaged.
- ***I certify that I will accurately and completely report my work hours.***

Resident Employee Name (please print) _____

Employee Signature _____ **Date** _____