Advanced Upper GI Surgery Fellowship

PROGRAM MANUAL

2018

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FHGSR at its option, may change, delete, suspend or discontinue parts of, or the policy in its entirety, at any time, without prior notice. In the event of a policy change, employees will be notified. Any such action shall apply to existing as well as to future employees.

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The following material is a program-specific supplement to the Graduate Medical Education (GME) manual. Referral to, and familiarity with, each manual is expected by your Program Director and the Graduate Medical Education Committee.

Program Mission & Education Statement

Mission:

To extend the healing ministry of Christ by preparing compassionate and competent surgeons.

Education:

The purpose of the Upper Gastrointestinal (GI) & Hepato-Pancreato-Biliary (HPB) surgery fellowship is to provide an organized educational program with guidance and supervision which facilitates the fellow's personal and professional development while ensuring appropriate and safe patient care. Ultimately, this will produce a surgeon capable of a high level of performance who is capable of providing outstanding care for patients with HPB and upper GI diseases.

We commit to:

- Provide fellows the opportunity to learn the fundamentals of basic science as applied to HPB and upper GI.
- Provide an experience in preoperative, operative, and postoperative care for patients in all areas of HPB and upper GI diseases.
- Require fellows to participate in research and provide teaching and mentoring of medical students and residents.
- Provide the fellow and faculty with educational goals and objectives at the beginning of each rotation, and the opportunity to complete peer evaluations at the end of the rotation.
- Provide the fellow with a summative evaluation of performance on a semi-annual basis to show progression of expertise.
- Provide the fellow with supervisory lines of responsibility, fair grievance policies, and resources for mental/emotional support.
- Provide a sufficient number of surgical cases to advance operative skill and surgical judgment.
- Provide educational conferences on a weekly basis. These conferences will follow a set format with a developed curriculum. Attendance is mandatory.
- Provide a working environment that is optimal for fellow education and patient care. This environment will be safe and will provide adequate space for sleep, food, and lounge/study facilities.

Program Personnel:

Program Director
Sebastian de la Fuente, MD
Office: (407) 303-7399, Cell: (407) 247-4207
Email: Sebastian.delafuente.MD@flhosp.org

Associate Program Director
W. Steve Eubanks, MD
Office: (407) 303-6962

Residency Coordinator
Maria C. Cepero
Phone: (407) 303-7203
Email: Maria.Cepero@flhosp.org

Program Faculty:

HPB Core Faculty:
- Sebastian de la Fuente, MD HPB Program Director
- Steve Eubanks, MD Associate Program Director, Director of Academic Surgery

Transplant Surgery:
- Lawrence T. Chin, MD
- Giridhar Vedula, MD

Radiology:
- Nicholas Feranec, MD

Recruitment, Eligibility & Selection:

Applicant Eligibility:

I. Medical School Diploma
II.
1. LCME (Liason Committee of Medical Education) graduates:
i. Letter from residency program director (if applicable)
ii. Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination)
1. Transcript directly from the FSMB (Federation of State Medical Boards)
iii. Acceptable explanation of any break in education (if applicable)
iv. Demonstrated written and spoken fluency in English language
2. AOA graduates:
i. Eligible for Doctor of Osteopathy diploma without reservations

ii. Dean's Letter
iii. Letter from residency program director (if applicable)
iv. Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination)
1. Transcript directly from the FSMB (Federation of State Medical Boards)
v. Demonstrated written and spoken fluency in English language III.

IV. Additional required documents:
i. Personal statement
ii. CV
iii. Transcript
iv. Dean's letter
v. Three letters of recommendation by surgeons
vi. USMLE/COMLEX scores, Part I and II (USMLE preferred) vii. Photograph

III. Reasons for Ineligibility:
A. Applicant does not demonstrate sufficient commitment to the specialty of HPB.
B. Applicant did not present favorable impression to faculty, resident physicians and/or residency coordinator during elective time or interview process at AdventHealth.
C. Quality of interaction during preliminary contact with staff suggests incompatibility with the mission and values of AdventHealth
D. Quality of personal statement (content, typographical and grammatical errors), including no obvious commitment to HPB
E. Limited verbal and written English skills, including the inability to write clearly and legibly

IV. Applicants must have successfully participated in formal clinical training, medical school, residency training, or full-time clinical practice within the last 24 months (from date of application to the residency program).

V. A personal interview at AdventHealth is required for applicants who wish to be considered for the position.

VI. Each interview completes an evaluation form which includes four areas:
1. Presentation
2. Attitude/Maturity/Motivation
3. Educational Background
4. Ability to function as a house officer and hit in as a team-player

VII. The files are reviewed and screened by the selection committee, program director and residency coordinator. The following criteria are utilized:
1. Personal statement
2. Dean's Letter
3. USMLE scores
4. Letters of recommendation
5. Input from fellow interaction with applicant

VIII. The program director may permit the waiver of one or more of these requirements under special circumstances.

Examinations, Licensure & Certification:

USMLE:

All application paperwork should be submitted directly to the Residency Coordinator for processing.

Licensure:

Until USMLE Step 3 is completed and the fellow is eligible to apply for full licensure in the State of Florida, the fellow must maintain a Florida Department of Health Training License. This training license fee will be paid by the Program, and the application and all supporting documents must be sent to the Department of State by the Program not later than April 1st in order to give adequate time to process the application for a start date of July 1st in the training program.

Certifications:

Fellows in HPB are required to maintain current certifications in ACLS and ATLS in order to be able to participate in the training program. We encourage the fellow to obtain ACLS certification prior to the start of training, however if ACLS is not in place, the fellow is required to complete certification as part of orientation in June. ATLS certification must be completed within the first year of training. Current ACLS certification must be in place in order to qualify for ATLS training. Further recertification will be paid for by the Program and is mandatory for continuation of training

Copies of all certifications must be given to the Residency Coordinator for permanent record.

Program Curriculum:

- Surgical Oncology 9 months
- Minimally Invasive Surgery 1 month
- Transplant Surgery 1 month
- Electives 1 month

For any rotations not available at AdventHealth, the Program will make such arrangements as necessary in order to provide the fellow with the requisite experience.

The fellow will be exposed to a wide variety of conditions during the duration of the fellowship. This will allow acquisition of advanced technical and clinical skills essential for the professional clinical care of patients with complex GI and HPB diseases. This is due to the referral nature of our facility, as well as attraction of complex cases by the nationally and internationally renowned faculty. The fellow's time will be spent between core surgical oncology rotations, as well as minimally invasive and transplant rotations. Rotations are typically shared with a junior general surgery resident with equal responsibility in the care of patients. Fellows are not required to take in-house calls but are responsible for the management of patients at all time with faculty supervision.

Expected Case Load:

100 cases, including 40 pancreatic resections, 20 major liver procedures, 15 major biliary procedures, upper GI (gastrectomies, partial gastrectomies, fundoplications, myotomies, etc)

The curriculum of this HPB Fellowship includes the following goals and objectives, as detailed by the ACGME core competencies.

- 1. Patient care, including laparoscopic and robotic minimally invasive techniques
- 2. Medical knowledge with an emphasis on multi-disciplinary oncology patient care
- 3. Practice-based learning and improvement
- 4. Interpersonal and communication skills
- 5. Professionalism
- 6. Systems-based practice

Pancreaticoduodenectomy – competency
Advanced upper GI/HPB fellowship

Fellowship	Phase	Technical Expectations
Month 1-2	1	1. OR preparation & surgical planning: 2. Positioning of patient 3. Check equipment preference/availability 4. Laparotomy 5. Use of abdominal wall retractor and assembly
Month 2-3	2	6. Mobilization of right colon 7. Extended Kocher maneuver
Month 4-5	3	8. Identification of critical anatomy: Middle colic, SMV, portal vein 9. Tunnelization of pancreas
Month 6-7	4	10. Portal dissection
Month 8-10	5	11. Hepaticojejunostomy 12. Gastrojejunostomy/duodenojejunostomy
Month 10-12	6	13. Pancreaticojejunostomy

Distal pancreatectomy – competency
Advanced upper GI/HPB fellowship

Fellowship	Phase	Technical Expectations
Month 1-2	1	1. OR preparation & surgical planning: 2. Positioning of patient 3. Check equipment preference/availability 4. Port placement
Month 2-3	2	5. Gastric mobilization, gastrocolic ligament dissection/colonic mobilization
Month 4-5	3	6. Retropancreatic tunnelization
Month 6-12	4	7. Parenchymal transection

Hepatic resections – competency
Advanced upper GI/HPB fellowship

Fellowship	Phase	Technical Expectations
Month 1-2	1	1. OR preparation & surgical planning: 2. Positioning of patient 3. Check equipment preference/availability 4. Laparotomy 5. Use of abdominal wall retractor and assembly
Month 2-3	2	6. Mobilization coronary ligaments and retroperitoneal attachments
Month 4-5	3	7. Identification of critical anatomy: Suprahepatic venous control
Month 6-7	4	8. Portal dissection
Month 8-12	5	9. Parenchymal transection

Reading Assignment:

Esophagus:

1. Cunningham D, Allum WH, Stenning SP, et al. Perioperative chemotherapy versus surgery alone for resectable gastroesophageal cancer. N Engl J Med 2006; 355:11-20.
2. Macdonald JS, Smalley SR, Benedetti J, et al. Chemoradiotherapy after surgery compared with surgery alone for adenocarcinoma of the stomach or gastroesophageal junction. N Engl J Med 2001;345:725-730.
3. Siewert JR, Stein HJ. Adenocarcinoma of the gastroesophageal junction: classification, pathology and extent of resection. Dis Esophagus 1996;9:173-182.
4. Siewart JR, Feith M, Werner M, Stein HJ. Adenocarcinoma of the esophagogastric junction. Results of surgical therapy based on anatomical/topographic classification in 1,002 consecutive patients. Ann Surg 2000;232:353-361.
5. Larghi A, Lightdale CJ, Ross AS, Fedi P, et al. Long-term follow-up of complete Barrett's eradication endoscopic mucosal resection (CBE-EMR) for the treatment of high-grade dysplasia and intramucosal carcinoma. Endoscopy 2007;39: 1086-1091.
6. Homs, M.Y., et al., Single-dose brachytherapy versus metal stent placement for the palliation of dysphagia from oesophageal cancer: multicentre randomised trial. Lancet, 2004. 364(9444): p. 1497-1504.
7. Meredith KL, Weber JM, Turaga KK, et al. Pathologic response after neoadjuvant therapy is the major determinant of survival in patients with esophageal cancer. Ann Surg Oncol 2010;17:1159-1167.
8. Ng T, Vezeridis MP. Advances in the surgical treatment of esophageal cancer. Journal of Surgical Oncology 2010; 101:725-729.

Stomach:

Adenocarcinoma:

1. Graham DY Schwartz JT, Cain GD, Gyorkey F. Prospective evaluation of biopsy number in the diagnosis of esophageal and gastric carcinoma. Gastroenterology 1982;82:228-231.
2. Botet JF, Lightdale CJ, Zauber AG, et al. Endoscopic ultrasound in the pre-operative staging of gastric cancer: A comparative study with dynamic CT. Radiology. 1991;181:426-432.
3. Okada K, Fujisaki J, Kasuga A, et al., Endoscopic ultrasonography is valuable for identifying early gastric cancers meeting expanded-indication criteria for endoscopic submucosal dissection. Surg Endosc. 2010, 1279-1284.
4. Cooper JS, Guo MD, Herskovic A, Macdonald JS, Martenson JA, Jr., Al-Sarraf M, et al. Chemoradiotherapy of locally advanced esophageal cancer: long-term follow-up of a prospective randomized trial (RTOG 85-01). Radiation Therapy Oncology Group. JAMA 1999;281(17):1623-1627.
5. Ajani AJ, Winter K, Okawara GS, et al. Phase II trial of preoperative chemoradiation in patients with localized gastric adenocarcinoma (RTOG 9904): Quality of

combined modality therapy and pathologic response. JCO 2006;24:3953-3958.
6. Lim S, Muhs BE, Marcus SG, Newman E, Berman RS, Hiotis SP. Results following resection for stage IV gastric cancer; are better outcomes observed in selected patient subgroups? J Surg Oncol. 2007;95(2):118-122.
7. Hartgrink HH, van de Velde CJH, Putter H, et al. Extended lymph node dissection for gastric cancer: who may benefit? Final results of the randomized Dutch gastric cancer group trial. J Clin Oncol 2004;22:2069-2077.
8. Schwarz RE, Smith DD. Clinical impact of lymphadenectomy extent in resectable gastric cancer of advanced stage. Ann Surg Oncol. 2007;14:317-328
9. Cuschieri A, Weeden S, Fielding J, et al. Patient survival after D1 and D2 resections for gastric cancer: long-term results of the MRC randomized surgical trial. Surgical Co-operative Group. Br J Cancer 1999;79:1522-1530.

GIST:

1. Blesius A, Cassier PA, Bertucci F, et al. Neoadjuvant imatinib in patients with locally advanced non metastatic GIST in the prospective BFR14 trial. BMC Cancer 2011;11:72.
2. Hirota S, Isozaki K, Moriyama Y, et al. Gain-of-function mutations of c-kit in human gastrointestinal stromal tumors. Science 1998;279:577-580.
3. Miettinen M, Lasota J. Gastrointestinal stromal tumors: review on morphology, molecular pathology, prognosis, and differential diagnosis. Arch Pathol Lab Med 2006;130:1466-1478.
4. Demetri GD, von Mehren M, Blanke CD, et al. Efficacy and safety of imatinib mesylate in advanced gastrointestinal stromal tumors. N Engl J Med 2002;347:472-480.
5. Verweij J, Casali PG, Zalcberg J, et al. Progression-free survival in gastrointestinal stromal tumours with high-dose imatinib: randomised trial. Lancet 2004;364:1127-1134.
6. von Mehren M, Heinrich MC, Joensuu H, et al. Follow-up results after 9 years (yrs) of the ongoing, phase II B2222 trial of imatinib mesylate (IM) in patients (pts) with metastatic or unresectable KIT+ gastrointestinal stromal tumors (GIST) [abstract]. J Clin Oncol 2011;29(15_Suppl):Abstract 10016.

Neuroendocrine:

1. Pasieka JL, McKinnon JG, Kinnear S, et al. Carcinoid syndrome symposium on treatment modalities for gastrointestinal carcinoid tumours: symposium summary. Can J Surg 2001;44:25-32.
2. Gilligan CJ, Lawton GP, Tang LH, et al. Gastric carcinoid tumors: the biology and therapy of an enigmatic and controversial lesion. Am J Gastroenterol 1995;90:338-352.
3. Oberg K, Kvols L, Caplin M, et al. Consensus report on the use of somatostatin analogs for the management of neuroendocrine tumors of the gastroenteropancreatic system. Ann Oncol 2004;15:966-973.
4. Kvols LK, Moertel CG, O'Connell MJ, et al. Treatment of the malignant carcinoid

syndrome. Evaluation of a long-acting somatostatin analogue. N Engl J Med 1986;315:663-666.
5. Jensen RT, Fraker DL. Zollinger-Ellison syndrome. Advances in treatment of gastric hypersecretion and the gastrinoma. JAMA1994;271:1429-1435.

Pancreas:

Adenocarcinoma:

1. Hahn SA, Greenhalf B, Ellis I, et al. BRCA2 germline mutations in familial pancreatic carcinoma. J Natl Cancer Inst 2003;95:214-221.
2. Agarwal B, Abu-Hamda E, Molke KL, et al. Endoscopic ultrasound- guided fine needle aspiration and multidetector spiral CT in the diagnosis of pancreatic cancer. Am J Gastroenterol 2004;99:844-850
3. Callery MP, Chang KJ, Fishman EK, et al. Pretreatment assessment of resectable and borderline resectable pancreatic cancer: expert consensus statement. Ann Surg Oncol 2009;16:1727-1733.
4. Yeo CJ, Abrams RA, Grochow LB, et al. Pancreaticoduodenectomy for pancreatic adenocarcinoma: postoperative adjuvant chemoradiation improves survival. A prospective, single-institution experience. Ann Surg 1997;225:621-633.
5. Leach SD, Lee JE, Charnsangavej C, et al. Survival following pancreaticoduodenectomy with resection of the superior mesenteric- portal vein confluence for adenocarcinoma of the pancreatic head. Br J Surg 1998;85:611-617.
6. Traverso LW, Longmire WP, Jr. Preservation of the pylorus in pancreaticoduodenectomy. Surg Gynecol Obstet 1978;146:959-962.
7. Povoski SP, Karpeh MS, Jr., Conlon KC, et al. Association of preoperative biliary drainage with postoperative outcome following pancreaticoduodenectomy. Ann Surg 1999;230:131-142.
8. Washington K, Berlin J, Branton P, et al. Protocol for the Examination of Specimens from Patients with Carcinoma of the Exocrine Pancreas. 2011. Available at: http://www.cap.org/apps/docs/committees/cancer/cancer_protocols/2011/PancreasExo_11protocol.pdf.
9. Klinkenbijl JH, Jeekel J, Sahmoud T, et al. Adjuvant radiotherapy and 5-fluorouracil after curative resection of cancer of the pancreas and periampullary region: phase III trial of the EORTC gastrointestinal tract cancer cooperative group. Ann Surg 1999;230:776-782
10. Neoptolemos JP, Stocken DD, Friess H, et al. A randomized trial of chemoradiotherapy and chemotherapy after resection of pancreatic cancer. N Engl J Med 2004;350:1200-1210.
11. Oettle H, Post S, Neuhaus P, et al. Adjuvant chemotherapy with gemcitabine vs observation in patients undergoing curative-intent resection of pancreatic cancer: a randomized controlled trial. JAMA 2007;297:267-277.
12. White RR, Hurwitz HI, Morse MA, et al. Neoadjuvant chemoradiation for localized adenocarcinoma of the pancreas. Ann Surg Oncol 2001;8:758-765.
13. Breslin TM, Hess KR, Harbison DB, et al. Neoadjuvant chemoradiotherapy for adenocarcinoma of the pancreas: treatment variables and survival duration. Ann

Surg Oncol 2001;8:123-132.
14. Bilimoria KY, Talamonti MS, Sener SF, et al. Effect of hospital volume on margin status after pancreaticoduodenectomy for cancer. J. Am. Coll. Surg. Oct 2008;207(4):510-519.
15. Conroy T, Desseigne F, Ychou M, et al. Randomized phase III trial comparing FOLFIRINOX versus gemcitabine as first-line treatment for metastatic pancreatic adenocarcinoma: Preplanned interim analysis results of the PRODIGE 4/ACCORD 11 trial [abstract]. J Clin Oncol 2010;28(suppl_7s):Abstract 4010.
16. Moore MJ, Goldstein D, Hamm J, et al. Erlotinib plus gemcitabine compared with gemcitabine alone in patients with advanced pancreatic cancer. A phase III trial of the National Cancer Institute of Canada Clinical Trials Group. J Clin Oncol 2007;25:1960-1966.
17. Neoptolemos J, Buchler M, Stocken DD, Bassi C, et al. Adjuvant chemotherapy with fluorouracil plus folinic acid vs gemcitabine following pancreatic cancer resection: a randomized controlled trial. JAMA 2010;304:1073-1081.

IPMN:

1. Augustin T, Vandermeer TJ. Intraductal papillary mucinous neoplasm: a clinicopathologic review. Surg Clin North Am. 2010 Apr;90(2):377-98.
2. Waters JA, Schmidt CM. Intraductal papillary mucinous neoplasm--when to resect? Adv Surg. 2008;42:87-108.
3. Tanaka M, Fernández-del Castillo C, Adsay V, Chari S, Falconi M, Jang JY, Kimura W, Levy P, Pitman MB, Schmidt CM, Shimizu M, Wolfgang CL, Yamaguchi K, Yamao K; International Association of Pancreatology. International consensus guidelines 2012 for the management of IPMN and MCN of the pancreas. Pancreatology. 2012 May-Jun;12(3):183-97.

Neuroendocrine tumors:

1. Hochwald SN, Zee S, Conlon KC, et al. Prognostic factors in pancreatic endocrine neoplasms: an analysis of 136 cases with a proposal for low-grade and intermediate-grade groups. J Clin Oncol 2002;20:2633-2642.
2. Bilimoria KY, Bentrem DJ, Merkow RP, et al. Application of the pancreatic adenocarcinoma staging system to pancreatic neuroendocrine tumors. J Am Coll Surg 2007;205:558-563.
3. Halfdanarson TR, Rabe KG, Rubin J, Petersen GM. Pancreatic neuroendocrine tumors (PNETs): incidence, prognosis and recent trend toward improved survival. Ann Oncol 2008;19:1727-1733.
4. Campana D, Nori F, Piscitelli L, et al. Chromogranin A: is it a useful marker of neuroendocrine tumors? J Clin Oncol 2007;25:1967-1973.
5. Rosch T, Lightdale CJ, Botet JF, et al. Localization of pancreatic endocrine tumors by endoscopic ultrasonography. N Engl J Med 1992;326:1721-1726.
6. Thompson NW. Management of pancreatic endocrine tumors in patients with multiple endocrine neoplasia type 1. Surg Oncol Clin N Am 1998;7:881-891.

Acute and chronic pancreatitis

1. Issa Y, van Santvoort HC, van Goor H, Cahen DL, Bruno MJ, Boermeester MA. Surgical and Endoscopic Treatment of Pain in Chronic Pancreatitis: A Multidisciplinary Update. Dig Surg. 2013 Apr 26;30(1):35-50.
2. Andersen DK, Frey CF. The evolution of the surgical treatment of chronic pancreatitis. Ann Surg. 2010 Jan;251(1):18-32.

Liver:

Hepatocellular carcinoma:

1. Bruix J, Sherman M. Management of hepatocellular carcinoma: An update. AASLD Practice Guidelines; 2010. Available at: http://www.aasld.org/practiceguidelines/Documents/HCCUpdate2010.p df.
2. Breedis C, Young G. The blood supply of neoplasms in the liver. Am J Pathol 1954;30:969-977.
3. Cholongitas E, Papatheodoridis GV, Vangeli M, et al. Systematic review: The model for end-stage liver disease--should it replace Child-Pugh's classification for assessing prognosis in cirrhosis? Aliment Pharmacol Ther 2005;22:1079-1089.
4. Malinchoc M, Kamath PS, Gordon FD, et al. A model to predict poor survival in patients undergoing transjugular intrahepatic portosystemic shunts. Hepatology 2000;31:864-871.
5. Dohmen K. Many staging systems for hepatocellular carcinoma: evolution from Child-Pugh, Okuda to SLiDe. J Gastroenterol Hepatol 2004;19:1227-1232.
6. Jarnagin WR. Management of small hepatocellular carcinoma: a review of transplantation, resection, and ablation. Ann Surg Oncol 2010;17:1226-1233.
7. Pawlik TM, Poon RT, Abdalla EK, et al. Critical appraisal of the clinical and pathologic predictors of survival after resection of large hepatocellular carcinoma. Arch Surg 2005;140:450-457.
8. Chok KS, Ng KK, Poon RT, et al. Impact of postoperative complications on long-term outcome of curative resection for hepatocellular carcinoma. Br J Surg 2009;96:81-87.
9. Liapi E, Geschwind J-FH. Intra-arterial therapies for hepatocellular carcinoma: where do we stand? Ann Surg Oncol 2010;17:1234-1246.

Colorectal cancer metastatic to liver:

1. Abdalla EK, Vauthey JN, Ellis LM, et al. Recurrence and outcomes following hepatic resection, radiofrequency ablation, and combined resection/ablation for colorectal liver metastases. Ann Surg 2004;239:818-825
2. Charnsangavej C, Clary B, Fong Y, et al. Selection of patients for resection of hepatic colorectal metastases: expert consensus statement. Ann Surg Oncol. 2006;13:1261-8.
3. Fong Y, Cohen AM, Fortner JG, et al. Liver resection for colorectal metastases. J Clin Oncol 1997;15:938-946.

4. Adam R, Avisar E, Ariche A, et al. Five-year survival following hepatic resection after neoadjuvant therapy for nonresectable colorectal. Ann Surg Oncol 2001;8:347-353.
5. Pawlik TM, Olino K, Gleisner AL, et al. Preoperative chemotherapy for colorectal liver metastases: impact on hepatic histology and postoperative outcome. J Gastrointest Surg. 2007 Jul;11(7):860-8.
6. Bartlett DL, Berlin J, Lauwers GY, et al. Chemotherapy and regional therapy of hepatic colorectal metastases: expert consensus statement. Ann Surg Oncol. 2006;13:1284-92.

Cholangiocarcinoma:

1. Malhi H, Gores GJ. Cholangiocarcinoma: modern advances in understanding a deadly old disease. J Hepatol 2006;45:856-867.
2. Lim JH. Cholangiocarcinoma: morphologic classification according to growth pattern and imaging findings. AJR Am J Roentgenol 2003;181:819-827.
3. Nathan H, Aloia TA, Vauthey J-N, et al. A proposed staging system for intrahepatic cholangiocarcinoma. Ann Surg Oncol 2009;16:14-22.
4. Jarnagin WR, Fong Y, DeMatteo RP, et al. Staging, resectability, and outcome in 225 patients with hilar cholangiocarcinoma. Ann Surg 2001;234:507-517
5. Heimbach JK, Haddock MG, Alberts SR, et al. Transplantation for hilar cholangiocarcinoma. Liver Transpl 2004;10:65-68.
6. Sudan D, DeRoover A, Chinnakotla S, et al. Radiochemotherapy and transplantation allow long-term survival for nonresectable hilar cholangiocarcinoma. Am J Transplant 2002;2:774-779.

Others:

1. Glazer ES, Tseng JF, Al-Refaie W, et al. Long-term survival after surgical management of neuroendocrine hepatic metastases. HPB (Oxford) 2011;12:427-433.
2. Gedaly R, Daily MF, Davenport D, et al. Liver transplantation for the treatment of liver metastases from neuroendocrine tumors: an analysis of the UNOS database. Arch Surg 2011;146:953-958.
3. Mayo SC, de Jong MC, Pulitano C, et al. Surgical management of hepatic neuroendocrine tumor metastasis: results from an international multi-institutional analysis. Ann Surg Oncol 2010;17:3129-3136.

Gallbladder:

1. Duffy A, Capanu M, Abou-Alfa GK, et al. Gallbladder cancer (GBC): 10-year experience at Memorial Sloan-Kettering Cancer Centre (MSKCC). J Surg Oncol 2008;98:485-489.
2. Pawlik TM, Gleisner AL, Vigano L, et al. Incidence of finding residual disease for incidental gallbladder carcinoma: implications for re-resection. J Gastrointest Surg 2007;11:1478-1486.

3. Reid KM, Ramos-De la Medina A, Donohue JH. Diagnosis and surgical management of gallbladder cancer: a review. J Gastrointest Surg 2007;11:671-681.
4. Valle JW, Wasan HS, Palmer DD, et al. Cisplatin plus gemcitabine versus gemcitabine for biliary tract cancer. N Eng J Med 2010;362:1273-1281.

Sarcoma:

1. Coindre J, Terrier P, Guillou L, et al. Predictive value of grade for metastasis development in the main histologic types of adult soft tissue sarcomas: a study of 1240 patients from the French Federation of Cancer Centers Sarcoma Group. Cancer 2001;91:1914-1926.
2. Riad S, Griffin AM, Liberman B, et al. Lymph node metastasis in soft tissue sarcoma in an extremity. Clin Orthop Relat Res 2004:129- 134.
3. Pisters PW, Leung DH, Woodruff J, et al. Analysis of prognostic factors in 1,041 patients with localized soft tissue sarcomas of the extremities. J Clin Oncol 1996;14:1679-1689.
4. Dileo P, Demetri GD. Update on new diagnostic and therapeutic approaches for sarcomas. Clin Adv Hematol Oncol 2005;3:781-791.
5. Mocellin S, Rossi CR, Brandes A, Nitti D. Adult soft tissue sarcomas: conventional therapies and molecularly targeted approaches. Cancer Treat Rev 2006;32:9-27.
6. Fleming JB, Berman RS, Cheng SC, et al. Long-term outcome of patients with American Joint Committee on Cancer stage IIB extremity soft tissue sarcomas. J Clin Oncol 1999;17:2772-2780.
7. Gerrand CH, Wunder JS, Kandel RA, et al. Classification of positive margins after resection of soft-tissue sarcoma of the limb predicts the risk of local recurrence. J Bone Joint Surg Br 2001;83:1149-1155.
8. Zagars GK, Ballo MT, Pisters PWT, et al. Surgical margins and reresection in the management of patients with soft tissue sarcoma using conservative surgery and radiation therapy. Cancer 2003;97:2544-2553.
9. Sadoski C, Suit HD, Rosenberg A, et al. Preoperative radiation, surgical margins, and local control of extremity sarcomas of soft tissues. J Surg Oncol 1993;52:223-230.
10. Adjuvant chemotherapy for localised resectable soft-tissue sarcoma of adults: meta-analysis of individual data. Sarcoma Meta-analysis Collaboration. Lancet 1997;350:1647-1654.

Colon

1. Schneider EC, Malin JL, Kahn KL, et al. Surviving colorectal cancer. Cancer 2007;110: 2075-82.
2. Hampel H, Frankel WL, Martin E, et al. Screening for the Lynch syndrome (hereditary nonpolyposis colorectal cancer). N Engl J Med 2005;352:1851-1860.
3. Washington MK, Berlin J, Branton P, et al. Protocol for the examination of specimens from patients with primary carcinoma of the colon and rectum. Arch Pathol Lab Med 2009;133:1539-1551.
4. LeVoyer TE, Sigurdson ER, Hanlon AL, et al. Colon cancer survival is associated

with increasing number of lymph nodes analyzed: a secondary survey of intergroup trial INT- 0089. J Clin Oncol 2003;21:2912-2919.
5. The Clinical Outcomes of Surgical therapy Study Group. A comparison of laparoscopically assisted and open colectomy for colon cancer. N Engl J Med 2004;350:2050-2059.

Rectum:

1. Nash GM, Weiser MR, Guillem JG, et al. Long-term survival after transanal excision of T1 rectal cancer. Dis Colon Rectum 2009;52:577-82.
2. Twelves C, Wong A, Nowacki MP, et al. Capecitabine as adjuvant treatment for stage III colon cancer. N Engl J Med 2005;352(26):2696-2704.
3. O'Connell MJ, Martenson JA, Wieand HS, et al. Improving adjuvant therapy for rectal cancer by combining protracted-infusion fluorouracil with radiation therapy after curative surgery. N Engl J Med 1994; 331:502-507.
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Program Goals and Objectives:

PATIENT CARE:

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

1. Patient Care Learning Activities during surgical rotations which provide experience in this competency development include:

    a. Inpatient and outpatient patient care experiences
    b. Operative patient care experiences
    c. Operative log completion and review
    d. Case review at M&M conference
    e. Case discussion at weekly resident conferences
    f. Bedside teaching
    g. Ward rounds
    h. Operating room instruction
    i. Journal Club participation

2. Fellows are expected to:
    a. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
    b. Gather essential and accurate information about their patients
    c. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
    d. Develop and carry out patient management plans
    e. Counsel and educate patients and their families
    f. Use information technology to support patient care decisions and patient education
    g. Perform competently all medical and invasive procedures considered essential for the area of practice
    h. Provide health care services aimed at preventing health problems or maintaining health

i. Work with health care professionals, including those from other disciplines, to provide patient-focused care

Fellow Assessment includes observation of performance in these areas:

a. Medical Interviewing
b. Physical Examination
c. Procedural Skills- on patients and on simulators
d. Clinical Judgment
e. Ongoing Care.
f. Communication with staff and colleagues

MEDICAL KNOWLEDGE:

Fellows must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Medical Knowledge Learning Activities during surgical rotations which provide experience in this competency development include:

a. Weekly resident conferences
b. Presentations at Surgical Case Conferences
c. Educational experiences in clinic, hospital, operating room
d. Regularly scheduled weekly/monthly conferences (departmental and/or service specialized conferences)
e. Critical Review of literature in preparation for Journal Club

Fellows are expected to:

a. Demonstrate an investigatory and analytic thinking approach to clinical situations
b. Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT:

Fellows must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Practice-Based Learning and Improvement Learning Activities during surgical rotations which provide experience in this competency development include:

a. Case review at weekly M&M Conference
b. Case log review during rotation and at quarterly performance reviews
c. Case discussion at weekly resident conferences
d. Discussions at Journal Club
e. Presentations at Surgical Case Conferences

Fellows are expected to:

a. Analyze practice experience and perform practice-based improvement activities using a systematic methodology

b. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
c. Obtain and use information about their own population of patients and the larger population from which their patients are drawn
d. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
e. Use information technology to manage information, access on-line medical information; and support their own education
f. Facilitate the learning of students and other health care professionals

Fellow Assessment includes observation of performance in these areas:

a. Appraisal of scientific evidence
b. Maintenance of Portfolio
c. Presentations at Journal Club
d. Knowledge of study designs, statistical methods
e. Analysis of own practices-self evaluations
f. Data gathering and feedback
g. Use of information technology
h. Student education

INTERPERSONAL AND COMMUNICATION SKILLS:

Fellows must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.
Interpersonal and Communication Skills Learning Activities during surgical rotations which provide experience in this competency development include:

a. Patient care experiences in outpatient clinic and hospital
b. National exposure at professional meetings, networking opportunities
c. Teaching interactions with student learners; analysis of student feedback on teaching
d. Teaching of junior level residents

Fellows are expected to:

a. Create and sustain a therapeutic and ethically sound relationship with patients
b. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
c. Work effectively with others as a member or leader of a health care team or other professional group

Fellow Assessment includes observation of performance in these areas:

a. Compassion for patients and their families
b. Counseling, education, and informed consent instructions to patients
c. Patient inclusion in treatment decisions
d. Listens to patients, and other members of the health care team

e. 360 evaluations by nurses and mid level practitioners
f. Communicate effectively with faculty and the attending

PROFESSIONALISM:

Fellows must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Professionalism Learning Activities during surgical rotations, which provide experience in this competency development, include:

a. Professionalism seminars
b. Surgical faculty and other role modeling
c. Personal presentations at regional and national conferences
d. Performance during Mock Oral Examination
e. Journal Club
f. Recording of case logs

Fellows are expected to:

a. Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; a commitment to excellence and on-going professional development
b. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
c. Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

Fellow Assessment includes observation of performance in these areas:

a. Regard for welfare of others
b. Adheres to a code of moral and ethical values
c. Respectful of patients and their families
d. Respectful of other members of the health care team
e. Provides prompt consultations upon request
f. Sensitive to patients' cultural backgrounds
g. Accountable for own actions
h. Reliability
i. Punctual

SYSTEMS-BASED PRACTICE:

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Systems-Based Practice Learning Activities during surgical rotations which provide experience in this competency development include:

a. Case review at M&M Conference
b. Journal Club
c. Planning discharge of complicated patients initializing case management to coordinate rehabilitation, home health, and nursing homes

Fellows are expected to:

a. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
b. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
c. Practice cost-effective health care and resource allocation that does not compromise quality of care

d. Advocate for quality patient care and assist patients in dealing with system complexities
e. Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Fellow Assessment includes observation of performance in these areas:

a. Provides cost-effective care
b. Advocates for patients within the health care system
c. Refers patients to appropriate practitioners and agencies
d. Accesses assistance within the health care system for coordination and management of ongoing care
e. Discharges patients in a timely and appropriate manner

A chief resident and a fellow must not have primary responsibility for the same patient

Research and Scholarly Activity Requirements:

It is required by the program that the fellow participates in research and scholarly activities.

The fellows will be required to complete research projects as outlined by the Research Committee which meets with the fellows at minimum on a quarterly basis.

PROCESS:

This requirement will be accomplished through one-on-one mentoring by faculty of choice and/or team work with peers. The fellow will also be responsible for the completion of certain tasks with the guidance from faculty and research coordinator.

REQUIREMENTS:

In order to graduate from the Fellowship Program, fellows are required to complete the following:

1) IRB certification-Collaborative Institutional Training Initiative(CITI)

2) At least (1) publishable manuscripts (original articles, case series, review manuscript, book chapters)

3) Presentation at national or international meetings

RECOMMENDED READING/RESOURCES:

- AdventHealth Institutional Review Board Handbook.
- AdventHealth Office of Research Administration Handbook.
- IRB NET user's manual.
- International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals: Writing and editing for biomedical publication www.icmje.org.
- Outlines and articles on how to write case reports, scientific papers, and preparation for presentations are available through the Research Coordinator.

INSTITUTIONAL REVIEW BOARD (IRB) CERTIFICATION COMPLIANCE REQUIREMENTS

Instructions for the completion of Collaborative Institutional Training Initiative Program **(CITI training)** www.citiprogram.org

- Once registered, go to The AdventHealth group.
- Select Course: Basic Human Subjects - Biomedical, Social Behavioral Basic Course
- Select Curriculum: Human Subjects Research – Biomedical Research Investigators
- Select HIPS Course
- Select Good Clinical Practices Course (GCP)
- Upload your course completion reports to your user profile on www.irbnet.org.
- Notify your GS Research Coordinator.
- Notify the GME research staff.

IMPORTANT REMINDERS
FOR RESEARCH OR PUBLISHABLE PROJECTS

1) ALL research projects and case report writing must be submitted to the Office of Research Administration (ORA) and Institutional Review Board (IRB) for approval.

2) DO NOT begin study or case report writing until IRB approval has been obtained.

3) Data collected prior to IRB approval cannot be included in the current research.

4) Any changes to a research protocol and/or investigators must be submitted to and approved by the IRB.

BASIC REQUIREMENTS FOR RESEARCH PROJECTS

1) IRB & ORA requirements: CITI training certificate

2) Proposal – Guidelines for case report, clinical trial, prospective & retrospective observational proposal are available through the GS & GME's Research Coordinators or through the Office of Research Administration website.

3) IRB & ORA Applications: contact the GME Research Staff to determine which forms are needed pertaining to your project.

4) All documents should be typed and submitted to the GME Research Staff electronically at Victor.Herrera.md@flhosp.org and Josephine.Gaabucayan@flhosp.org.

5) Only the GME Research Staff will have a full access status to your IRB Net project in order for them to upload and submit documents. **ALL DOCUMENTS WILL BE UPLOADED AND SUBMITTED ONLY BY THE GME RESEARCH STAFF.**

6) Should there be any changes in your protocol or research project after IRB submission, please notify the GME Research Staff immediately**.**

Respective faculty advisor or faculty of choice will mentor residents/fellows in their scholarly activities and research projects.

The Department of Medical Education provides a Research Manager, full-time Research Coordinator and a statistician to assist and monitor your research project.

At the current time, the Program does not offer the option of an entire year spent in laboratory research.

Conferences and Teaching Rounds:

- Weekly tumor boards are on Tuesday at 7 am (Cancer Center- First floor Room 182) - ***Mandatory***
- Weekly conferences will be held on Friday mornings from 7:00 am to 8:00 am and fellows will be given dedicated time to attend (GME Conference room- Cancer Center 2nd floor). Attendance will be monitored via sign-in sheets, and is ***mandatory*** unless by exception made by the Program Director.
- ***Mandatory*** teaching rounds are on Thursdays at 7:00 am.
- Monthly HPB Radiology conference - ***Mandatory*** (Radiology conference room across from Steward waiting room)

Evaluations and Process:

Fellows will be continually evaluated based on the following six competencies.

1. Patient Care: Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Among other things, fellows are expected to:
    - Gather accurate information in a timely manner.
    - Generate an appropriate differential diagnosis.
    - Implement an effective patient management plan.
    - Competently perform the diagnosis and therapeutic procedures and emergency stabilization.
    - Prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
    - Provide health care services aimed at preventing health problems or maintaining health.
    - Work with health care professionals to provide patient-focused care.

2. Medical Knowledge: Fellows must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of this knowledge to patient care. Among other things, fellows are expected to:

- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information.
- Properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient.
- Complete disposition of patients using available resources.
- Seniors on remediation will attend a board review course earlier in the year with the opportunity to repeat the course if the fellow does not improve

3. Practice-Based Learning: Fellows must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Among other things, fellows are expected to:
    - Analyze and assess their practice experience and perform practice-based improvement.
    - Locate, appraise and utilize scientific evidence related to their patient's health problems.
    - Apply knowledge of study design and statistical methods to critically appraise the medical literature. Utilize information technology to enhance their education and improve patient care.
    - Facilitate the learning of students and other health care professionals.

4. Interpersonal and Communication Skills: Fellows must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates. Among other things, fellows are expected to:
    - Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age specific differences.
    - Demonstrate effective participation in and leadership of the health care team.
    - Develop effective written communication skills.
    - Demonstrate the ability to handle situations unique to the practice of emergency medicine.
    - Effectively communicate with out-of-hospital personnel as well as nonmedical personnel.

5. Professionalism: fellows must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Fellows are expected to demonstrate a set of model behaviors that include but are not limited to:
    - Treats patients/family/staff/paraprofessional personnel with respect.
    - Protects staff/family/patient's interests/confidentiality
    - Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues.
    - Able to discuss death honestly, sensitively, patiently, and compassionately.

- Unconditional positive regard for the patient, family, staff, and consultants.
- Accepts responsibility/accountability.
- Openness and responsiveness to the comments of other team members, patients, families, and peers.

6. Systems-Based Practice: Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Among other things, fellows are expected to:
    - Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
    - Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
    - Practice cost-effective health care and resource allocation that does not compromise quality of care.
    - Advocate for and facilitates patients' advancement through the health care system.

Fellows Performance:

Fellows will be evaluated by the faculty/preceptor at the end of each rotation. Evaluations will be reviewed periodically, usually quarterly, by the faculty and Program Director. Faculty evaluations and results from written examinations will be utilized in determining the progress of the fellow. The Program Director will meet with the fellow at least quarterly to review performance. Any necessary remediation or counseling will be determined by the Program Director and when indicated, individuals may be placed on probation or suspended. Evaluations will be kept in the fellow's personnel file and will be accessible to the fellow through the Surgical Residency office under supervision.

Fellow Evaluation of Faculty Teaching:

Fellows will submit anonymous evaluations of the program, rotations, and faculty on an on-going basis through New Innovations. The results of these evaluations will be reviewed by the Program Director and appropriate feedback will be given to individual faculty members.

Other Evaluations of Fellows:

Fellows will be evaluated by means of a 360-degree approach which will include evaluations by peers (senior residents), nurses, and patients. The results of these evaluations will also be discussed with the fellow during quarterly meetings.

Confidentiality Process:

All evaluations, counseling and probationary actions involving a fellow will be kept in a confidential fashion. Under no circumstances will such actions be discussed in a public forum. Additionally, all evaluations of faculty by fellows will be treated as confidential by the Program Director.

Supervision Policy:

A fellow's privilege of conditional independence, progressive authority and responsibility, and supervisory roles in patient care is delegated by the program director and faculty members. The program director evaluates the fellow's abilities based on specific criteria that are guided by specific national standards.

Every fellow is assigned to a designated service. The attending surgeon on that service is responsible for the overall care of each individual patient admitted to the service as well as for the supervision of the fellow assigned to the patient. All patients are admitted in the name of the attending surgeon and fellows make the attending aware of each admission and treatment plan. There is a clear chain of command centered on graded authority and clinical responsibility.

Fellows can function in two capacities: indirectly supervised and directly supervised.

Direct Supervision:

The supervising physician is physically present with the fellow and patient

Indirect Supervision:

-The supervising physician can be physically within the hospital or other sites of patient care and is immediately available to provide Direct Supervision.
- The supervising physician is not physically present within the hospital or other sites of patient care, but is immediately available by means of telephonic and/or electronic devices to provide Direct Supervision.

Oversight:

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

Fellows can evaluate outpatients, write prescriptions, write orders and progress notes, and otherwise complete medical records. Fellows cannot function without either direct or indirect supervision by an attending physician with privileges at AdventHealth or fellow as outlined in the competency guidelines, for patient care and is credentialed to perform the indicated procedures. The fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
The attending surgeon is expected to:

- Confirm (or change) the diagnosis
- Approve the operative procedure and procedure timing
- Be available or physically present (as dictated by his/her judgment) during the operative procedure and assure that it is properly carried out
- Supervise postoperative care
- Assure continuing care after the patient leaves the hospital

The fellow will keep the attending fully informed and document patient care with written progress notes. However, the supervising physician can provide feedback of procedures/encounters after care is delivered.

Faculty supervision assignments will be of sufficient duration to assess the knowledge and skills of the fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

Please see below:

Patient Management Competencies:

1. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)

2. 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.

3. Evaluation and management of critically-ill patients, either immediately postoperatively or in the ICU, including the conduct of monitoring, and orders for medications, testing, and other treatments.

4. Management of patients in cardiac or respiratory arrest (ACLS required)

Procedural Competencies:

5. Carry-out of advanced vascular access procedures, including central venous catheterizations, temporary dialysis access, and arterial cannulation

6. Repair of surgical incisions of the skin and soft tissues

7. Repair of skin and soft tissue lacerations

8. Carry-out advanced and complex surgical procedures under the supervision of faculty.

Patient Charting Responsibilities:

Inpatient Charting:

See the "Health Information Management" section of the AdventHealth Graduate Medical Education policy manual.

Outpatient Charting:

Fellows are encouraged to learn to chart concurrently with patient care. Ordering labs, xrays and medications during the visit is a must, and charting the note during the visit aids in efficiency. Charts are expected to be completed within 48 hours of the visit and any charts still "open" after two (2) weeks will be considered "Delinquent."

Delinquent Charts:

- Prompt and timely completion of charts (within 48 hours) is expected.

- Accumulation of charts longer than one (1) week will result in issuance of a notification.

- Failure to complete charts within 2 weeks will result in loss of one-half day of vacation time in order to complete the records.

Medical Records:

See also the GME Manual section on "Health Information Management."

- Health care providers must maintain adequate medical records to:
    - Afford continuity of patient care
    - Document that quality care has been rendered o Justify payment for services rendered o Serve as defense against malpractice claims
    - Function as a basis for submitting required reports to appropriate governmental agencies

- All operative reports should be dictated immediately, but **absolutely** within 24 hours of the time of operation. They should contain sufficient information concerning the pathology found as well as techniques used.
- Discharge summaries are to be completed the day of discharge. Correct terminology is essential, both for diagnosis and operation. Complete diagnoses, including complications and operations are necessary.
- Keep in mind that the patient's record could become a legal document, which you may be asked to interpret and defend in a court of law many years from now. It, therefore, should not be treated as a forum for unproven opinions, personality comments, assumptions, or derogatory statements to consultants, patients, peers, etc.: record the facts, omit opinions, judgments, and assumptions. Never EVER alter a medical record after a query regarding the care of a patient.
- Death Certificates must be completed within 72 hours of the patient's death.
- Medico-legal issues, such as adverse events, angry patients or family members, etc. should be relayed to the attending immediately. A lack of timely intervention frequently exacerbates problems.
- Delinquency in record completion may result in loss of vacation time or loss of OR privileges in order to correct deficiencies.

Confidentiality (HIPPA):

Compliance with HIPPA regulations is mandatory. All information presented to you by a patient, by a doctor about a patient, by a patient's family about a patient, with few exceptions, is CONFIDENTIAL.

- Do not discuss patients with others while walking in the halls, in the elevator, in the cafeteria, or while in any public areas.
- During Grand Rounds and conferences, patients are never to be presented by their names.
- Copies of discharge summaries, operative reports, and other medical data are confidential and must be disposed of by acceptable legal means when no longer needed.
- Confidential, locked shred bins are provided in the out-patient office as well as on the units. Do not place any confidential information in waste baskets or other receptacle that eventually ends up in a commercial or city dump.
- In all instances, patients are to be treated with the same respect and confidentiality that you would afford your own family members.
- Cases presented at morbidity and mortality conference are confidential and summaries sent to AdventHealth patient safety organization are protected as part of the patient safety work product.

Dismissal & Grievance:

Dismissal/Non-Renewal:

Dismissal or non-renewal may occur because of failure of the fellow to comply with his/her responsibilities or failure to demonstrate appropriate medical knowledge or skill as determined by the program's supervising faculty. Dismissal may also occur where there is misconduct. Examples of misconduct include but are not limited to: being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment); the use of abusive language, fighting or encouraging a fight; threatening, attempting, or causing injury to another person while on the premises. Please refer to the GME Policy Manual for specific policies.

A fellow is usually not dismissed without a probationary period, except in instances of flagrant misconduct. In other circumstances, it is the responsibility of the Program Director to document a warning period prior to dismissal or failure to reappoint a fellow and to demonstrate efforts for the provision of opportunities for remediation. Such opportunities must be provided and documented for the fellow to discuss with the Program Director the basis for probation, the expectations of the probationary period, and the evaluation of the fellow's performance during the probationary period. Discussions will be documented and placed in the fellow's personnel file. The fellow is entitled to a copy of the documentation upon request.

In the event that a fellow is to be dismissed or his/her contract not renewed, s/he may initiate a formal grievance procedure. Grievance procedures will follow the policy stated in the GME Manual.

Grievance:

Grievance procedures have been established by the Graduate Medical Education Committee and may be referred to in the GME manual.

Professional Relationships:

Patient Care:

- Team: The team (attending physician, fellow, resident, nurse, pharmacist, and student) is responsible for each patient's care. Quality care for the individual patient is the ultimate goal of each team member.
- Intern/resident: The intern has the primary responsibility for patient care except within the Intensive Care Unit. S/he should evaluate the patient, write the necessary orders, perform the primary patient care procedures, and act as the primary physician with respect to the patient and his family. S/he dictates the discharge summary on each patient for whom they are responsible.
- Fellow: The fellow is an active participant in the patient's care and is directly responsible for all care of the patient within the Intensive Care Unit.

S/he conducts rounds and examines the patient every day with the junior resident. S/he does not dictate therapy, but does advise the junior resident of alternate possible explanations, direction of evaluation, or treatments. S/he also writes an admission note. S/he selects applicable articles from the surgical literature to enhance the education of his/her team and augment patient care. All consultations will be directed to the senior resident, and s/he will see consultations and make appropriate disposition.

- Attending Surgeon: The attending surgeon holds ultimate responsibility for every aspect of patient care. S/he is also actively engaged in patient care and rounds on all patients. S/he is responsible for providing guidance and experience in all facets of the patient's care. S/he will round at designated times daily throughout the week and will be available on call for other problems.

Nursing Staff:

- The nursing staff is an integral part of the health-care team. Personal and professional courtesy will be extended to the nursing staff at all times. The nursing staff will be included on rounds whenever possible and should be advised of any changes in treatment plans, special requests, or anticipated problems.
- Fellows are responsible for a significant contribution to the education of the nursing staff. Such information is vital to assist them in taking better care of the patients. Explanation and thoughtfulness will yield manifold results.
- Simple "pick-up-after-yourself" and care in performance of procedures will allow the nursing staff more time with your patients.

Pharmacy Staff:

- The pharmacist is another vital member of the health-care team. S/he is responsible for all medications dispensed in the hospital.
- S/he is also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicities, administration forms, and combinations.
- It is the pharmacist's legal and professional responsibility to ensure that the intent of your order is fulfilled. When the pharmacist questions an order, s/he is doing so to ensure that the patient receives the appropriate medication in the appropriate dosage.
- If you are paged by the pharmacist, it is your duty to respond quickly and courteously.

Fellow Interaction with Medical Students:

Fellows will be expected to participate in the education and mentoring of medical students. This will enhance their training and will include:

- Teaching requisite patient care procedures
- Instructing in the development of logical approaches to clinical problems

- Encouraging reading in General Surgery texts and journals, providing the student with select review articles on topics concerning their patients
- Instructing and assisting in the development of good patient care and treatment
- Ensuring attendance at all necessary conferences
- Reviewing each student's "work-ups" and providing constructive criticism
- Treating the medical student in a professional and courteous manner
- Maintain a professional interpersonal relationship with the medical students. Any concerns should be brought to the attending on service or program director.
- Assigning cases and patients
- Enforcing reading and preparation for specific cases that they will observe in the operating room

Continuity of Care/Night Call Activities:

Continuity of care is an important facet of training. There are multiple ways of obtaining this training. Among them are time spent in the practice office with pre- and post-surgical patients, another is in-house call. Fellows are not required to take in-house calls, but are expected to come to evaluate patients at night if the clinical situation mandates. Fellows are also required to participate in emergent complex operations after hours if deemed necessary by the attending surgeon.

Clinic Requirements:

The fellows are required to participate and see patients in clinic at least once a week.

Night Call:

The objective of night call activities is to provide fellows with patient care experiences throughout a 24-hour period, adding to their continuity of care experience.

Pager Call:

At-home call (pager call) is defined as call taken from outside the assigned institution.

- Fellows taking pager call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
- The Program Director and faculty must monitor the demands of pager call in the program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- Responsibilities while on pager call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate.

Transitions of Care:

- Fellows are responsible for providing safe and effective transitions of care during hand-off situations. Sign out sessions occur twice daily to ensure adequate communication and appropriate transfer of patient information
- Morning sign out begins at 6:30am daily, at the end of the on-call shift with transfer of patient information from the prior night's on call residents and the oncoming team/on-call residents and nurse practitioner.
- At 5:00pm during the week, transition of care occurs between the surgical oncology service residents and the oncoming resident on-call. During this time all the day's surgeries are discussed in preparation for post-operative checks that evening. Additionally, the status of each patient on the general surgery service are communicated to the oncoming resident to ensure safe and effective patient care.
- Residents and fellows are instructed during the annual communication and patient safety lectures on proper, complete and successful transitions of care.

On-Call Guidelines:

- Responsibilities while on call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate. Additionally, any significant changes in patient coordination will be communicated to a senior resident and the responsible attending surgeon.

- Support systems: The fellow on call will have access to support from the faculty member/surgeon on call during all call assignments, when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

The pagers can be accessed from hospital phones by dialing "87" or from outside the hospital by calling (407) 303-5599. Wait for the tone before inputting pager number and return number. Alternatively, text pagers can also be accessed for short text messages via "Wireless Office Messenger" on the hospital computer. A list of pager numbers will be made available to you for easy reference of the numbers frequently contacted. Personal communication devices may be used as primary lines of communication instead of the pager. As long as the proceeding communications are met.

Other Policies:

Dress and Grooming:

All individuals on the surgical service are expected to look and act as responsible physicians. Professional appearance and manners are to be exercised at all times in all environments, even though the work and conditions may be very stressful. Appropriate grooming and attire are always required. Good personal hygiene is mandatory. Use of

deodorant is encouraged, and to be considerate of patients and fellow staff, fellows should not wear strong fragrances.

The fellow is expected to follow the dress code as printed in the GME manual. A white coat with name tag attached is to be worn at all times while on duty. Scrubs may not be worn in the outpatient office. At any time that the fellow is scheduled to be in the operating room, clean scrubs will be worn, including changing to fresh scrubs after a dirty/bloody case. The fellow must ensure that no body fluids are on his/her clothes/shoes when out of the operating room. Please refer directly to the GME Manual for specific dress requirements.

Work Environment:

Providing a sound academic and clinical education must be balanced with concerns for patient safety and fellow well-being. The program will ensure that the learning objectives of the program are not compromised by excessive reliance on fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of fellows' time and energies. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of our patients.

Leave:

General guidelines for time away can be found in the GME manual. Program-specific guidelines follow:

- Vacation/Sick Leave: Fellows are allowed 20 days to be used for leave/sick per academic year. This time includes vacation, sick leave, and is in addition to granted days for Board Examinations.
- There will be no vacation time taken in July, January, or June – unless specifically approved by the Program Director.
- All scheduled vacation during the year should be approved and coordinated by the program director.
- The week of leave will also include the weekend following the vacation week(s). The weekend ***prior*** to leave is not part of the vacation and may or may not be granted depending on the call schedule – subject to approval by the Program Director.
- Sick leave or Emergency leave will first be deducted from credited holiday time and then from the last week of leave if necessary.
- Education: AdventHealth provides the fellow with an annual continuing education allowance and paid leave to attend educational activities that will contribute to the quality of their training.
- With the exception of the education leave allowance, leave may not be carried over from one appointment year to the next, and there is no payment for unused time.

- FMLA: Please refer to the GME Manual for specific policy on family and medical leave, extended sick leave, maternity leave, paternity leave, and adoption leave.
- Written request for time off is mandatory and must be submitted to the office of the Program Director. Initial requests will be solicited prior to the start of the academic year while the annual schedule is being written. Requested vacation periods are not guaranteed. Requests for changes must be accompanied by prearrangement of who will cover the fellow's absence on a service with mandatory coverage.
- **Holidays**: Per previous mention, there are six national holidays that are observed at AdventHealth (New Year, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas). Coverage of these holidays will be rotated among the fellow and resident on service while maintaining duty hour compliance. Coverage hours will be the same as on weekends.
- **Unexcused Absences:** If the fellow does not show up for assigned hours, including night call, without notifying the Program Director, the absence will be considered unexcused. Unexcused time will be taken from the fellow's leave bank. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction.

Elective Guideline:

The fellow may choose to take one month for an away elective during their fourth year. This will be approved at the discretion of the Program Director and the following conditions must be met:

- The fellow must be in good standing in the program with a minimum of 350 cases at the time of request.
- The elective must demonstrate educational merit and be an operative rotation, not an observership.
- Preceptor and Off-Site agreements must be in place at the time of the rotation.
- During the away elective, the following is expected of the fellow:
    - The fellow will continue to check designated AdventHealth email address on a daily basis for communication/updates.
    - Attendance and participation in M&M, Case Presentations, and didactic conferences on a weekly basis at elective site as outlined by the ACGME program requirements.
    - On-going and current recording and documentation of participation in cases through the case log system.
    - The fellow is responsible for acquiring and paying for living arrangements during the elective month.

Stress, Fatigue, and Impairment:

The Program Director and faculty realize that fellowship training is a time of high stress. They will make every effort to monitor fellows on their rotations for signs of stress, fatigue, and impairment. The fellow can assist on his/her own behalf by communicating problems

with his/her preceptor, faculty advisor, or the Program Director. Signs and symptoms of fatigue, stress, or impairment include some of the following:

1. Recent changes in behavior, including irritability, mood swings, inappropriate behavior, a breakdown in logical thought, trembling, slurred speech
2. Irresponsibility, such as failure to respond to calls, late arrivals at rounds or call, rounding at irregular times, neglect of patients, incomplete charting, unexplained absences
3. Inaccurate or inappropriate orders or prescriptions
4. Insistence on personally administering patients' analgesics or other mood-altering medications rather than allowing nursing staff to carry out orders
5. Poor concentration or poor memory, such as failure to remember facts about current and/or recent individual patients
6. Depression
7. Evidence of use or possession of alcohol or other drugs while on duty; intoxication at social events
8. Anger, denial, or defensiveness when approached about an issue
9. Unkempt appearance and/or poor hygiene
10. Complaints by staff or patients
11. Unexplained accidents or injuries to self
12. Noticeable dependency on alcohol or drugs to relieve stress
13. Isolation from friends and peers
14. Financial or legal problems
15. Loss of interest in professional activities or social/community affairs

In situations in were the fellow feels stress, fatigue, or impairment that would disable him/her to perform their current patient care duties, the fellow should take the following steps:

- Contact the Program Coordinator
- The Program Coordinator will contact the Program Director and Supervising Attending informing them of the fellows' status. The Program Director will put in place the backup system to ensure proper continuity of patient care. Adequate transportation to return home will be offered to the fellow.
  (Adequate resources can include: Money for taxi, money for public transportation, one-way transportation service, transportation service which includes option to return to the hospital or facility the next day, reliance on other staff or fellows to provide transport, or making use of in-house call room facilities).
- The Program Coordinator will contact the fellow and Supervising Attending to inform them of the plan that has been put in place.

If the Program Director feels that a fellow has been showing signs of consecutively being stressed, fatigued, or impaired, the Program Director may choose to call a meeting with the fellow. The problem will be discussed, and the Program Director will make recommendations for resolving the problem. Such recommendations may include use of

services within AdventHealth such as the Employee Assistance Program, Employee Health Services, Physician Support Services, or referral to a counselor or psychiatrist. For further information, please refer to the GME Manual.

Resources:

AdventHealth, along with the medical staff and Graduate Medical Education is committed to providing safe, effective, timely, and respectful medical care while fostering an environment that promotes practitioner health. We affirm that substance use disorders and other behavioral health disorders are treatable illnesses and after treatment, practitioners can return to the safe and effective practice of medicine with appropriate monitoring.

Employee Assistance Program (EAP):

This program assists faculty, staff, and their families with the resources they need to resolve personal, family, or job-related problems. EAP offers a free of charge and comprehensive worksite-based program to assist in the prevention, early intervention, and resolution of problems that may impact job performance. The EAP is staffed with well-trained, caring professionals who listen and offer support and guidance. EAP is confidential and voluntary. You can contact EAP at: (407) 303-3690 (or tie: 844-3690).

Employee Health Clinic:

The employee health clinic handles pre-employment physicals, performs annual physical assessments and PPD tests, and administers vaccinations. It also provides triage and evaluation for work-related injuries during normal business hours and does educational promotions, blood-borne pathogen counseling and treatment, and follows up on TB and other infectious disease exposures. The employee clinic can be reached at: (407) 3031535 (or tie: 844-1535).

Physician Support Service:

This service is available to medical staff, including fellows and their family members. The service may be utilized by contacting (407) 691-5476. Your Residency Coordinator will have pamphlets and business cards for your use if you have questions about this service.

Faculty Psychologists:

The faculty psychologists on the staff of Graduate Medical Education are also available to the fellows and their families as a resource in times of stress.

General Information:

Cerner:
Cerner is the computer software that fellows use to communicate regarding hospital and our hospital outpatient setting.

Electronic communication device:
Pager is available to the surgical service if desired. A stipend is expected to be used for purchase of an individual communication device (e.g. smart phone, android, tablet, etc.) That device will be used as the primary method of communication while on duty. The device should be turned on during all duty hours and the battery should be checked frequently to assess signal strength. Damaged or lost devices shall be the responsibility of the fellow and alternative means of communication is to be obtained as soon as possible.

While covering the Emergency Department or Operating Room, devices should not be unattended or turned off. Other staff should be able to respond to the call if the fellow is not able to do so.

Not answering phone calls, texts, emails or pages during assigned duty hours will be considered grounds for discipline and/or dismissal from the residency.

As stated previously, damaged or lost pagers will be charged back to the fellow. There is currently a charge of $79.00 to replaced damaged or lost pagers.

Fellow File Access:
The GMEC requires that the fellow's file is regarded as confidential, is maintained in a secure location, and is available only to the following:

1. Program Director
2. Residency Coordinator
3. Director of Academic Affairs
4. Administrator of Medical Education
5. Chair of Medical Education
6. Fellow (under supervision)

The GMEC authorizes the Program Director, Director of Academic Affairs, Administrator of Medical Education or the Chair of Medical Education to disclose the file or portions thereof to others whom they deem to have a legitimate need for the information or as authorized in writing by the fellow. The GMEC policy requires that the exterior of each file will state "Confidential Information – Access to this File and its Information is governed by the GME Manual on fellow File and Access." Electronic files will have this statement on its opening or at a place within the file designated by the Program Director.

Fellow Workspace, Email, Lockers & Mailboxes:

Office space is provided in the General Surgery Office Suite in the Health Village Medical Office Building as well as in the Academic Office. Computers with inter- and intranet access are available and access to Cerner EMR for medical records and laboratory reports. Please keep the workspace neat and uncluttered to be considerate of your fellow fellows and the office staff.

Fellows are issued an Outlook email account through the Hospital. Your email must be checked on a daily basis for updates/schedule changes/ and program information. Fellows will also be trained to use the New Innovations system and will be expected to use it for curriculum, etc. Both your hospital email and New Innovations may also be accessed from your home computer.

Lockers are provided, as well, for storage of personal items. They will be located in the call rooms of the hospital.

Fellow mailboxes for regular mail and schedules are located in the General Surgery Administrative office suite. These mailboxes must not become a repository for outdated information, stale food, etc. and mail and notices should be dealt with **on a weekly basis** and cleaned out.

Travel:

Fellows may be sent to regular or national meetings at the discretion of the Program Director. Fellows also are allowed conference time during their years of training. They must submit a time away request which must be approved by the Program Director prior to attending the meeting. Presentation of research project at a regional meeting is encouraged.

Enough time in advance of any meeting must be allowed to register at the reduced trainee rate, and for adjustments in the program schedule to cover in the absence of the fellow. Request for attendance at meetings is not guaranteed, and in the case of conflicts, scheduled vacations, and service coverage/commitments take priority.

Travel guidelines and expense allowances have been established by the GMEC (please refer to the GME manual section on Continuing Education Allowance and FH Expense Report Regulations).