Surgical Critical Care Fellowship Program Handbook 2019 – 2020

910 Madison Building
Second Floor
Suite 220
(901) 448-8140 office
(901) 448- 8472 FAX

Surgical Critical Care Website

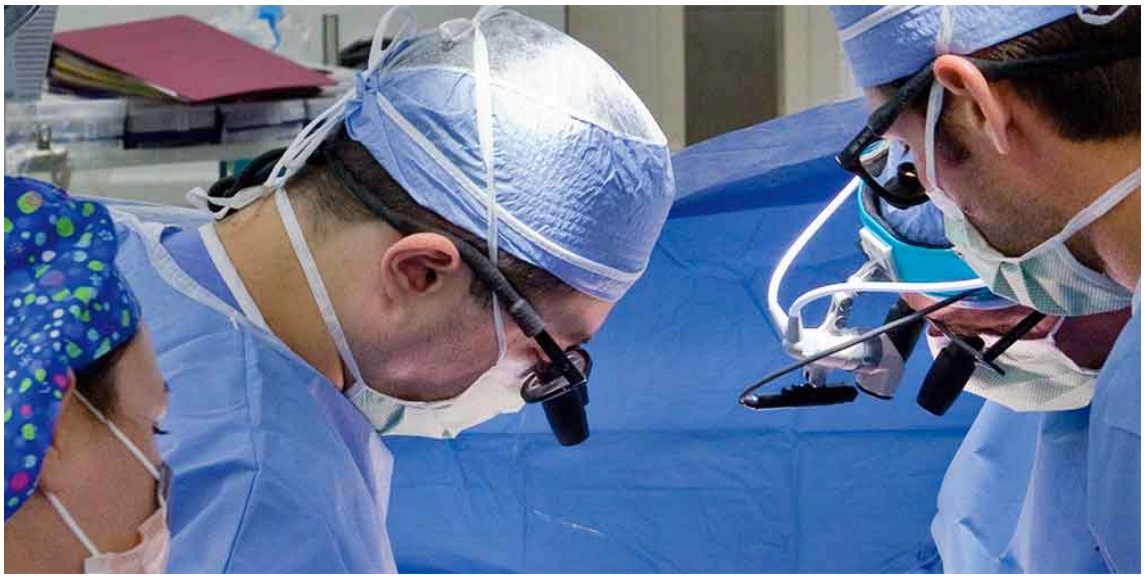
Table of Contents

Program Mission

During the one-year surgical critical care experience, the fellows will broaden their basic skills and fundamental knowledge about diseases, disorders, and conditions; diagnosis and assessment methods; and surgical procedures that fall within the study of acute surgical problems and critical care. Not only will the fellow expand their fund of knowledge, but they will also gain experience interacting with patients and families; improving their patient care practices and correlating their practices within the health care system on a larger scale. Each fellow will be competent in each of the six core competencies outlined by the ACGME. Patient
Care, Medical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems Based Practice provide the foundation for the program's goals and objectives.

After completion of the surgery critical care program, the fellows are expected to achieve the following goals to receive their Certificate of Completion:

- Diagnose and manage critically ill surgical patients, to include appropriate interventions and procedures.
- Create, design, implement, and analyze research projects.
- Expand and develop the ability to teach associates, fellows in training, and other critical care personnel.
- Learn to administer and manage a critical care unit with emphasis on allocation and utilization of resources and on ethical principles in the delivery of healthcare.



CONTACT INFORMATION

SCC Fellowship Administration

Dina Filiberto, MD
SCC Fellowship Program Director
910 Madison Ave, Room 220
Memphis, TN 38163
901-448-8140

Flavenia Leaper
SCC Fellowship Program Coordinator
910 Madison Ave, Room 220
Memphis, TN 38163
901-448-8140

David Shibata, MD, FACS
Professor and Chair,
Department of Surgery

SURGICAL CRITICAL CARE FACULTY				
Name	**Office phone #**	**Email**	**Assistant**	**Asst. email**
Martin A. Croce, MD	901-448-8140	mcroce@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Louis J. Magnotti, MD	901-448-8140	lmagnott@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Tiffany K. Bee, MD	901-448-8370	tbee@uthsc.edu	Courtney Bishop	cbishop@uthsc.edu
Peter E. Fischer, MD	901-448-8140	pfischer@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Cory R. Evans, MD	901-448-8140	cevans25@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Dina Filiberto, MD	901-448-8140	dfiliber@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Catherine Seger, MD	901-448-8140	cseger@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Emily Lenart, MD	901-448-8140	elenart@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Isaac Howley, MD	901-448-8140	ihowley@uthsc.edu	Flavenia Leaper	fleaper@uthsu.edu
Richard Lewis, MD	901-448-8140	rlewis15@uthsc.edu	Flavenia Leaper	fleaper@uthsc.edu
Gayle Minard, MD	901-448-8370	gminard@uthsc.edu	Courtney Bishop	cbishop@uthsc.edu
George Maish, MD	901-448-8370	gmaish@uthsc.edu	Courtney Bishop	cbishop@uthsc.edu
Timothy C. Fabian, MD	901-448-8370	tfabian@uthsc.edu	Courtney Bishop	cbishop@uthsc.edu

1st YEAR FELLOWS			
Name	**PGY Level**	**Pager #**	**Email**
Davis Berry	6	(901) 242-0041	dberry8@uthsc.edu
Rahil Dharia	6	(901) 242-0004	rdharia@uthsc.edu
Dih-Dih Huang	6	(901) 242-0198	dhuang15@uthsc.edu

Contact for the on-call fellow at ROH:
MEDCOM 901-545-8181

SITE INFORMATION

Regional One Health is Memphis' primary county hospital. It houses approximately 295 beds and provides unique opportunities for the management of an underserved, inner city patient population. Fellows primarily rotate on the trauma intensive care unit (TICU), the general intensive care unit (GICU), and the trauma stepdown unit (TSDU).

Presley Regional Trauma Center
The Presley Regional Trauma Center is contained within Regional One Health. Since opening in 1983, the trauma center has become one of the highest-volume centers in the United States. Over 4500 patients a year sustaining both blunt and penetrating injury are managed using the trauma team concept. Diagnostic, operative, and intensive care faculty supervision, together with a multispecialty team approach, ensures both optimal patient care and excellent resident/fellow education. The center receives patients not only from the Memphis metropolitan area but also by helicopter from North Mississippi, Eastern Arkansas, Southern Missouri and West Tennessee within a 150-mile radius.

An elaborate communication system allows the senior surgeon to assist the paramedic in the prehospital phase of resuscitation anywhere in the Memphis area. The center operates independently of the adjacent emergency room and is staffed with surgeons, nurses, and technicians solely dedicated to trauma. The Trauma Unit contains its own resuscitation area, imaging center (plain film, CT, MRI), four dedicated operating rooms, and a 22-bed Trauma Intensive Care Unit, and a four-bed Neurosurgery Intensive Care Unit. All facilities are located on the same floor and within proximity to insure rapid diagnostic and therapeutic intervention with the least movement of the injured patient. The helipad elevator opens into the resuscitation area.

Regional One Health 877 Jefferson Avenue
Memphis, TN 38103
901-545-7700 (hospital operators)

Regional One Health
Heath Information Manager
Buffy Bell
901-545-6319

Site Director
Martin A. Croce, MD
901-448-8140

LeBonheur Children's Hospital is the region's pediatric tertiary care center. The LeBonheur Pediatric Intensive Care Unit (PICU), with approximately 1,600 - 1,800 admissions annually, provides all critical care services for active programs in pediatrics, general surgery, neurosurgery, otolaryngology and craniofacial reconstruction, orthopedics, transplantation, and trauma. The patient population is about 60% medical patients and 40% surgical, with all patients being managed by the critical care team. The LeBonheur ICUs serve as a regional and national referral center for children/neonates who require the most advanced diagnostic and therapeutic services. These include advanced respiratory care technologies (such as: High Frequency Oscillatory Ventilation, Nitric Oxide and Heliox), Extra Corporeal Membrane Oxygenation, Continuous Renal Replacement Therapy (or peritoneal and hemodialysis), and multi-modal Neuro-monitoring. LeBonheur is the only hospital in the region recognized as an ECMO Center of Excellence by the International Extracorporeal Life Support Organization (ELSO). An elective rotation at LeBonheur is available to the surgical critical care fellow with an interest in pediatric surgical critical care.

Le Bonheur Children's Hospital 848 Adams Avenue
Memphis, TN 38103
901-287-5437

Medical Records
901-287-6076

Site Director
Regan F. Williams, MD

ROTATION & ASSIGNMENT SCHEDULES

Curriculum

To provide the highest quality of training, the fellow rotates through three different units in 2-month rotations, completing two rotations in each unit over a 12-month period. In the unit, the fellow is responsible for supervising turnover rounds with the resident or nurse practitioner, assisting the resident or nurse practitioner with any procedure if necessary, and helping the attending surgeons during their rounds.

During the first year of fellowship, each fellow takes 2 overnight trauma calls per week. One fellow takes call on Friday night and one fellow takes call on Saturday. No fellow takes call on Sundays. If the fellow is not on call, they do not come in over the weekend. This allows for an average of 3 days off over the course of 3 weeks. The fellows are provided time off for preparation and completion of the General Surgery Qualifying exam, Certifying exam, and presentation of any potential research. Time off for vacations and special events are provided if advanced notice is given. If the fellow chooses to do a second year of fellowship, he or she assumes the same clinical call schedule as the rest of the faculty (average 3-4 calls per month).

Clinical Rotations

Trauma Intensive Care Unit (TICU)

The TICU is a 22-bed unit that accommodates the most critically-injured patients in the hospital. A PGY-3 categorical general surgery resident provides 24-hour coverage of the patients in this unit. The TICU is located on the first floor of the trauma center and has direct access to both the Critical Care Assessment (CCA) and the trauma operating rooms.

General Intensive Care Unit (GICU)

The GICU consists of 18 ICU beds and 15 Progressive Care Unit (PCU) beds that are shared amongst the Surgical Critical Care (SCC) team and the Medical ICU (MICU) team. The SCC team will admit critical trauma and emergency general surgery patients to these units. Occasionally, the SCC team will act as a consultant for critical care management for other services and help with invasive procedures (i.e. tracheostomy, percutaneous feeding tube placement) for the MICU team. A categorical or preliminary general surgery intern provides 24-hour coverage of the general surgery and trauma patients in these units.

Trauma Stepdown Unit (TSDU)

The TSDU is a 14-bed unit that provides an intermediate level of care for trauma patients between the ICU and the surgical/trauma ward. All the patients in this unit are admitted to the trauma service. Nurse practitioners provide 24-hour coverage of the patients in this unit.

Block Diagram

Two Month Block	Fellow A	Fellow B	Fellow C
July 1 – August 31	TICU	GICU	TSDU
September 1 – October 31	GICU	TSDU	TICU
November 1 – December 31	TSDU	TICU	GICU
January 1 – February 28	TICU	GICU	TSDU
March 1 – April 30	GICU	TSDU	TICU
May 1 – June 30	TSDU	TICU	GICU

TICU = Trauma Intensive Care Unit; GICU = General Intensive Care Unit; TSDU = Trauma Stepdown Unit

Night Call Schedule for 3 Week Period

Week	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	Off	Fellow A	Fellow B	Fellow C	Fellow A	Fellow B	Fellow C
2	Off	Fellow B	Fellow C	Fellow A	Fellow B	Fellow C	Fellow A
3	Off	Fellow C	Fellow A	Fellow B	Fellow C	Fellow A	Fellow B

Rotation Specific Objectives

Regional One Health (ROH)

By the end of the Trauma Center Rotation at the ROH, all fellows are expected to expand and cultivate skills and knowledge learned during previous training and to achieve the following objectives based on the six general competencies. The fellow should exhibit an increasing level of responsibility and independency as he or she progresses throughout the year. A one-month elective in the Burn ICU at ROH is available to the fellows should they have an interest in burn care, and the critical care patient care objectives as outlined below are applicable to this elective rotation.

SUPERVISION OF FELLOWS

The Department of Surgery follows the University of Tennessee Resident Supervision Policy #410, which is available: http://www.uthsc.edu/graduate-medical-education/policies-and-procedures/documents/resident-supervision.pdf service and for the supervision of the resident(s) and fellow(s) assigned to the patient. **There is a clear chain of command centered around graded authority and clinical responsibility.**

Levels of Supervision:

Direct
– supervising physician is physically present with the resident and/or fellow and the patient
Indirect
– direct supervision immediately available – supervising physician is physically present in the hospital or other site of patient care, and is immediately available
– direct supervision available – supervision physician is not physically present within the hospital or other site of patient care, but is immediately available by electronic or telephone modalities, and is available to provide direct supervision
Oversight
– supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

Admissions
The attending surgeon must be notified of each admission. Each patient is admitted under the name of an attending.

Surgery
The senior resident or fellow must immediately notify and receive concurrence for any patient going to the operating room. Supervision of residents/fellows will always meet or exceed hospital policy. Attendings will document their participation in the supervision process. An attending must always be available for consultation and support. Information regarding the responsible attending should be available to residents/fellows, faculty members and patients. Site directors of all integrated and affiliated hospitals in the program must assure the program director that these policies are being followed.

The attending surgeon is expected to:

- Confirm (or change) the diagnosis.
- Approve the operative procedure and procedure timing.
- Be immediately available or physically present (as dictated by his/her judgment) during the operative procedure and assure that it is properly carried out. Exceptions are only allowed for life/limb threatening emergencies.
- Supervise the post-operative care.
- Assure continuing care after the patient leaves the hospital.

Supervising Physicians

Faculty members delegate portions of care to residents/fellows, based on the needs of the patient and the skills of the residents. Fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on patient needs and the skills of the individual resident or fellow.

Transfer
The attending surgeon must be notified of patient transfer to a higher level of care, such as transfer from the floor to the intensive care unit.

End of Life Decisions
The attending surgeon should be informed of and involved in end of life decisions, including, but not limited to, do not resuscitate orders and withdrawal of support.

Specific Clinical Activities and Level of Supervision

Clinical Activity	Resident Level	Method of Instruction	Instructor Level	Supervision Level	Requirements to perform without Direct Supervision	Method to confirm competency
Evaluate and manage critical illness following surgery or trauma	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Identify the indications for critical care admission and discharge	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Appropriately use advanced technology and instrumentation to monitor the physiologic status of children or adults of both sexes	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Provide pre-operative assessment, operative, and post-operative management of complex surgical illness related to trauma or complications	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

Provide post-transplantation management	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Initiate appropriate and complete diagnostic and treatment plans	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Manage blunt and penetrating trauma, and use FAST (Focused Assessment with Sonography for Trauma)	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Formulate and implement patient care plans	Fellow	Direct Patient Care Trauma Conference Turnover Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Manage patients suffering from acute lung injury and ARDS following surgery, trauma, burns, or pancreatitis	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Under appropriate supervision of faculty, perform, monitor and interpret the results of the following comprehensive evaluations: • Multidisciplinary evaluation of critical illness • Angiography • CT scans	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

• MRI • Electrocardiograms • Cardiac assist devices						
Implement the following specialized treatments into the care of the critically ill patient: • Nutritional support to treat and prevent malnutrition, apply parenteral and enteral nutrition • Monitor and assess metabolism and nutrition • Sepsis management • Complex ventilator management • Organ support • Abdominal sepsis and peritonitis • Conscious sedation	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Diagnose, manage, and treat life-threatening disorders, including single and multiple organ system dysfunction, homodynamic instability/compromise, and complex coexisting medical problems	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Under appropriate supervision of faculty, perform the following procedures essential for the care	Fellow	Direct Patient Care Trauma	Attending	Direct	Observed Skill Impression of competence perceived by	Clinical Rating Form Direct Observation w/

of the critically ill patient: • Life support • Resuscitation with the use of crystalloids /blood products • Hemodynamic management (in and non-invasive) • Vasopressor and vasodilator therapy		Conference Rounds Role Modeling			staff	Feedback
Manage a difficult airway and respiratory systems by performing the following procedures: • Endoscopy • Open or Percutaneous Tracheostomy • Cricothyroidotomy • Nasal and Oral Endotracheal Intubation	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Under appropriate supervision of faculty, perform the following procedures essential for the care of critically ill patients with acute and chronic neurologic disease, emergencies, and head and face injuries: • Nasal Packing • Intracranial Pressure monitoring and Electroencephalogram to evaluate cerebral function • Ventriculostomy	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

• Lateral Canthotomy • Hypothermia application for cerebral trauma						
Definitively manage and treat neck traumas including: • Vascular and Aerodigestive Injuries • Soft tissue injuries Definitively manage the following chest injuries: • Cardiac injuries, cardiac tamponade • Thoracic vascular injuries • Tracheobronchial and lung injuries • Empyema, decortications (open and VATS)	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Under appropriate supervision of faculty, perform the following procedures essential for the care of patients with chest injuries: • Pulmonary resections • VATS • Bronchoscopy • Advanced thoracoscopic techniques • Damage control techniqu	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

es • Trans-esophageal and pericardial cardiac ultrasound • Apply transvenous pacemakers • Emergency thoracotomy						
Definitively manage patients with the following abdomen or pelvis injuries: • Gastric, small intestine, and colon injuries, inflammation, bleeding, perforation, and obstructions • Duodenal injury • Rectal injury • Diverticulitis • Cholecystitis • Liver injury (all grades) • Splenic injury, infection, inflammation, or diseases Pancreatic injury, infection, or inflammation • Severe acute pancreatitis • Acute and Chronic Renal failure, ureteral, and bladder injury • Injuries to the female reproductive tract • Acute operative	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

conditions in the pregnant patient • Abdominal compartment syndrome • Peritonitis, perforated viscus, or abdominal sepsis • Major abdominal and pelvic vascular injury, rupture, or acute occlusion						
• Gastrostomy (open and percutaneous) & jejunostomy • Gastrointestinal intubation and endoscopic techniques • Apply parenteral and enteral feedings • Manage stomas, fistulas, and percutaneous catheter devices • Hepatic resections • Pancreatic resection and debridement • Damage control techniques • Abdominal wall reconstruction • Resection debridement for infection or ischemia • Advanced laparoscopic	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
• Radical soft-tissue debridement for necrotizing infection • On-table arteriography • Damage control techniques including temporary shunts	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

• Acute thromboembol ectomy • Hemodialysis access, permanent • Fasciotomy, upper and lower extremity • Amputations, lower extremity (hip disarticulation, above knee, below knee, trans-met)						
• Split thickness, full-thickness skin grafting Thoracic and abdominal organ harvesting for transplantation • Operative management of burn injuries • Upper gastrointestinal endoscopy • Colonoscopy • Core rewarming • Diagnostic and therapeutic ultrasound	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Treat all forms of shock utilizing conventional and state of the art technology (e.g., pneumatic anti-shock garments, traction, and fixation devices)	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Analyze the computations of cardiac output and of systemic and pulmonary vascular resistance	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

Perform and provide instruction of the theory and techniques of CPR	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling ACLS	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback
Utilize titrate inotropic and vasopressor drips based on hemodynamic monitoring	Fellow	Direct Patient Care Trauma Conference Rounds Role Modeling	Attending	Direct	Observed Skill Impression of competence perceived by staff	Clinical Rating Form Direct Observation w/ Feedback

Specialty Specific Objectives

Medical Knowledge	**SPECIALTY SPECIFIC OBJECTIVES**			
	Acquire an advanced body of knowledge and level of skill in the management of critically ill surgical patients to assume the leadership role in teaching and in research in surgical critical care	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Demonstrate familiarity with the didactic	Direct Patient Care	Clinical Rating Form	Semi annually
Competency	Required Skill(s)	Teaching Method(s)	Formative Evaluation Method(s)	Frequency of Evaluation
	knowledge required to adequately care for the critical care and trauma patient. Fellows should be able to define and defend their management plans	Trauma Conference Journal Club Rounds	Direct Observation w/ Feedback Mock Orals	Daily Annually
	Integrate knowledge of fluid, electrolyte and acid base pathophysiology and therapy in the care of the critically ill patient	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Demonstrate the knowledge of monitoring and medical instrumentation that is essential for the care of the critically ill patient and apply knowledge to patient care practices	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Demonstrate an understanding of the physiology, pathophysiology, diagnosis, and therapy of disorders of the cardiovascular, respiratory, gastrointestinal, genitourinary, neurological, endocrine, musculoskeletal, and immune systems as well as of infectious diseases.	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually

	Develop an in-depth knowledge of the following medical problems and apply knowledge to patient care practices: • Metabolic, nutritional, and endocrine effects of critical illness (related to DM, DI, adrenal and thyroid dysfunction) • Hematologic and coagulation disorders • Critical obstetric and gynecologic disorders Trauma, thermal, electrical, and radiation injuries • Inhalation and immersion injuries • Critical pediatric surgical conditions • Transplantation and cell biology	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Demonstrate an understanding of the pharmacokinetics and dynamics of drug metabolism and excretion in critical illness	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually

	Implement knowledge of indication and complications of hemodialysis, pharmacokinetics, drug interactions, and application of hyperbaric oxygen therapy into patient care practices	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Integrate biostatistics and experimental design into research projects	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Classify types of infections	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually

	Cite the advantages and disadvantages of endpoints of resuscitation, including vital signs and other physical examination findings, base deficit, lactate levels, and global oxygen delivery and consumption variables	Direct Patient Care Trauma Conference Journal Club Rounds	Clinical Rating Form Direct Observation w/ Feedback Mock Orals	Semiannually Daily Annually
	Describe the mechanisms and clinical signs and symptoms of blunt cerebrovascular injury, and	Direct Patient Care Trauma Conference	Clinical Rating Form Direct Observation w/	Semiannually Daily

Competency	Required Skill(s)	Teaching Method(s)	Formative Evaluation Method(s)	Frequency of Evaluation
	explain potential treatment for these patients	Journal Club Rounds	Feedback Mock Orals	Annually
Practice Based Learning and Improvement	SPECIALTY SPECIFIC OBJECTIVES			
	Educate the health professional team, as well as, patients and families regarding critical care ethical issues	Direct Patient Care Trauma Conference Journal Club M & M Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Undertake investigations into the various areas of surgical critical care, such as new instrumentation, identification of important physiologic parameters, evaluation of pharmacologic agents in critically ill patients, or health outcomes and/or health policy issues related to surgical critical care	Direct Patient Care Trauma Conference Journal Club M & M Conference	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Participate in quality improvement processes such as M & M conference and performance improvement conference	Direct Patient Care M & M Conference	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Develop patient safety monitoring and error restriction process	Direct Patient Care M & M Conference	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Compare clinical practice, patient safety, and quality of care with evidence-based medicine.	Direct Patient Care Trauma Conference Journal Club M & M Conference	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Educate the health professional team, as well as, patients and families regarding critical care ethical issues	Direct Patient Care Trauma Conference Journal Club M & M Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Implement new scientific advances and clinical approaches from a variety of sources into current patient care practices.	Direct Patient Care Journal Club M & M Conference	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily

Competency	Required Skill(s)	Teaching Method(s)	Formative Evaluation Method(s)	Frequency of Evaluation
	Analyze and evaluate medical literature and examine alternate sources for information that pertains to their patient's health problems.	Journal Club	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Teach the specialty of critical care to fellow fellows, medical students, and interns.	Direct Patient Care Trauma Conference Journal Club M & M Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Maintain appropriate records documenting practice activities (such as patient logs).	Direct Patient Care	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
Interpersonal and Communication Skills	**SPECIALTY SPECIFIC OBJECTIVES**			
	Initiate appropriate consultations with other specialists and construct a clinical plan for complex critical care problems	Direct Patient Care Role Modeling Grand Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Educate and communicate to patients and families all treatment options, outcomes and patient prognosis	Direct Patient Care Role Modeling	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Demonstrate effective communication with patients and families, both listening and conveying information with appropriate degree of complexity	Direct Patient Care Role Modeling	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Develop collaborative relationships with consulting services for optimizing the timing of interventional procedures	Direct Patient Care Role Modeling	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually

	Demonstrate respect, compassion, integrity and responsiveness to the	Direct Patient Care	Clinical Rating Form Direct Observation w/	Semi annually

Competency	Required Skill(s)	Teaching Method(s)	Formative Evaluation Method(s)	Frequency of Evaluation
	needs of the patients and families	Role Modeling	Feedback 360-degree evaluation	Daily Annually
Professionalism	**SPECIALTY SPECIFIC OBJECTIVES**			
	Approach discussions of ethical issues (including advanced directive and end-of-life issues) with sensitivity	Direct Patient Care Role Modeling Journal Club Trauma Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Demonstrate respect, compassion, integrity, punctuality, reliability, and honesty with regards to patients and colleagues.	Direct Patient Care Role Modeling	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Display initiative and leadership.	Direct Patient Care Role Modeling Trauma Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Acknowledge errors, alert patients and appropriate health care providers about the errors and create a plan of action to minimize them.	Direct Patient Care Role Modeling M & M Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
	Demonstrate concern for the educational development of students and fellows.	Direct Patient Care Role Modeling Journal Club Trauma Conference	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually

	Maintain patient confidentiality.	Direct Patient Care Role Modeling	Clinical Rating Form Direct Observation w/ Feedback 360 degrees	Semiannually Daily

Competency	Required Skill(s)	Teaching Method(s)	Formative Evaluation Method(s)	Frequency of Evaluation
			evaluation	Annually
	Compassionately respond to issues of culture, age, gender, ethnicity, and disability in patient care.	Direct Patient Care Role Modeling	Clinical Rating Form Direct Observation w/ Feedback 360-degree evaluation	Semiannually Daily Annually
Systems-Based Practice	**SPECIALTY SPECIFIC OBJECTIVES**			
	Administer a surgical critical care unit and appoint, educate, and supervise specialized personnel, establish policy and procedures for the unit, and coordinate the activities of the unit with other administrative units within the hospital	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Implement the principles and techniques of administration and management as it relates to surgical critical care unit	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Utilize medications safely and determine cost effectiveness of various therapeutic interventions	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Demonstrate an understanding of the impact of a trauma system on regionalization of trauma care	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily

	Demonstrate an understanding of cost-effective patient care in a tertiary care hospital setting	Direct Patient Care M&M Conference Turnover Conference	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily

Competency	Required Skill(s)	Teaching Method(s)	Formative Evaluation Method(s)	Frequency of Evaluation
		Rounds		
	Partner appropriately with other health care providers, including consulting physicians, nurses, pharmacists, respiratory therapists, and physical and speech therapists.	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Demonstrate an understanding of the role of discharge planning and selection of appropriate discharge venue (rehabilitation facility vs. skilled nursing facility vs. home)	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Describe the clinical, ethical, economic and legal decision-making processes related to aspects of surgical critical care	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Demonstrate an understanding of the art and science of trauma team administration and to achieve a working understanding of the major issues in trauma care such as, resource allocation, costs and ethical dilemmas	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily
	Demonstrate knowledge of business aspects of medical practice including coding, billing, and insurance.	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily

	Demonstrate knowledge of how the health care system including other physicians, nurses, and health care professionals affect their patient care practices.	Direct Patient Care M&M Conference Turnover Conference Rounds	Clinical Rating Form Direct Observation w/ Feedback	Semiannually Daily

LeBonheur Children's Hospital Surgical ICU (ELECTIVE ROTATION)

An elective rotation at LeBonheur Children's Hospital is available to the SCC fellow with an interest in pediatric surgical critical care. LeBonheur is the region's pediatric tertiary care center. The LeBonheur pediatric ICU (PICU), with approximately 1,600 - 1,800 admissions annually, provides all critical care services for active programs in pediatrics, general surgery, neurosurgery, otolaryngology and craniofacial reconstruction, orthopedics, transplantation, and trauma. The patient population is about 60% medical patients and 40% surgical, with all patients being managed by the critical care team. The LeBonheur neonatal ICU (NICU) offers the highest level of care (level IV) available in the region, receiving transfers from surrounding areas. The 300+ admissions per year to the NICU mainly comprise surgical and cardiac neonates along with some infants who need multispecialty care. The LeBonheur ICUs serve as a regional and national referral center for children/neonates who require the most advanced diagnostic and therapeutic services. These include advanced respiratory care technologies (such as: High Frequency Oscillatory Ventilation, Nitric Oxide and Helix), Extra Corporeal Membrane Oxygenation, Continuous Renal Replacement Therapy (or peritoneal and hemodialysis), and multi-modal Neuro-monitoring. LeBonheur is the only hospital in the region recognized as an ECMO Center of Excellence by the International Extracorporeal Life Support Organization (ELSO).

Le Bonheur Trauma and Burn Care Learning Objectives	**Competencies Evaluated**
Direct the initial Emergency Department evaluation and resuscitation of the injured or burned child. Identify and appropriately manage shock in the injured child. Interpret physiologic data in the context of the age of the child. Appropriately order and interpret diagnostic and imaging studies.	Patient Care, Medical Knowledge, Practice-based Learning and Improvement
Manage the care of the critically ill, multi-system trauma patient, according to the overall objectives of the program, with specific attention to the following: Control of increased intracranial pressure in victims of traumatic brain injury Management of hemorrhagic shock Respiratory support Nutritional support Operative intervention, as necessary Vascular support (intra-venous and intra-arterial)	Patient Care, Medical Knowledge, Practice-based Learning and Improvement
Prioritize treatment of injuries based upon the physiologic readiness of the child.	Patient Care, Medical Knowledge
Manage the initial resuscitation and care of burn patients: Selection and quantification of initial resuscitation fluids. Assessment of burn extent. Observation of primary burn repair in the operating room. Patient evaluation for inhalation injury and its management. Assessment and care of burn wound infection.	Patient Care, Medical Knowledge, Practice-based Learning and Improvement
Provide administrative leadership of the trauma service, including conducting bedside rounds, assigning duties to residents and physician extenders, coordinating care between multiple physician and ancillary providers.	Patient Care, Medical Knowledge, Interpersonal and Communication Skills

Participate in Trauma Department process improvement.	Practice-based Learning and Improvement, Interpersonal and Communication Skills,

Le Bonheur Trauma and Burn Care Learning Objectives	Competencies Evaluated
	Professionalism
Actively participate in the education of junior house staff.	Systems-based Practice, Interpersonal and Communication Skills, Professionalism
Demonstrate effective and compassionate communication skills with parents, children, and other caregivers.	Systems-based Practice, Interpersonal and Communication Skills, Professionalism
Facilitate the early identification of victims of child-abuse.	Patient Care, Medical Knowledge

PICU Learning Objective	Competencies Evaluated
To learn how to complete effectively and efficiently an assessment and management plan for pediatric surgical and medical patients.	Medical knowledge, Patient care
To learn appropriate preparation and equipment setup for an admission in to the ICU.	Medical knowledge
To learn a multifaceted approach to perioperative patient management, with emphasis on safe transport of patient, fluid therapy and pain control.	Medical knowledge, Patient care
To develop the required invasive and non-invasive clinical skills (e.g. intravenous and arterial access, airway management, hemodialysis and ECMO techniques) and the necessary judgment to provide quality care to children of all ages undergoing diagnostic, therapeutic and/or surgical procedures.	Medical knowledge, Patient care
Residents will learn the basics of cardiorespiratory resuscitation and emergency airway management in infants and children.	Medical knowledge, Patient care
Residents will recognize shock and understand the pathophysiology responsible for the clinical and physical findings.	Medical knowledge, Patient Care
Residents will learn to interpret systemic arterial, central venous, intracranial and cerebral perfusion pressures and initiate management decisions to reach a desired effect.	Systems-based practice, Medical Knowledge
Residents will develop a methodical approach to the initial and daily evaluation and decision-making process for the critically ill pediatric patient.	Practice-based practice
Residents will learn the indications for cardiac support and become proficient in the utilization of pharmacologic support when indicated.	Medical knowledge, Practice based learning and improvement

Residents will become skilled at interpreting arterial and venous blood gas analysis in the pediatric intensive care patient, and	Practice based learning and improvement

PICU Learning Objective	Competencies Evaluated
manage their ventilation to change their physiology and optimize the pulmonary function.	
Residents will learn fluid, serum electrolyte, and urine output requirements change during the management and ongoing care of the pediatric intensive care patient, and institute resuscitation and interventions appropriately.	Patient care, Practice based learning and improvement
Residents will gain knowledge required to provide adequate and appropriate nutritional support to the critically ill infant or child.	Systems-based practice, Patient Care
Resident will learn how immunodeficiencies may lead to and/or affect the management of critical ill infants and children. This will include neoplastic, as well as infectious, etiologies.	Medical Knowledge
Residents will learn indications for and mechanisms for initiation and management of renal failure to include hemodialysis and peritoneal dialysis.	Patient care, Practice based learning and improvement
To become familiar with the recognition and management of complications arising in the PICU from procedures and medications.	Patient care, Medical Knowledge
To foster feelings of compassion, respect, understanding and service toward patients and their families.	Professionalism, Interpersonal and Communication Skills
To reinforce the ethical principles of patient care.	Professionalism
To understand the appropriate roles of the generalist pediatrician, anesthesiologist, surgeon and the intensivist in these settings.	Professionalism, Interpersonal and Communication Skills
To develop and practice sensitivity to culture, age and gender issues.	Professionalism, Interpersonal and Communication Skills
To learn effective supervision of other pediatric and critical care trainees.	Systems-based practice
To learn the process of self-evaluation and upholding of standards and the process of self- regulation of the profession	Professionalism
To better understand the principles and methodology of a systems-based practice and its role in improving patient safety in the PICU.	Systems-based practice
To understand the basic requirements for successful administration of a pediatric critical care unit	Systems-based practice, Professionalism, Practice-based Learning
To participate in the decision making in the admitting, discharge, and transfer of patients in the PICU.	Professionalism, Patient Care

To promote effective communication with patients, families, colleagues and care team members	Professionalism, Interpersonal and Communication Skills

PICU Learning Objective	Competencies Evaluated
To develop and model effective communication between anesthesiologists, surgeons, intensivists and pediatricians	Systems-based practice, Interpersonal and Communication Skills

NICU Learning Objective	Competency Evaluated
Residents will learn the personnel framework of a neonatal intensive care unit, to include neonatology, nursing, respiratory therapy, dietary services, pharmacy, and ancillary staff.	Interpersonal and communication skills, Professionalism
Residents will understand basic newborn transitional physiology (closure of patent foramen oval, ductus arteriosus, and pulmonary compliance/perfusion).	Medical knowledge
Residents will become proficient in identifying normal and abnormal physical exam findings for premature and term infants.	Medical knowledge, Patient care
Residents will develop a methodical approach to the initial and daily evaluation and decision-making process for the NICU patient.	Medical knowledge, Patient care
Residents will learn about and care for the neonatal Cardiovascular System including: patent ductus arteriosus, common cardiac defects and needed surgery, and using cardiac medications. Residents will learn the indications for cardiac support and become proficient in the utilization of pharmacologic support when indicated.	Medical knowledge, Practice based learning and improvement, Patient Care
Residents will learn about and care for the neonatal digestive system including: development (anatomical, physiological, and biochemical), disorders of digestion, GI anomalies and intestinal obstruction, GI hemorrhage, necrotizing enterocolitis	Medical knowledge, Practice based learning and improvement, Patient Care
Residents will learn about and care for the neonatal diseases of the liver including: TPN-related cholestasis and hepatic malformations.	Medical knowledge, Practice based learning and improvement, Patient Care
Residents will learn about and care for the neonatal central nervous system disturbances including: assessment of neurologic function, disorders of development, intracranial hemorrhage, seizure disorders, hypoxic-ischemic encephalopathy, neuromuscular disorders	Medical knowledge, Practice based learning and improvement, Patient Care
Residents will learn about and care for the Neonatal kidney and the urinary tract, renal development and physiology, renal failure, urinary tract malformations	Medical knowledge, Practice based learning and improvement, Patient Care

Residents will learn about and care for Neonatal orthopedic problems, neonatal musculoskeletal disorders, bone and joint infection, congenital	Medical knowledge, Practice based learning and improvement, Patient Care

NICU Learning Objective	Competency Evaluated
deformities of the extremities	
Residents will learn about and care the neonatal respiratory system including: assisted ventilation, persistent pulmonary hypertension, chronic lung disease, air leak syndromes. The resident will become skilled at understanding arterial and venous blood gas analysis in premature and term newborns, and management of the various ventilators (high frequency oscillator, Servo, and Dragger) to appropriately effect change in neonates requiring ventilatory assist.	Medical Knowledge Practice based learning and improvement, Patient Care
Residents will learn about and care for neonatal nutritional and metabolic requirements. Residents will learn how fluid, serum electrolyte, and urine output requirements change during the management and ongoing care of the critically ill newborn and institute resuscitation and interventions appropriately for severely premature, premature, and term infants.	Medical knowledge, Practice based learning and improvement, Patient Care
Residents will exhibit skills demonstrating their understanding of systems-based practice, including effective time management, utilization of consult and referral systems on local and national levels, and effectively advocate for their patients.	Systems-based practice, Patient Care, Professionalism

DIDACTIC SCHEDULE

- Weekly Trauma/Surgical Critical Care Conference: Held every Thursday morning following turnover in the Trauma Training Center. Sessions cover the fundamentals of both Surgical Critical Care and Trauma Care. Fellows are required to attend and present.

- Division of Trauma/Surgical Critical Care Performance Improvement: Every other week. Review of performance improvement and patient safety issues. Fellows are required to attend and encouraged to participate.

- Division of Trauma/Surgical Critical Care Morbidity and Mortality Review: Held every other week. Review of trauma/SCC specific morbidities and mortalities – includes input from anesthesia, orthopedics, neurosurgery in addition to SCC core faculty. Fellows are required to attend and encouraged to participate.

- Department of Surgery Mortality and Morbidity Conference: Held every Wednesday. Case presentations of morbidity, mortality and interesting cases. Fellows are encouraged to attend.

- Surgery Grand Rounds: Held every other week. Topics of interest presented by faculty, visiting faculty, senior residents, and fellows. Fellows are encouraged to attend.

- Journal Club: Held monthly. Discussion of 2-3 topical journal articles with emphasis on critical analysis. Fellows are encouraged to attend.

- Turnover Conference (Morning Report): Held daily. Presentation and discussion of overnight admissions to trauma service. Presentation and discussion of care plans for those patients requiring operative intervention. Fellows are required to attend.

POLICIES AND PROCEDURES

The Surgical Care Fellowship Program follows all ACGME and UT GME Policies and Procedures.
http://www.uthsc.edu/graduate-medical-education/policies-and-procedures/index.php

REQUIRED EXAMINATION SCHEDULE

There are no required examinations.

SCHOLARLY ACTIVITY

Each incoming fellow will be encouraged to take on scholarly activity (i.e. original research, drafting of review paper or text chapter) early in the year, and will meet regularly with the PD to track progress. Completion of this project is not required for graduation.

RESIDENT CLINICAL AND EDUCATIONAL WORK HOURS

Clinical and educational work hours **must** be limited to **more than 80 hours per week**, a**veraged over a four-week period**, inclusive of all in-house clinical and educational activities, and clinical work done from home.

Clinical and educational work hours include all clinical and academic activities related to the fellowship program; i.e., patient care (both inpatient and outpatient), administrative work related to patient care, the provision for transfer of patient care, time spent in-house during call activities, moonlighting (internal and external), and scheduled academic activities such as conferences. Clinical and educational work hours do not include reading and preparation time spent away from the duty site. Graduate medical education clinical and educational work hour standards incorporate the concept of graded and progressive fellow responsibility leading to the unsupervised practice of medicine.

- Clinical work done from home must be counted toward the 80-hour weekly maximum.
- Clinical work periods for all residents/ fellows must not exceed 24 hours continuous scheduled clinical assignments.
- Clinical work hour exceptions may be granted the Review Committee to support specialty-specific rotations approved by institution, for up to a maximum of 88 hours based on sound education rational.
- Residents who have appropriately handed off patients following conclusion of scheduled work period have the flexibility to voluntarily remain at work in unusual circumstances, if in their judgement, those circumstances benefit patient care or education. Such additional time must be counted toward the 80-hour limit. All residents/fellows must have at least 14 hours free of clinical work after 24 hours of clinical assignment.

Clinical and educational work hour must be recorded in New innovations **weekly**, as required by the GME office. Fellows are responsible for entering sick/vacation leave and for entering justification for **all** violations.

MANDATORY TIME FREE CLINICAL AND EDUCATIONAL WORK HOURS:

- Clinical and educational work hours must be limited to more than 80 hours per week, averaged over a four-week period.
- One day off in seven
- In-house calls no more often than three days

MAXIMUM CLINICAL WORK AND EDUCATIONAL PERIOD LENGTH:

- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
    - Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
    - Additional patient care responsibilities **must not** be assigned during this time. (**no new patients, no surgery, no clinic**)

CLINICAL AND EDUCATION WORK HOUR EXCEPTION

- In rare circumstances, after handing off all other responsibilities, a fellow, 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 will be counted toward the 80-hour weekly limit.

TRANSITIONS OF CARE/HAND-OFF POLICY

In addition to UT GME Handoffs and Transitions of Care Policy residents must follow these program specific policies:

Transitions may occur:

- Face to face
- Over the telephone
- Via secure computer network

Information transferred must include:

- Patient name
- Account number
- Room number
- Responsible attending and resident contact information
- Patient age
- Diagnosis and surgeries performed or pending
- Allergies
- Resuscitation status
- Antibiotics
- Pending tests
- “To do” list

All information must be transmitted in compliance with HIPPA

ALERTNESS AND FATIGUE MITIGATION

A ***required*** lecture/presentation dedicated to this topic is given during the Basic Science conference following surgical grand rounds (see ROH conference schedule above). This is the only ***required*** basic science conference for the SCC fellows. The accompanying slide presentation will be available on the general surgery website (http://www.uthsc.edu/surgery/conferences_schedule.php).

If the on-call fellow is too fatigued to provide adequate patient care, he or she will check out with the appropriate ICU resident to ensure that there is no interruption in the patient care process. The fellow will then inform the on-call attending surgeon and program director to allow for the necessary modifications and be dismissed from the remainder of his or her duties for that shift.

PROGRAM ELIGIBILITY AND SELECTION CRITERIA

Applicant must have completed ACGME accredited 5-year General Surgery Residency and successfully passed USME Step 3.
Applicant must be able to meet a rigid work schedule.
Applicant must have 3 letters of recommendation.
Evaluation of applicant interview by the SCC Faculty.

MILESTONES

The Milestones are designed only for use in evaluation of fellows in the context of their participation in ACGME accredited residency or fellowship programs. The Milestones provide a framework for assessment of the development of the fellow in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

https://www.acgme.org/Portals/0/PDFs/Milestones/SurgicalCriticalCareMilestones.pdf

FELLOWS EVALUATION

Each accredited program is responsible for utilizing appropriate methods of performance evaluation of residents consistent with ACGME common program requirements and the requirements of its Residency Review Committee (RRC). Competency-based goals and objectives based on performance criteria for each rotation and training level will be distributed annually to residents and faculty either in writing or electronically and reviewed by the resident at the start of each rotation. Each residency program's evaluation policies and procedures must be in writing. Residents will be evaluated based on the Competencies and the specialty-specific Milestones. Additionally, all residents are expected to be in compliance with GMEC and University of Tennessee Health Science Center policies which include but are not limited to the following: University of Tennessee personnel policies1 , University of Tennessee Code of Conduct, sexual harassment, moonlighting, infection control, completion of medical records, and federal health care program compliance policies. Quality Improvement/Clinical Competency Committee Peer review evaluation by a Quality Improvement (QIC)/Clinical Competency Committee (CCC) is integral to the graduate medical education process. Each program's QIC/CCC should review all resident/fellow performance evaluations and assessments of progress at least semi-annually. The QIC/CCC will advise the Program Director regarding resident progress, including promotion, remediation, and dismissal. Under the Tennessee Patient Safety and Quality Improvement Act of 2011, the records of the activities of each QIC/CCC are designated as confidential and privileged. Resident/fellow evaluation documentation and files that are reviewed by a program's QIC/CCC are protected from discovery, subpoena or admission in a judicial or administrative proceeding.

1. Procedure
    a. A QIC/CCC must be appointed by the program director.
        i. At a minimum, the QIC/CCC must include 3 members of the program's faculty, at least one of whom is a core faculty member.
        ii. Others eligible for appointment to the QIC/CCC include faculty from the same and other programs, or other health professionals who have extensive contact and experience with the program's residents.
        iii. All members should work directly with the program's residents on a regular basis. b. Responsibilities of the QIC/CCC include:

        i. Members must meet, at a minimum, semi-annually. Ad hoc meetings may occur as necessary.
        ii. The Committee will select a Committee Chair, which cannot be the program director.
        iii. Review all resident evaluations at least semi-annually.
        iv. Determine each resident's progress on achievement of the specialty specific Milestones.
        v. Meet prior to the residents' semi-annual evaluation.
        vi. Advise the Program Director regarding each resident's progress.
        vii. Make recommendations to the Program Director for additional or revised formative evaluations needed to assess resident's performance in the Milestone sub-competency levels.

FORMATIVE EVALUATION

1. Faculty members must directly observe, evaluate and frequently provide feedback on resident performance during each rotation or similar educational assignment. Each program is required to use the web-based evaluation system in New Innovations to distribute a global assessment evaluation form. Faculty attending will complete this online evaluation to document resident performance at the end of each rotation/educational assignment.

a. For block rotations of greater than three months in duration, evaluation must be documented at least every three months.
b. Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.

2. These evaluations should be reviewed for completeness by program leadership, with follow-up by the program director or coordinator to address inadequate documentation; e.g., below average performance ratings without descriptive comments or inconsistencies between written assessments and statistical data.

3. Completed electronic evaluations are reviewed by the resident. Any evaluations that are marginal or unsatisfactory should be discussed with the resident in a timely manner and signed by the evaluator and resident.

4. In addition to the global assessment evaluation by faculty, multiple methods and multiple evaluators will be used to provide an overall assessment of the resident's competence and professionalism. These methods may include narrative evaluations by faculty and non-faculty evaluators, clinical competency examinations, in-service examinations, oral examinations, medical record reviews, peer evaluations, self-assessments, and patient satisfaction surveys.

5. The program must provide assessment information to the QIC/CCC for its synthesis of progressive resident performance and improvement toward unsupervised practice.

6. Using input from peer review of these multiple evaluation tools by the QIC/CCC, the program director (or designee) will prepare a written summary evaluation of the resident at least semiannually. The program director or faculty designee will meet with and review each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones and strengths as well as plans for improvement. The program director (or designee) and resident are required to sign the written summary that will then be placed in the resident's confidential file. The resident will receive a copy of the signed evaluation summary and will have access to his or her performance evaluations.

7. If adequate progress is not being made, the resident should be advised, and an improvement plan developed to provide guidance for program continuation. The improvement plan must document the following:

- Competency-based deficiencies;
- The improvements that must be made;
- The length of time the resident must correct the deficiencies; and
- The consequences of not following the improvement plan. Improvement plans must be in writing and signed by both the program director and resident.

8. If unacceptable or marginal performance continues and the resident is not meeting program expectations, another review should take place in time to provide a written notice of intent to the resident at least 30 days prior to the end of the resident's current if he or she must extend training at the current level or will not have their contract renewed. If the primary reason(s) for non-promotion or non-renewal occurs within the last 30 days of the contract period, the residency program must give the resident as much written notice as circumstances reasonably allow.

SUMMATIVE EVALUATION

1. At least annually, the program director will provide a summative evaluation for each resident documenting their readiness to progress to the next year of the program, if applicable. This evaluation should assess current performance based on written evaluations, faculty observations and other documented performance measures that have been reviewed by the program's QIC/CCC. The summative evaluation will be discussed with the resident and a copy signed by the program director and resident will be placed in the confidential resident file.
2. The program director will also provide a final evaluation upon completion of the program. This evaluation will become part of the resident's permanent record maintained in the GME office and will be accessible for review by the resident. The end-of-program final evaluation must:

    • Use the specialty-specific Milestones, and when applicable the specialty-specific case logs, to ensure residents can engage in autonomous practice upon completion of the program.

    • Verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. • Consider recommendations from the QIC/CCC.

PROGRAM AND FACULTY EVALUATIONS

Fellow Evaluation of Program and Faculty Residents must be given the opportunity to evaluate their program and teaching faculty at least once a year. This evaluation must be anonymous, confidential, and in writing. Online evaluations using New Innovations can provide anonymity and confidentiality for the resident. In the case of small or one-person fellowships, the evaluations may be collated with the core program to ensure confidentiality. The results of residents' assessments will be included in the annual program evaluation.

Program Evaluation

The Program Evaluation Committee (PEC) consists of 10 faculty members and fellow representatives. This committee is responsible for reviewing the curriculum and developing and implementing new educational activities. It is responsible for reviewing and updating rotation goals and objectives. It will review ACGME standards and ensure compliance. It will render a formal, written annual program evaluation with a plan for improvement.

The fellows and faculty submit evaluations of the program and individual rotations (anonymously) on the New Innovations website annually. All aspects of the program are evaluated, including conferences, personnel, rotations and faculty. The PEC reviews these evaluations, fellow and faculty scholarly activity, and ABS (American Board of Surgery) pass rates. These are presented at the Annual Program Evaluation (APE) meeting. The program effectiveness is formally reviewed. This meeting ensures the fellowship program follows ACGME standards. An action plan is devised for areas that need improvement and/or change.

LEAVE POLICIES

All fellows are allowed three (3) weeks, consisting of 21 days (Monday – Sunday) of paid annual (vacation) leave per year, plus leave as noted in the institutional requirements for family, maternity and paternity leave. Vacation requests must be submitted to the program director by July 21 by email. Educational leave (for meetings) is not counted as vacation if approved by the program director. Leave for interviews must be requested by email to the program director. Interview days are considered annual leave days or regularly scheduled days off.

Fellows are allotted three (3) weeks of paid sick leave per twelve-month period for absences due to personal or family (spouse, child, or parent) illness or injury. A physician's statement of illness or injury may be required for absences of more than three (3) consecutive days or an excessive number of days throughout the year.
Sick leave is non-cumulative from year to year. Fellows are not paid for unused sick leave. Under certain

circumstances, additional sick leave without pay may be approved.

In addition to approval from the PD, a leave request form must be completed by the fellow.

The American Board of Surgery requires that all fellows applying for certification must have no fewer than **48 weeks of full time clinical activity in surgical critical care or anesthesiology critical care accredited by the ACGME** (from the ABS website). The fellow may be required to make up any time missed in accordance with the Fellowship Program and Board eligibility requirements.

LEGAL INQUIRIES

All inquiries from attorneys (unless they are from the University of Tennessee Office of General Counsel) should be referred to the attending. Inquiries from insurance officials or hospital officials should also be answered in generalities, and then referred to the attending. This is the case, even if you are assured that no litigation is intended. If you are served with papers or there are hints at litigation, the attending surgeon and program director should be informed immediately, and you will be assisted in contacting the University Counsel (901-448-5615)

MEDICAL RECORDS

Medical records are legal documents. They are maintained for continuity of patient care, document quality care, justify payment, reporting to government agencies, and serve as a defense against malpractice claims. They should never be used to air disagreements with other services or comment on the care of other services or hospital personnel. Correct terminology is important.

All records must be timed and dated and signed and include block letter of your name after the signature and a pager number (or other contact number). A pre-op note should be entered on all patients. A History and Physical must be performed within 30 days prior to admission and updated within 24 hours of admission or before transport to the operating room. All operative reports must be dictated within 24 hours of surgery. Discharge summaries should be dictated at the time of discharge.

Fellows who are delinquent with medical record completion are subject to the same penalties as the faculty – suspension of operative and/or admitting privileges. Suspension of privileges may result in loss of vacation days.

Never alter a medical record after a query is made regarding the care of the patient.

MEETING ATTENDANCE/TRAVEL

Fellows are eligible to attend meetings for presentation (oral or poster) of their research. The Department of Surgery will fund (at University rates) the meeting registration, travel and hotel fees. The educational leave does not count as vacation.

A travel request form must be submitted to the program director for approval 6 weeks in advance of the meeting for scheduling purposes. http://www.uthsc.edu/surgery/residency/documents/travel-request.pdf. Once travel has been approved, the fellow should complete a leave request form (see above) and send an e-mail to Flavenia Leaper (fleaper@uthsc.edu) one month in advance including the following:

- Name of Conference
- Travel Dates (arrival/departure)
- Conference Dates (you are permitted to travel one day before conference begins and one day after conference has ended)
- Location

Travel reimbursement is based on GME policy. Travel is a privilege and not a right; all residents and fellows under Graduate Medical Education are required to know and follow all UT travel policies. GME will NOT ask

for exceptions to the travel policy. All travelers must sign an attestation stating that everyone understands the travel policy and agrees to follow it. GME will not process any new travel for any fellow or program until the forms are returned from the fellow and program administration.

Failure to follow GME policy and use appropriate GME forms may result in non-reimbursement.

Receipts submitted for reimbursement of all other expenses MUST show total and payment information.
All travel reimbursement will be direct deposited into the fellow's account.

Airline tickets purchased through Expedia or Travelocity are not reimbursable by the University of Tennessee. ALL airline receipts must show the class of service (Coach) or designated letter to receive reimbursement.

MOONLIGHTING

Moonlighting is not permitted. Violation of this policy may result in dismissal.

CASE LOG

All fellows must keep two written records of their experience: a summary record documenting the numbers and types of critical care patients; and an operative log of numbers and types of operative experiences, including bedside procedures. Cases should be logged at least monthly and will be monitored by the residency coordinator and program director. Failure to keep up with case logs may result in loss of vacation days.

PROFESSIONALISM

Honesty is expected always. Violation of this policy is grounds for immediate dismissal.
All fellows are expected to look and act as a responsible physician. Professional appearance and manner are to be exercised in all environments, even though the work and conditions may be very stressful. All patients are to be treated with the respect you would wish afforded to your family members.

It is never acceptable to swear at a patient, regardless of the language used by the patient or family member. It is never acceptable to strike a patient.

Fellows are expected to dress professionally whenever at work. Scrubs are acceptable attire but should be clean and free of blood and other body fluids. Attire should be changed as soon as possible after a contaminated or bloody case. Your white coat should be clean.

Collegiality and respect for other members of the health care team is essential to good patient care. When called for a consult or called by a nurse for a question, the response should, always, be professional and courteous.

GRADUATION POLICY

The program director will provide a summative evaluation to graduating fellows upon completion of the program. The end-of-program summative evaluation will include documentation of the resident's performance during the final period of education and verification that the resident has demonstrated sufficient competence to enter practice without direct supervision. A full description of these actions may be viewed on the GME website under academic performance improvement policy.

DIVERSITY

Statement will be placed here.

WELLNESS

Your fellowship can be one of the most rewarding yet challenging times of your life. UTHSC GME recognizes that you need to concentrate on your own mental and physical wellness to help you better serve your patients and lead a healthier, happier life. These resources can help maintain your well-being by lowering your stress, identifying problem areas, avoiding burnout, and learning how to achieve a healthy work/life balance.

The Surgical Critical Care Program ensures full coverage of patient care when a fellow is unable to attend work with a specific staff person assigned as back-up.

UTHSC Resources

- **Resident and Fellow Wellness Champions**
- **Campus Recreation**
- **SASSI**
- **Student Assistance Program** (SAP)
- **University Health Services** (UHS)

Suicide Hotline 1-800-273-8255 OR Crisis Text by texting TALK to 74

Hospital Contacts

LeBonheur Children's Hospital

Dictation

287-5100

Meal Allotments

Cheryl Wilkinson
c/o Physician and Referral Services
850 Poplar Avenue, Bldg. 2
Memphis, TN, 38105
901-287-5158 (Office)/901-287-4790 (Fax)

Medical Records

901-287-6076

Security (Badges and Parking)

901-287-4456

Regional One Health

Help Desk (IT)

901-545-7480

Meal Allotments

Brad Jordan
Administrative Coordinator
901-545-7509 (Office)
901-515-9503 (Fax)
bjordan@regionalonehealth.org

Medical Records

Buffy Bell
901-545-6319

Medical Staff Services

Shari Wahl Yendrek, BPS-HA
Director, Medical Staff Services and Resident Liaison
901-545-8336 (Office)
901-515-9486 (Fax)

Scrubs Access

Brenda Wells
Supervisor, Laundry Services
877 Jefferson Avenue
Memphis, TN 38103
901-545-7990 (Office)
901-545-7169 (Fax)
901-301-7145 (Cell)
BMcFarland@regionalonehealth.org

Resources

American Board of Surgery

http://www.absurgery.org/

New Innovations

Duty Hours

http://www.new-innov.com/pub/

Department of Surgery website

http://www.uthsc.edu/surgery/

American Association for the Surgery of Trauma

http://www.aast.org

Eastern Association for the Surgery of Trauma

http://www.east.org