

Frequently Asked Questions: Critical Care Surgery, Pediatric Surgery, & Vascular Surgery
Review Committee for Surgery
ACGME

Question	Answer
Duration and Scope of Education	
<p>What type of information is required by the Review Committee regarding the introduction of a Vascular Surgery integrated program when the sponsoring institution already has an independent Vascular Surgery program?</p> <p>[Program Requirement Vascular Surgery: Int.C.1. and Int.C.2.]</p>	<p>Sponsoring institutions that submit an application for an Integrated Vascular Surgery program (0+5) where a Vascular Surgery independent program (5+2) is already present, must indicate in the Program Information Form (PIF) whether it plans to run program formats simultaneously or if it plans to phase out the independent program format once the integrated program format has graduated its first cohort of residents. If the sponsoring institution decides to maintain a vascular surgery independent program after having previously indicated that it would close that program, the sponsoring institution must make a request to the Review Committee. The request must include supporting documentation of the adequacy of case volume to support both programs simultaneously.</p>
Program Director Qualifications	
<p>Why are there required qualifications for new program directors?</p> <p>[Program Requirements: Surgical Critical Care II.A.2 Pediatric Surgery II.A.3 Vascular Surgery II.A.3]</p>	<p>In the past, young faculty members were frequently appointed as program directors with the expectation of “learning on the job” in a role that was often limited to “custodian” and “contact person.” Today, a surgical residency is very complex, and the accreditation requirements are extensive, so it is important that individuals are already prepared to take on the role, are already respected, senior members of the faculty, and have reached a stage in their academic practices that enables them to truly devote the time and effort required to oversee a high quality residency program.</p>
<p>Why must a program director be Board-certified in the specialty/subspecialty of the program?</p> <p>[Program Requirements: Surgical Critical Care II.A.2.c Pediatric Surgery II.A.3.c Vascular Surgery II.A.3.c]</p>	<p>As a senior leader and role model, the program director is expected to be an expert in the specific field of the program. Current Board certification is the minimum benchmark of expertise.</p>
<p>What type of educational and administrative experience is required before appointment as a new program director?</p>	<p>In order to be prepared to function as a new program director, individuals must already have a comprehensive understanding of and ability in educational and evaluation methods, active experience in managing and administering a complex organization, and</p>

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<p>[Program Requirements: Surgical Critical Care II.A.2.a Pediatric Surgery II.A.3.a Vascular Surgery II.A.3.a]</p>	<p>leadership and communication skills. Individuals who are appointed as new program directors should have served for at least five years as a GME faculty member with at least two years at the institution at which they are being appointed as program directors. Individuals should (where applicable) have been promoted or be eligible for promotion to the rank of Associate Professor. Individuals should have already served as an associate residency program director for at least one year.</p>
<p>Why must a new program director have an active, unrestricted license to practice medicine in the state in which the program is located and unrestricted credentials at the primary clinical site?</p> <p>[Program Requirements: Surgical Critical Care II.A.2.c Pediatric Surgery II.A.3.c Vascular Surgery II.A.3.c]</p>	<p>As a senior role model and respected clinical leader, a program director must be recognized as an expert in the practice of surgery, must be fully cognizant of the requirements for licensure and credentialing, and should be actively engaged in the practice of surgery in the clinical site where the program is located.</p>
<p>Why must the program director have documented scholarly activity, and what types of scholarly activity are sufficient?</p> <p>[Program Requirements: Pediatric Surgery II.A.3.e]</p>	<p>The program director sets the tone for the scholarly environment of the residency program. In order to be effective in this capacity, the program director must be recognized and respected by faculty members and residents as having demonstrated success in scholarship. It is highly recommended that the program director have documented scholarly activity in all three areas described in the Program Requirements. Because it is expected that both faculty members and residents are involved in research and publications, the program director should have evidence of peer-reviewed publication during the most recent five-year period. In addition, the program director should have contributed to the field of surgery by analyzing or reviewing clinical practice. It is highly desirable that a program director has actively participated in national or regional surgical meetings and served on committees of national or regional surgical organizations. Although there are other ways to demonstrate scholarship, the Review Committee recommends these guidelines for demonstration of scholarly activity by program directors.</p>
Duty Hours	
<p>What types of physicians are acceptable as identifiable appropriately-credentialed and privileged attending physicians who are</p>	<p>Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include ABMS appropriately-credentialed surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment,</p>

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<p>ultimately responsible for each patient's care?</p> <p>[Program Requirement: VI.D.1]</p>	<p>procedures must be supervised by appropriately credentialed ABMS-certified critical care physicians (e.g., anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.).</p>
<p>Who may provide direct supervision to PGY-1 residents?</p> <p>[Program Requirement: VI.D.5.a).(1)]</p>	<p>Each program is responsible for having clear policies for supervision. Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or manage a particular clinical scenario and include more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined relationship outlined in the supervision policy may directly supervise PGY-1 residents.</p>
<p>What does "indirectly with direct supervision immediately available" mean?</p> <p>[Program Requirement: VI.D.5.a).(1)]</p>	<p>For certain tasks, supervision may be provided "indirectly" (supervising physician not physically present) by phone/text/e-mail discussion. When needed (as outlined by the programs supervision policy) or requested by the resident, the supervising physician must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes.</p>
<p>What are examples of defined tasks for which PGY-1 residents may be supervised indirectly and examples of defined tasks for which PGY-1 residents should have direct supervision until competency is demonstrated?</p> <p>[Program Requirement: VI.D.5.a).(1)]</p>	<p>Indirect supervision is allowed for:</p> <ul style="list-style-type: none"> a. Patient Management Competencies <ul style="list-style-type: none"> 1. evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests 2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests 3. evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments 4. transfer of patients between hospital units or hospitals 5. discharge of patients from the hospital 6. interpretation of laboratory results b. Procedural Competencies <ul style="list-style-type: none"> 1. performance of basic venous access procedures, including establishing intravenous access 2. placement and removal of nasogastric tubes and Foley catheters 3. arterial puncture for blood gases

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	<p>Direct supervision is required until competency is demonstrated for:</p> <p>a. Patient Management Competencies</p> <ol style="list-style-type: none"> 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 post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments 4. management of patients in cardiac or respiratory arrest (ACLS required) <p>b. Procedural Competencies</p> <ol style="list-style-type: none"> 1. carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation 2. repair of surgical incisions of the skin and soft tissues 3. repair of skin and soft tissue lacerations 4. excision of lesions of the skin and subcutaneous tissues 5. tube thoracostomy 6. paracentesis 7. endotracheal intubation 8. bedside debridement
<p>What skills should members of the caregiver team have and how should these be ensured across the team?</p> <p>[Program Requirement: VI.E.]</p>	<p>All members of the caregiver team should be provided instructed in:</p> <ol style="list-style-type: none"> 1. recognition of and sensitivity to the experience and competency of other team members; 2. time management; 3. prioritization of tasks as the dynamics of a patient's needs change; 4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;

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	6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. compliance with work hours limits imposed at the various levels of education; and, 8. team development.
<p>Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?</p> <p>[Program Requirement: VI.G.5.c).(1).]</p>	<p>Yes. Such circumstances include:</p> <ol style="list-style-type: none"> 1. Continuity of care for patients, such as for: <ol style="list-style-type: none"> a. a patient on whom a resident operated/intervened that day who needs return to the operating room (OR); b. a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care; c. a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable; d. a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient's family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated. 2. a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.
<p>A program offers a one-month acute care surgery rotation that has residents working 12-hour shifts alternating weeks of nights and day shifts. Is this considered a night float rotation?</p> <p>[Program Requirement: VI.G.6.]</p>	<p>Yes. These residents cannot work more than six consecutive nights during the night shift weeks, there must be two months off between such rotations, and the two weeks of night shifts count toward the total time on night float.</p>
<p>A program offers a one-month rotation with four residents where, in lieu of call every fourth night, each resident groups their call into five or six consecutive nights as a night shift. Is this considered a night float rotation?</p> <p>[Program Requirement: VI.G.6.]</p>	<p>Yes in part. The consecutive nights would count as one week toward the total amount of night float, but a two-month hiatus would not be required between such rotations.</p>
<p>A program offers a rotation for three</p>	<p>Yes. The six weeks of night shifts would count toward the 15-month maximum allowable</p>

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<p>successive months alternating night shifts for two weeks with day shifts for two weeks. Is this allowed?</p> <p>[Program Requirement: VI.G.6.]</p>	<p>for any resident over the five-year residency. There must be two months between such rotations.</p>
<p>A resident who completed one year as a non- designated preliminary resident is matched at the same program as a PGY-1 categorical surgery resident. During their preliminary year the resident worked four months on night float rotations. Will the maximum number of night float months allowed for this resident during their five-year categorical residency be 20 months or are they allowed only 11 months?</p> <p>[Program Requirement: VI.G.6.]</p>	<p>Since they will be starting the program as a PGY-1 categorical resident they will be allowed to work 11 months of night call over the five years. Had they matched as a PGY-2 resident they would have been allowed only 16 months.</p>
<p>A resident completes two years as a categorical resident during which time the resident worked seven months on night float rotations. The resident then does two years in the lab during which time the resident worked two months on night float rotations. The resident is now starting the final three years of the program. What is the maximum number of months of night float allowed for this resident during the final three years of the program?</p> <p>[Program Requirement: VI.G.6.]</p>	<p>Eight months is allowed since the resident worked seven during the first two years of her clinical education. The two months worked during the lab time should not be counted toward the 15-month total.</p>
<p>A resident completes two years as a categorical resident at one program during which time the resident worked eight months on night float rotations. The resident transfers to another program as a</p>	<p>Seven months will be allowed since the resident already worked eight months at the other program, and the maximum number of night float months must not exceed 15 during the five years of clinical education for any one resident.</p>

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categorical PGY-3. What is the maximum number of months of night float the resident will be allowed during the final years of the program? [Program Requirement: VI.G.6.]	

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