ARAS Handbook

Reviewed/Revised

October 2018

Dear Program Administrator:

Welcome! The ARAS Executive Committee is proud to provide to you the Association of Residency Administrators in Surgery **Handbook**. This Handbook is designed to be a quick reference for the seasoned Administrator, as well as serving as a helpful guide and resource for the new Administrator. This Handbook should not be considered a replacement for any guidelines, policies, or procedures set forth by your GME office or your Program Director. Most sections of the Handbook contain an introduction, referral to the internet if applicable, suggested documentation for program/office files and some of the responsibilities and tasks of the program Administrator.

It would be impossible to include all the information you need to know about surgery programs, especially since each program has its own unique features and methods of accomplishing the same tasks. Each program Administrator has a different level of responsibility depending on their respective program. If you are a new Administrator, this handbook can be a starting point to get you on your way. Over time, you will need to adapt the contents to fit your particular program and responsibilities. Please feel free to add your own program materials, comments, ideas, or any other information you feel is important at the end of each section. You should update the enclosed information as necessary to maintain the most up-to-date handbook.

To be a successful General Surgery Residency Administrator takes time, commitment, training, knowledge, skill development, and teamwork. Your training will be on-going as you learn something new every day. Your ability to lead, to be flexible, to continually adapt to change and to keep it all together is essential to the ongoing success of your surgery program. Your role is multifaceted and extremely important.

Innovations in computer software, website(s), and communication technology have impacted the way we do our jobs. The Accreditation Council for Graduate Medical Education (ACGME) uses the General Surgery Resident Operative Experience Log and the Next Accreditation System (NAS). The American Board of Surgery (ABS) has also moved forward with a web-based system for tracking chief resident operative data as well as for making application for entrance to the general surgery qualifying examination (QE). As more and more technology is introduced, and as processes change, the need for this handbook to be updated will become clear. We hope all Administrators will continue to provide valuable insight and suggestions for additions and improvement to this handbook. Your input, knowledge, and expertise are valuable to the success of all program Administrators. Please contact the Association of Residency Administrators in Surgery Executive Committee with your thoughts and ideas.

Sincerely,

ARAS Executive Committee

ARAS Handbook
Table of Contents

ACCREDITATION

Accreditation Council for Graduate Medical Education (ACGME)

The following information was taken directly from the ACGME website. It is important for an Administrator to remember to check the ACGME website often to look for important news, announcements, and updates. The website contains information on all facets of the ACGME and provides educational material such as the "glossary of terms," which most Administrators find extremely helpful.

ACGME at a Glance:

- The Accreditation Council for Graduate Medical Education is a private, nonprofit council that evaluates and accredits residency programs in the United States.

- The ACGME was established in 1981 from a consensus in the academic medical community for an independent accrediting organization. Its forerunner was the Liaison Committee for Graduate Medical Education, established in 1972.

- The mission of the ACGME is to improve health care by assessing and advancing the quality of resident physicians' education through exemplary accreditation.

- The ACGME's chief executive officer is Thomas J. Nasca, MD, MACP.

- In academic year 2016-2017, there were 10,700 ACGME-accredited residency programs in 154 specialties and subspecialties. The number of active full-time and part-time residents for academic year 2016-17 was 130,000.

- The ACGME has 27 Review Committees (one for each of the 26 specialties, one for a special one-year transitional -year general clinical program, and one for institutional review). Each Review Committee comprises about 6 to 15 volunteer physicians. Members of the Residency Review Committees are appointed by the AMA Council on Medical Education and the appropriate medical specialty boards and organizations. Members of the Institutional Review Committee and Transitional Year Committee are appointed by the ACGME Executive Committee and confirmed by the Board of Directors.

- The ACGME's member organizations are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies. Member organizations each nominate four members to the Board of Directors, which also includes two resident members—the chair of the Council of Review Committee Residents and a resident member

appointed by the Resident and Fellow Section of the AMA—three public directors, the chair of the Council of Review Committees, one to four at-large directors, and a non-voting federal representative.

Accreditation and Review Committees (RC)

Description of Review Committees:

There are three types: the Residency Review Committee (RRC), the Transitional Year Review Committee (TYRC), and the Institutional Review Committee (IRC). Each committee sets accreditation standards, provides peer evaluation of programs or institutions to assess the degree to which the program or institution complies with the published set of educational standards, and confers an accreditation status for programs and institutions meeting those standards.

Composition:

RRCs are composed of physician members, at least one of whom is a resident at the time of appointment. Members (except the resident member) are nominated by RRC 'appointing organizations' and confirmed by the ACGME Board of Directors. The current appointing organizations are the American Medical Association's (AMA) Council on Medical Education, the ABMS specialty board that certifies physicians within the specialty (The American Board of Surgery), and in most cases, the professional college or other professional organization or society associated with the specialty (American College of Surgeons.)

The IRC and TYRC are composed of voting members, including a resident member, appointed by the ACGME Board of Director's Executive Committee and confirmed by the ACGME Board of Directors.

Institutional Requirements

To gain and maintain accreditation, residency programs are expected to comply with the Accreditation Standards for their discipline. In addition, institutions sponsoring residency programs are expected to adhere to a set of Institutional Requirements. Compliance with the ACGME's standards is measured through periodic review of all programs. Information can be found on the ACGME website under the "Institutions" tab about accreditation through the ACGME Institutional Review process, its requirements, procedures and FAQ as well as updates, newsletter and appointment process for Review Committee members.

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

Next Accreditation System (NAS)

A continuous accreditation model based on key screening parameters –this list is not all encompassing and is subject to change:

- Annual program data (resident/fellow/faculty information, major program changes, citation responses, program characteristics, scholarly activity, curriculum)
- Aggregate board pass rate
- Resident clinical experience
- Resident/Fellow Survey and Faculty Survey
- Semi-annual resident Milestone evaluations
- 10-year Self –Study and Self Study Site Visit
- Clinical Learning Environment Review (CLER) Site

Accreditation Data System (ADS)

ADS is a web-based system that contains critical accreditation data for all sponsoring institutions and programs. The application serves as an ongoing communication tool with programs and sponsoring institutions, as well as Residency Review Committee staff. ADS incorporates several ACGME applications and functions.

An update will be required on an annual basis – things to consider:

- Know when your update will take place and mark your calendar well in advance
- Watch for the notification from the ACGME notifying you of your program's timeframe to review your information and provide an update
- Design a system to have all of the information you will need easily accessible at the time of the update

PROGRAM MANAGEMENT

ACGME General Surgery Operative Log Management System

The Resident Case Log System is a web application within ADS where residents and fellows (in certain specialties) are required to log their clinical experiences on an individual case basis. Depending on the specialty, the components used to build these cases are Common Procedural Terminology (CPT) codes, International Classification of Diseases (ICD9) codes, and/or descriptors. Programs have access to the system and are able to review the information logged by their residents or fellows through the reporting and search tools. These data are grouped into specialty-specific categories by the Review Committees, and may be used as program performance indicators.

Procedures for categorical and preliminary residents must be entered into the system correctly and in a timely manner. For preliminary residents, these cases will document their general surgery experience. For categorical residents, these cases are tracked as an outcome measurement for the competencies as well as documentation towards meeting the required standard. If a resident transfers to another surgical training program, the cases will be transferred to the new program. If a preliminary resident transfers to a new program, the cases will transfer only if the resident is advancing to the next level of training.

Residents take credit for one procedure per patient per day. These procedures are classified as "primary" and count toward the residents' total number of cases. Secondary procedures are additional procedures performed on that same patient and day. While these do not count toward the resident's total cases to meet ACGME/American Board of Surgery requirements, they may be used by the resident to document total experience when applying for hospital privileges after training.

The RC for Surgery requires each chief resident to graduate with a minimum of 850 total major cases including a minimum of 200 in the chief or PGY5 year. The RC for Surgery also requires a minimum number of index cases in each of the defined categories (see table).

To access the Resident Case Log System, log on to the ACGME homepage at www.acgme.org. On the left toolbar select Data Collection Systems, and then select Resident Case Log System. You will need your ACGME program log-in ID and password. You should establish yourself as an administrator (including the Program Director) for this system. This will give you full access to the operative data and reports, as well as be able to update program information such as resident, faculty, rotations, and institutions. You could also log in case through Accreditation Data System by clicking on "Case Logs"

This database is also used for submission of the chief residents' operative cases to the RC for Surgery and the American Board of Surgery. The instruction manual on how to enter cases can be found on the ACGME website at www.acgme.org . **It is very important that correct, up to date information be maintained for each resident to ensure an accurate record of all procedures.**

Things to consider: This application is designed to allow residents to enter cases on a regular basis at their convenience.

1. To enter new residents:
   - Log into Accreditation Data System (ADS)
   - Click on "Resident" located on the top blue bar.
   - Click on "Add Residents"
   - Complete all fields. ACGME will send an email to the residents with log in and password.
2. Provide each new resident with a copy of the operative log manual found on the ACGME website.
3. Use report functions to print operative reports and defined category reports for program director evaluation sessions with each resident. Each resident's experience should be reviewed and discussed during the evaluation session.
4. Add any new attendings, hospitals, or rotations each academic year.
5. Monitor requirement changes.
6. Use the year-end tab to run operative reports at the end of the academic year. This needs to be completed by August 1st so the completing residents can be archived in the ACGME system.
7. Review the Resident Activity Report at least monthly to ensure resident data entry is current. (Tip: Use the Brief or Full Detail Report to detect gaps in data entry).

It is recommended that the program director and program administrator review the logs frequently to ensure residents are logging cases in a timely fashion and to avoid deficiencies.

ACGME Credit Roles for Surgery Residents

Residents must function in the role of Surgeon for a minimum of 850 operative procedures in the five years of residency, including for at least 200 operative procedures in the chief resident year.

A resident may be considered the Surgeon only when he or she can document a significant role in the following aspects of management:

- determination or confirmation of the diagnosis;
- provision of pre-operative care;
- selection and accomplishment of the appropriate operative procedure; and,
- direction of the post-operative care.

For multi-procedure operations, residents must record all procedures performed and indicate which procedure is to count as the primary procedure. When more than one resident is involved in the same patient/same day/same operation/same procedure, a senior resident may take credit as Surgeon, while another resident may take credit as First Assistant; or, a senior resident may take credit as Teaching Assistant while a more junior resident takes credit as Surgeon Junior Years. If two residents perform different procedures on the same patient (different CPT codes), then each may take credit as Surgeon.

Major Organ Trauma, No Operation Required (MOTNOR)

- The CPT code for recording non-operative trauma is 99199.

Guidelines include:

- The category "major organ trauma, no operation required" is defined as patients with major organ trauma who were admitted to a specialty care unit in the hospital, i.e., SICU, CCU, Burn Unit, etc.
- The most senior resident on the trauma service should claim credit for the MOTNOR case. In the instance where there is no trauma service, a fourth- or fifth-year general surgery resident may claim credit.
- If the patient subsequently requires a general surgery operative procedure that may be claimed in the defined category.

Non-Operative Trauma-Team Leader Resuscitation

The CPT code for recording Team Leader Resuscitation under Non-Operative Trauma is 92950.

Guidelines include:

- The subcategory of Team Leader Resuscitation is defined as the team leader directing the management of a patient who has sustained trauma and is critically-ill from injury.
- Critical illness includes a range of conditions, including shock due to hemorrhage with resulting hypovolemia/fluid loss, organ injury, obstructive physiology due to pneumothorax, cardiac tamponade, etc.
- Because no current CPT code exists to report Non-Operative Trauma-Team Leader Resuscitation, the Case Log System uses CPT code 92950 (Cardiac Arrest with Cardiopulmonary Resuscitation) to aid in the search function when logging this procedure. Cardiac arrest and/or CPR is NOT required for the resident to log Non-Operative Trauma-Team Leader Resuscitation.

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

Abbreviations for use in the Case Log System

SC = Surgeon Chief; to be used for cases credited as "Surgeon" during the 12 months of Chief Year.

SJ = Surgeon Junior; to be used for cases credited as "Surgeon prior" to Chief Year.

TA = Teaching Assistant; to be used for a chief resident working with a junior resident who takes credit as "Surgeon."

- The minimum required number of 25 TA cases may be reported during the PG-4 and 5 years. TA cases may count toward total cases, but may not count towards the 200 minimum cases needed to fulfill the operative requirements for Chief Year.

FA = First Assistant; to be used for any instance in which a resident assists at an operation with another surgeon—an attending or more senior resident—responsible for the operation (not credited toward the total number of major cases).

Defined Category Minimum Numbers

The following table lists the minimum case numbers for general surgery residents that will go into effect for the 2017-2018 academic year.

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

Category		Minimum
Skin, Soft Tissue		**25**
Breast		**40**
	Mastectomy	5
	Axilla	5
Head and Neck		**25**
Alimentary Tract		**180**
	Esophagus	5
	Stomach	15
	Small Intestine	25
	Large Intestine	40
	Appendix	40
	Anorectal	20
Abdominal		**250**
	Biliary	85
	Hernia	85
	Liver	5
	Pancreas	5
Vascular		**50**
	Access	10
	Anastomosis, Repair, or Endarterectomy	10
Endocrine		**15**
	Thyroid or Parathyroid	10
Operative Trauma		**10**
Non-operative Trauma		**40**
	Resuscitations as Team Leader	10
Thoracic Surgery		**20**
	Thoracotomy	5
Pediatric Surgery		**20**
Plastic Surgery		**10**
Surgical Critical Care		**40**
Laparoscopic Basic		**100**
Endoscopy		**85**
	Upper Endoscopy	35
	Colonoscopy	50
Laparoscopic Complex		**75**
Total Major Cases		**850**
	Chief Year Major Cases	200
	Teaching Assistant Cases	25

AREA SPECIFIC REQUIREMENTS

Pediatric Operative Experience for Surgery Residents

Pediatric cases count not only the codes listed under Pediatrics for Defined Category, but also the patient type when Pediatric (<13 Yrs) is selected for Appendectomy – Open or Laparoscopic codes. Those specific codes are:

ALIM TR-LARGE INT – Appendectomy – Open
44950 – Appendectomy
44955 – Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
44960 – Appendectomy; for ruptured appendix with abscess or generalized peritonitis

ALIM TR-LARGE INT – Appendectomy - Laparoscopic
44970 – Laparoscopy, surgical, appendectomy
44979 – Unlisted laparoscopy procedure, appendix

Things to consider for the changes in Pediatric Operative Experience:

1. Ensure all categorical residents are aware of this requirement.
2. Monitor resident progress regularly to ensure adequate operative experience.

Surgical Critical Care Experience for Surgery Residents

The system will allow residents to identify the required minimum 40 (as of 2018) surgical critical care index cases by using CPT Code 99292. Code 99292 will map to all seven of the surgical critical care conditions.

It is important for new users entering CPT code 99292 to understand that this index category is different from the other codes. CPT code 99292 (and it alone) will allow credit to be taken for multiple procedures on the same patient on the same day. You still need to mark one of the codes for credit, but on the report they will counted equally. After adding the second code, you will be prompted that the code is already in the selection list, simply click "Ok" to proceed.

Reports will provide both a summary of all instances in which the resident managed two of the seven index critical care conditions and a detailed report for each patient encounter that will identify all the conditions that were managed by the resident for any one patient.

Do not submit 40 of the same conditions. The completed logs should include experience, with at least one patient in all seven of the categories.

RRC CODE ASSIGNMENT TO NEW SURGICAL CRITICAL CARE PROCEDURES

To follow is a list of RRC procedure values that have been assigned to the newly developed Surgical Critical Care Patient Management Procedures.

8410 - Ventilatory Management
(>24 hrs on ventilator)

8420 - Bleeding
(non-trauma patient >3 units)

8430 - Hemodynamic instability
(Req. Inotropic/pressor support)

8440- Organ dysfunction
(renal, hepatic, cardiac failure)

8450 - Dysrhythmias
(requiring drug management)

8460 - Invasive line management/monitoring
(Swan-Ganz, catheter, arterial lines, etc)

8470 - Parenteral/enteral nutrition

File materials*:

1. Copy of the final Resident Operative Log signed and dated by both the resident and program director at the end of their training.
2. Copy of the final Critical Care Index Case Log signed and dated by both the resident and program director.

***These two items are no longer a requirement of the ACGME as far as signatures are concerned. But, it is still suggested that programs keep this information in the resident file. Helpful to save prior to the ACGME archiving the files.**

American Board of Surgery In-Training Exam (ABSITE)

The American Board of Surgery offers annually to general surgery residency programs the In-Training Examination (ABSITE), an examination designed to measure the progress attained by residents in their knowledge of basic science and the management of clinical problems related to general surgery. The ABSITE is copyrighted by the ABS and its contents may not be reproduced or disclosed in any manner, as described in detail in the ABS Ethics and Professionalism Policy.

The exam is administered by each individual program and must take place during the specific exam window mandated by the ABS. Upon notification by the ABS in mid-October, exams can be ordered. They consist of 250 multiple-choice questions; examinees are given five hours to take the online exam. The American Board of Surgery In-Training Examination (ABSITE) will be aligned to the SCORE® Curriculum Outline for General Surgery Residency. This curriculum outline lists Patient Care and Medical Knowledge topics to be covered in a five-year general surgery residency program. The Patient Care outline consists of 28 organ-based categories (including 574 topics). The Medical Knowledge outline consists of 13 categories (including 81 specific topics).

The content outline for the ABSITE is presented on page 11. In addition to the SCORE Patient Care and Medical Knowledge sections, the ABSITE will also address three additional topic areas: Radiology, Outcomes, and Ethics. The content outline displays targeted "weights" for each specific section in the examination. Given the large number of topics included in the outline, weights for most categories are generally small. The specific weight values are targets and actual percentages may vary slightly in the final examination.

Almost all content outline categories for the ABSITE will continue to address Clinical Management and Applied Science (e.g., Anatomy, Physiology, etc.) topics, although there are some categories where only one of these question types is primarily appropriate (e.g., Endoscopy, Trauma, Biostatistics, Immunology, etc.).

The primary focus of the ABSITE will be on Clinical Management. Target percentages for the ABSITE indicate that approximately 80% of the exam's questions will address Clinical Management topics and 20% Applied Science topics. Overall, goals for the examination also indicate that approximately 72% of the ABSITE questions will address SCORE Patient Care topics, 24% SCORE Medical Knowledge topics, and 4% "Other" topics. As noted above, these targeted weights are approximate and actual percentages in the final examination may vary slightly.

For more specific details on ABSITE topic areas/categories, please refer to the SCORE Curriculum Outline for General Surgery Residency, available from www.absurgery.org or www.surgicalcore.org.

Things to consider:

- Mid-October – look for notice from ABS to order ABSITE
- Determine number exams to be ordered and order exams
- If you have residents rotating at another institution during exam window make arrangements for them to take ABSITE while on rotation
- If you have residents from other institutions rotating at your institution during exam window, make arrangements for them to take ABSITE with you
- Process paperwork for payment of ABSITE ($70 for each exam)
- Determine date(s), time(s), location(s) ABSITE will be administered
- Reserve conference room (computer lab) for exam administration (each resident will need a computer to take the exam (laptop/iPad))
- Administer the exam during the exam window (For dates, please refer to the ABS website.)
- As instructed by ABS conduct a system check and browser download on each device to be used for testing
- On exam day, place a sign on door to read ***QUIET PLEASE – TESTING SITE***
- Notify residents of exam date, time and location. Check with program director for coverage and call policies
- Prepare seating chart per ABS instructions for each exam administration session
- Arrange for a proctor(s), usually the program Administrator serves as the second proctor
- Arrange for IT personnel to be available to help with any computer issues that may arise
- Provide exam instructions to residents as mandated by ABS
- Arrange for catering

File materials:

1. List of residents taking the exam by PGY year
2. ABSITE Order Form and payment confirmation
3. Seating Chart
4. Program ID number
5. Program ID number for residents rotating from other surgery programs, if applicable
6. ABS instruction booklet
7. Resident assigned ABS Identification Number
8. System check and download secure browser are both found on the homepage

Address: The American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103
Phone: (215) 568-4000, Fax Number: (215) 563-5718

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

ABSITE® CONTENT OUTLINE

ABSITE CONTENT TOPICS*		CATEGORY WEIGHTS (%)
SCORE Patient Care Category #	**Patient Care Category**	**72**
	ABDOMEN - TOTAL	**17**
1	Abdomen - General	3
2	Abdomen - Hernia	2.5
3	Abdomen - Biliary	3.5
4	Abdomen - Liver	3.5
5	Abdomen - Pancreas	3.5
6	Abdomen - Spleen	1
	ALIMENTARY TRACT - TOTAL	**14.5**
7	Alimentary Tract - Esophagus	2.5
8	Alimentary Tract - Stomach	3.5
9	Alimentary Tract - Small Intestine	3
10	Alimentary Tract - Large Intestine	3.5
11	Alimentary Tract - Anorectal	2
12	Endoscopy	2
13	Breast	4
14	Endocrine	4
15	Skin and Soft Tissue	3.5
16	Surgical Critical Care	5
17	Trauma	6
	VASCULAR - TOTAL	**4**
18	Vascular - Arterial Disease	2
19	Vascular - Venous	1
20	Vascular - Access	1
21	Transplantation	2
22	Thoracic Surgery	2
23	Pediatric Surgery	2
24	Plastic Surgery	2
25	Genitourinary	1
26	Gynecology	1
27	Head and Neck	1
28	Nervous System	1
SCORE Medical Knowledge Category #	**Medical Knowledge Category**	**24**
1	Anesthesia	1
2	Biostatistics and Evaluation of Evidence	1
3	Fluids, Electrolytes and Acid-Base Balance	3.5
4	Geriatric Surgery and End-of-Life Care	1.5
5	Immunology	1
6	Infection and Antimicrobial Therapy	3
7	Minimally Invasive Surgery - Principles	1
8	Nutrition and Metabolism	2
9	Oncology and Tumor Biology	2
10	Pharmacology	1
11	Preoperative Evaluation and Perioperative Care	4
12	Transfusion and Disorders of Coagulation	2
13	Wound Healing	1
Other Category	**Radiology**	**1**
Other Category	**Outcomes**	**2**
Other Category	**Ethics**	**1**

**Note - approximately 80% of items will address Clinical Management topics, 20% Applied Science topics.*

Conferences, Curriculum, and Educational Programming

The RC for Surgery requires sufficient didactic teaching to meet the goals of each component of the residency training program. These are outlined in the Program Requirements for General Surgery. Regularly scheduled conferences are conducted to help residents improve their fund of knowledge, evaluation of medical literature, research findings, and basic and clinical sciences. Requirements for resident attendance should be established. Resident and faculty attendance should be monitored and documented. Standards of faculty and resident attendance are defined by the ACGME. Be sure you are aware of the current requirement. Each recurring session must have a set of competency-based goals and objectives.

Morbidity and Mortality (M&M)

A weekly conference reviewing all complications and deaths with a systems or management learning objective for patient care and quality improvement is required by the RC for Surgery. Presented case(s) are discussed and/or critiqued by faculty, residents, and fellows. A Risk Management representative may be present during this conference. Some programs refer to this conference as an M & M conference; others may call it a weekly review of complications and deaths.

Basic Science Conference

Basic Science conference is designed as a formal review in a classroom setting of the basic and clinical sciences that is also required by the RC for Surgery. It should present a wide variety of topics and have faculty participation.

Grand Rounds

Grand Rounds is a regularly organized clinical teaching activity that consists of formal presentations by faculty, local community surgeons, residents and/or fellows, and visiting professors. Topics usually include general surgery, trauma surgery, vascular surgery, colon and rectal surgery, surgical oncology, pediatric surgery, burns, and thoracic surgery. Other topics deemed necessary for resident learning can also be included. Grand Rounds is typically 1 hour and is usually held each week.

Journal Club

Journal Club can be a regularly scheduled conference held to review evidence-based medicine and evaluate current surgical literature and research findings. Journal Club presents an excellent forum in which to assign 2 or 3 residents to complete literature searches on a particular topic for review at the conference. Approval of resident selected articles should be obtained from the program director or faculty member monitoring the session in advance.

Surgical Teaching Rounds

Teaching Rounds are performed on a service's patient list. These rounds are designed for the residents to present patients to the team, synthesize a plan of care, and evaluate past, present and future patient needs.

Surgical Textbook Review

The Textbook Review Conference helps prepare the resident for the ABSITE as well as the American Board of Surgery exam. In many programs, a quiz is distributed to assess the knowledge of the resident on the material assigned for the conference.

Additional Curriculum Topics

Depending on your program, other Core Conferences can be scheduled at selected times throughout the year. They focus on a common curriculum for all disciplines, and can include, but are not limited to, the following topics:

- Evidence Based Medicine
- Knot Tying/Wound Closure
- Nutrition
- Animal/Surgical Skills Labs
- Professionalism
- ABSITE/Board Review
- Discharge Planning
- Business & Debt Management
- Career Development
- Fundamentals of Critical Care Support
- Medical Ethics
- Quality Assessment/Risk Management
- Health Care Financing
- Medical Informatics
- Residents as Teachers
- Coding and Documentation
- Fatigue
- Cultural Diversity
- Human Factors

Things to consider:

1. Maintain documentation of attendance as required by the RC for Surgery.
2. Competency goals and objectives for each required conference may be found in your resident or faculty handbook.

3. Manage the logistics of the conference including room reservations, catering, faculty scheduling, equipment requests, sign-in sheets, CME paperwork, and flyers.
4. Ensure a copy of the resident presentation goes into the resident's portfolio/file.
5. Copies of journal club articles should be kept in a binder with the sign-in sheets and CME application, if applicable.
6. Any other CME applications should be maintained in a binder along with any backup paperwork from the conference.
7. Check to see if there are other conference responsibilities required by your program and program director.

Schedules and Work Hours

Rotation Schedule

Before the residency year begins, an academic planning session should be scheduled to include the program director, faculty, chief residents, and the program Administrator.
The rotation schedule shows in block form each resident's assignments for the year. The number and duration of blocks depends on the number of residents and the rotations offered. The clinical components of the resident's curriculum are described in the program requirements and must be covered.
Care should be taken to review what aspects each resident has completed in the principle components of surgery. Regardless of the method your program employs, the program Administrator needs to provide the appropriate paperwork and rotation evaluations to the resident and appropriate faculty, as well as assist the program director in tracking the principle components, secondary components, and elective experiences of each resident.

The Learning & Working Environment (Duty Hours/Call Schedule)

The revised requirements, which went into effect July 1, 2017, are intended to promote patient safety, resident and fellow well-being, and inter-professional team-based care by providing greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit, and to utilize flexibility in a manner that optimizes patient safety, resident well-being, and education.

Any department or program function that is required for resident participation must be counted in the duty hours. Also, any department or program function that can be construed as being required for resident participation may also be included in the duty hours.

File materials:

1. Resident Rotation Schedule
2. Call Schedule Examples (resident, faculty, trauma, continuity clinic, conference)
3. Other schedules include:
    - Vacation
    - Holiday
    - Annual National and Regional Conference dates and location

Things to consider:

1. Keep in mind, all programs operate differently. In some programs, the Administrator develops the schedules, while in other programs the chief residents are responsible for the schedules. In some programs the Administrator and chief resident work together to develop the schedules.
2. Determine who is responsible for developing and distributing the schedule and a deadline date for submission.
3. Find out the type of scheduling system used by your institution: Excel, Word, scheduling software, etc.
4. Maintain an electronic copy in your file.
5. Ensure that all policies and procedures are reviewed and updated annually.

The Program Requirements address principles, supervision of residents, fatigue, duty hours, on-call activities, moonlighting, and duty hours exception issues. A successful Administrator is familiar with this section and can provide valuable assistance with call schedule and duty hour management.

Special Requirements for New York Programs

If you are an Administrator of a New York State training program, you will need to familiarize yourself with the 405 Health Code that deals with resident work hours and supervision. All New York State programs are subject to those regulations.

Things to consider:

1. Check with your program director for program specific requirements and your GME office for institutional requirements for the monitoring and documenting of these processes.
2. Check your resident handbook for program policies on duty hours, supervision, on call responsibilities and moonlighting.

Institutional Agreements vs Program Letters of Agreement (PLA)

***** Institutional and Program Letters of Agreement (PLA) are two separate entities. *****

While institutional or affiliation agreements are the responsibility of the GME office at your institution, Program Letters of Agreement fall under the responsibility of the Program Director.

Institutional/Affiliation Agreements

The Institutional Requirements regarding institutional/affiliation agreements reads as follows: Current master affiliation agreements must be renewed every five years and must exist between the Sponsoring Institution and all of its major participating sites.

The ACGME requires that an affiliation agreement be in place between the home institution and the participating institution encompassing Medicare reimbursements, expenses such as travel and housing, malpractice insurance coverage, and faculty in charge of education and oversight for the rotation. In addition, the rotation must be approved by the host institution's program director and the DIO and/or GME office.

Program Letters of Agreement (PLA)

There must be a program letter of agreement between the program and *each* participating site providing a required rotation. The PLA must be renewed every five years.

The PLA should:

- Identify the faculty who will assume both educational and supervisory responsibilities for the residents;
- Specify their responsibilities for teaching, supervision, and formal evaluation of residents
- Specify the duration and content of the educational experience
- State the policies and procedures that will govern resident education during the assignment.

An example of an exception to the above:

A residency program sponsored by a University Hospital that requires a rotation/ assignment at the Children's Hospital would need a program letter of agreement if the two entities are operated by two different governing bodies (e.g., Board of Directors). However, if the two sites operate essentially as one entity, that is, they are governed by one governing body (e.g. Board

of Directors) neither a master affiliation agreement nor a program letter of agreement would be necessary. This reasoning applies to all closely associated sites, not only those between University and Children's Hospitals.

For more FAQs on Program Letters of Agreement please go to www.ACGME.org and enter Program Letters of Agreement under the **Search** button .

Sample PLA:

March 28, 2009

Program Director, M.D.
Director, Residency Education
Hospital Name
Hospital Address
Hospital City, State

Dear Program Director:

You have agreed to serve as a clinical training site for the Surgical Residents of (***your hospital name)*** as per our affiliate agreement. The fully executed affiliation agreement began in ***date of affiliation agreement and will continue until .*** As the Surgical Residency Program Director, you serve as the Director of Teaching Service for our residents. The following faculty has been identified as teaching staff:

Transplant	**Pediatric Surgery**
Name all teaching faculty	**Name all teaching faculty**

All teaching faculty are responsible for actively educating the residents assigned to their rotation in the preoperative, operative, and postoperative care of their patients. Additionally, further didactic education and interactive discussion should be provided to the residents as appropriate to their area of surgical practice and the goals and objectives of the above rotation. Attached are the Goals and Objectives for the ***(Place rotations here)*** rotations. All faculty members are required to familiarize themselves with this material. All residents must be supervised in the performance of their clinical duties and appropriate back up must be available at all times. All faculty members are required to complete an evaluation form, which will be sent electronically to the attending faculty as name above.

Goals and Objectives that govern these rotations are distributed to the residents at the beginning of the year in the Surgical Residents Handbook and are also given to them prior to the beginning of the rotation at your facility.

Please sign the attached and return to ***your hospital name and address***. Once again, we thank you for the valuable education that our residents are receiving at your institution.

Sincerely,

Surgical Residency Program Director

cc: ***Mail a copy of this letter, the PLA, and Goals & Objectives to the faculty and the Administrator at the participating site.***

PLACE ON HOSPITAL LETTERHEAD OR USE HOSPITAL LOGO

Academic Year _____

Place affiliated hospital name here

Your hospital name here

Transplant Surgery

September 1, 200X to September 30, 20XX (1 month)
PGY-3 – Resident Name.

November 1, 200X to November 30, 20XX (1 month)
PGY-3 – Resident Name

January 1, 200X to January 31, 20XX (1 month)
PGY-3 – Resident Name

Pediatric Surgery

October 1, 200X - October 31, 20XX (1 month)
PGY-3 – Resident Name

March 1, 200X to March 31, 20XX (1 month)
PGY-3 – Resident Name

_____ _____
Affiliated PD Signature Date
Title
Affiliated Facility

_____ _____
Your PD Name Date
Director, Surgical Residency Program
Your Facility

_____ _____
Your GMEC Director Name Date
Designated Institutional Official
Your facility

File materials:

1. Affiliation Agreement
2. Program Letter of Agreement
3. Goals & Objectives specific to rotation
4. Rotation schedule
5. All documentation required by affiliated site for your resident i.e., CV, medical malpractice insurance, letter of good standing, BLS/ACLS/ATLS certification, medical license, etc.
6. Check with your GME office regarding any specific documentation you might be required to provide.

Things to consider:

1. Completed application materials and any other required documentation in most cases must be to the affiliated hospital ***at least 30 days prior to the rotation***
2. Proper e-mail address and/or mailing address for each faculty member must be provided to you as the Administrator for evaluation purposes
3. Residents must evaluate the rotation and the faculty.
4. Away rotations must be noted for Medicare audit.
5. If it is allowed by the institution, note vacation information and/or away conference attendance to preceptor.
6. Provide resident with goals and objectives.
7. Manage other processes and activities as determined by the program director and/or GME office.

End of Year Activities

End of the year activities for PGY 1-4 categorical residents should consist of a review of compliance to curriculum and course requirements as well as a comprehensive review of their case data.

End of the year activities for the graduating PGY5 residents should consist of an exit interview with the program director and the GME Office. At this time, the finishing resident should be provided with all completion of training documentation needed to verify his/her experience in your program. These include, but are not limited to, documentation of completion of program curriculum, course requirements, and case acquisition compliance.

Things to consider:

1. Help graduating residents with information regarding the next phase of their career (license applications, credentialing request, etc.).
2. Prepare a packet of information to give to each departing resident to include a notarized copy of their diploma, USMLE Step 1,2,3 scores, copies of licenses and DEA, ATLS, BLS, and ACLS cards, FES and FLS certificate, ultrasound attendance, HIV/AIDS, medical errors completion, HIPAA completion, a signed copy of the ABS and RC Surgery defined categorical and operative experience.
3. Review SOL for electronic submission to RC for Surgery.
4. Complete exit paperwork for HR; collect badges, parking stickers, pagers, and call room keys. Check with Health Information Management regarding medical record completion.
5. Provide resident with a copy of his training portfolio.
6. Remind residents to close out hospital retirement accounts, if applicable.
7. Schedule final interview for chief residents with the program director.
8. Ensure final exit interview dictation is placed in chief resident file with a statement: ***I verify that the (resident name) has demonstrated sufficient competence to enter practice without direct supervision.***

File materials:

1. Signed proof of Exit Interview with Program Director
2. HR check-out sheet
3. Address change
4. Other documentation as required by your program or institution

Graduation

Graduation ceremonies will differ from program to program. These activities focus on the resident's successful completion of five years of training, the beginning of a new life, additional fellowship training and careers. All residents look forward to celebrating with peers, faculty, family, and friends. Most program Administrators manage this event.

Things to consider:

1. Check with program director for traditions and program policies that may govern the event.
2. Make location, speaker, dinner, and entertainment arrangements.
3. Notify the residents. Prepare guest list and send out invitations.
4. Solicit award nominations (teaching faculty of the year, intern of the year, resident of the year).
5. Prepare awards and/or gifts.
6. Prepare graduation certificates.
7. Prepare graduation program.

File materials:

1. Graduation Program
2. Graduation Invitation
3. Graduation Announcement
4. Awards and Gifts List

Evaluations

General Surgery Residency Program evaluations are an essential tool for documenting the quality of rotations, resident experience, competencies, and faculty observations. All faculty evaluations of residents must be maintained in the resident's file. All resident evaluations of faculty and rotations must be maintained in the department. Required evaluations include: faculty evaluating resident, resident evaluating faculty, and faculty and resident evaluating the program. Additional evaluations you may want to include are: peer, professional staff and self. Although it is not required that residents evaluate their rotations, this is a valuable tool for use in program evaluation and management.

The program director is responsible for developing and implementing formal mechanisms for evaluation as outlined in the Program Requirements.

Evaluation of Resident

The program must have formal mechanisms for monitoring and documenting each resident's acquisition of fundamental knowledge and clinical skills and his/her overall performance prior to progression to the level of supervised semi-independent patient management. The resident must be evaluated on the acquisition of knowledge, skills, and attitudes, and should receive formal feedback about these evaluations *at least twice a year*. Evaluations must provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal skills and communications skills, professionalism, and system base practice.

The program director is responsible for providing a written final, competency based evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record that is maintained by the program and is subject for review by the site visitor. Milestone must be use as one of the tools in the final summary. This evaluation must have the following statement placed above the program director's signature:
"I verify that the resident has demonstrated sufficient competence to enter practice without direct supervision."

Evaluation of Faculty

Residents must evaluate each member of the teaching faculty with whom they have worked at least annually in a confidential manner. Documentation of faculty evaluation should include teaching ability and commitment as well as clinical knowledge.

Evaluation of the Program (also see Annual Program Review)

The program director and teaching staff must conduct at least one annual program review with appropriate agenda and minutes to review program goals and objectives, the program's effectiveness in teaching and evaluation, breadth and depth of surgical experience, and the needs of the residents. At least one resident representative should participate in the annual review. In particular, the quality of the curriculum and the extent to which the educational goals have been met by residents must be addressed. The residency program should use resident performance and outcome assessment results in the evaluation of the educational effectiveness of the residency program. The residency program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.

This evaluation should include an assessment of the balance between the educational and service components of the residency. In addition, the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume, and variety of patients available to the program for educational purposes, and the quality of resident supervision should be evaluated. Confidential, written evaluations by residents should be utilized in the process. As part of the evaluation of the effectiveness of the program, the program director must monitor the performance by the program's graduates on the qualifying and certifying examination of the American Board of Surgery. Information gained from the results should be used to improve the program.

The ACGME requires programs to complete a resident survey every year. The information goes directly to the ACGME. The program will only receive the results if the required response rate has been achieved. The information gathered will be used at the time of program review. The ACGME notifies programs directly when their participation is required. This notification will include detailed information on accessing the survey and a deadline for completion. Residents/fellows will have 4 weeks to complete the survey. This survey is available on the ACGME website under Data Collection Systems > Resident Surgery.

Rotation Evaluation

Each resident should have the opportunity to evaluate each rotation. As with all resident initiated evaluations, this should be kept confidential. The program director should use the information provided as feedback for program management and improvement.

Program Evaluation and Improvement

The Program Evaluation Committee (PEC) consists of at least two faculty members and at least one residents. The PEC should meet at least once a year and is responsible for completing the Annual Program Evaluation (APE). The PEC is responsible for 1) planning, developing, implementing, and evaluating educational activities of the program, 2) reviewing and making recommendations for revision of the goals and objectives, 3) addressing areas of non-compliance with ACGME standards and survey, 4) review program annually using evaluations from faculty, residents and others.

Things to consider:

1. ACGME personnel may request printed and signed documentation that the program director completed a regular periodic evaluation of each resident.
2. At the end of each resident's rotation assign evaluations
   a. Attending

1) Evaluate residents

b. Residents

1) Evaluate faculty
2) Evaluate rotation
3) Additional evaluation tools your program may utilize
4) Resident peer evaluations should be listed

3. Coordinate Resident Evaluation Review
   Accreditation requires that all residents meet with the program director or advisor at least twice each year to deliver/receive the resident's evaluation. These evaluation sessions must be documented. For the purpose of remediation or probation, ensure that the resident's advisor is kept apprised of the resident's performance.

4. Evaluation Tracking
   a. Monitor the return of resident and faculty evaluations. Make sure the evaluations of the resident who is under remediation or placed on probation are received in a timely manner.
   b. Provide residents, faculty, advisors, and program director access to evaluations.
   c. File original evaluations in appropriate resident or faculty file.
5. Ensure SOL is updated after rotation

Change in Resident Status – Voluntary and Involuntary

Voluntary - A resident may request a leave of absence, or a termination of his/her employment. The resident should be provided the appropriate mechanism for doing this.

Involuntary – A resident may require a change in status when the resident is unable to progress in the program. In all cases, documentation to support this status change, as well as a plan of action should be in place.

Remediation: Used when the resident is not successful in his/her progress and needs more time to address deficiencies. Some examples of why a resident would not be promoted from one PGY to another are listed below. Be aware that for remediation several of these examples would need to be in place to justify a remediation program. Your GME office may require involvement in the remediation process and plan.

1. Inadequate medical knowledge as evidenced by low ABSITE scores.
2. Consistently poor evaluations.
3. Consistently inappropriate or unprofessional behavior as evidenced by patient, ancillary staff, peer or faculty complaints.

4. Low or failing scores on monthly basic and clinical science exams.
5. Low or failing scores on mock oral examinations.

A combination of these items will interfere with the resident's ability to progress in the program. The decision to remediate a resident is usually made by the Program Director after receiving feedback from the faculty, the residency evaluation committee within the department, the academic chairman, senior residents and documented instances such as the items listed above. A formal written document of the issues leading to the need for remediation is given to the resident. Remediation could include a change in the rotation schedule to allow more supervision and mentoring, a requirement to have a reading proctor, a requirement to take a formal educational course, or a requirement to repeat the entire year if the resident is not ready to progress to the next PGY experience.

Probation: Usually used when a resident continues exhibiting inappropriate behavior or patient care issues beyond remediation. The decision to place a resident on probation is usually made by a residency review committee within the department. The word "probation" will have a negative effect on the individual's residency and future career, since it must be reported to all parties making inquiry regarding the resident's performance. It should only be used when no other path has effected a correction in the behavior. The first step could always be a "period of intense observation" for a specified time or a strong letter of warning could be issued. In addition, a supplemental evaluation specific to the behavior under review could be given to the supervising faculty in addition to the standard, periodic evaluation. In some instances, behavior can only be improved with a referral to your institutions EAP program. If a resident is placed on probation, a letter must outline the issues leading to probation, steps that must be taken to be returned to a non-probationary status and a specific time frame (usually six months). Additionally, the consequences of failing to meet the stipulated goals must be listed, and the resident must be provided with a copy of the institution's Due Process guidelines. Be aware that several of these examples would need to be in place to justify a resident being placed on probation. Your GME office and Legal Department should be involved in the probation process and review the probation letter.

Non-renewal of contract: Although this is not technically a change in status it is used to minimize the negative impact of a dismissal when the activities are not as egregious. The decision to not renew a resident's contract is made by the program director with feedback documentation of the issues and outcomes of attempted remediation plans of action.

Dismissal: Dismissal of a resident is a very serious action. Proper documentation of a resident not achieving competence in the six general competencies must be documented with care. Each program is required to provide the resident with a policy that outlines the termination of unsatisfactory resident performance, due process procedures, and grievance procedures.

File materials:

1. Faculty Evaluations of Resident Performance including supplemental evaluations if used
2. Monthly basic/clinical science exam scores
3. Mock Oral examination results
4. ABSITE scores
5. Peer Evaluation
6. 360º Evaluations
7. Incident reports
8. Remediation and/or probation documentation

Things to consider:

1. If the decision is for the resident to repeat the year, this could impact the resident complement. An increase in the approved resident complement for any year requires prior approval from your GMEC, DIO and the Surgery RC. The program director must request a change in complement via ADS explaining the justification for the increase and whether this will be a temporary or permanent increase.
2. Policies that should be provided to the resident might include a policy on evaluation and advancement, probation, remediation, promotion and the grievance process.
3. Documentation is vital in this process. Resident file management is crucial.
4. Check with your program director and your GME office for the policies and procedures that govern your program.

Policies and Documentation

Your program director is responsible for ensuring compliance with policies and procedures for the following:

Grievance and Due Process
Duty Hours
Recruitment, Selection, Evaluation and Promotion of Residents
Disciplinary Action
Supervision of Residents
Moonlighting

A program handbook is not required but it is a convenient approach to collecting and updating all the information that must be made available to residents and faculty (policies and procedures, schedules, educational program goals, goals and objectives for each major

assignment and information on all required sites). This handbook can be either paper or electronic.

Residency Files

Resident files must be established for the documentation of the resident's education for the length of time they are in the program. Typical file contents should include:

- ERAS application
- ATLS, ACLS, BLS, FLS and FES certification
- personal data sheet/demographic information
- job description
- residency contract
- vacation requests
- research
- resident travel
- ABSITE scores
- mock oral board exam results
- faculty evaluations
- Resident Milestone
- Board application
- ACGME operative data
- Board passage score
- final evaluation from program director with certification statement affixed at the bottom
- transfer letter and evaluation*

*If resident transferred to your program from another

Other information may be tracked specific to your institution and program. **Always refer to legal counsel when it comes to your file retention policy**.

RECRUITMENT CYCLE

Recruitment

Be sure that your website is current and up-to-date and can provide prospective applicants with helpful information.

The Recruitment Process is one of the most important functions of the program Administrator. The goal is to recruit the best possible candidates who will excel in surgical residency training and become Board Certified general surgeons. Each program determines how many available positions they want to fill through the Match. In addition, each program has certain criteria applicants must meet to be granted an interview. Positions can be very competitive. For more details regarding the Match, refer to the Match section of this handbook.

There are several organizations that are part of the recruitment process. They include:

Electronic Residency Application Service (ERAS)

www.aamc.org/eras

ERAS Technical Support for Programs – Call the Helpdesk at (202) 828-0413

Web-based Program Director's WorkStation (PDWS)

General Surgery Programs use the Electronic Residency Application Service (ERAS) from the Association of American Medical Colleges (AAMC) to process applicants interested in their programs. ERAS is a service that transmits residency applications and supporting documentation from applicants and medical schools to residency programs via the Internet. ERAS was designed to help programs manage the recruitment process. If your program agrees to use the National Resident Match Program (NRMP) to fill your positions with the Match, then you most likely have an agreement to use ERAS for your application process. ERAS is user friendly and has a helpdesk to answer any questions you may have.

Things to consider:

1. Confirm use of ERAS during the recruiting season.
2. Determine interview dates and times, faculty and residents who will interview, number of applicants to invite overall, number to interview each day and invitation process (e-mail, telephone call, written letter).

3. Application materials and/or access the Web-based PDWS upon invitation by your DIO.
4. Once candidates have been selected to interview, send invitations via e-mail, phone call, or letter. Schedule candidates for interview days.
5. Organize the interview day. Send follow-up correspondence to each applicant after the interview.
6. Work with your program director to determine responsibility for other activities including involvement in pre-screening of applications
7. One document that you might want to ensure is accessible from your site is a copy of your residency contract. Many programs have a downloadable brochure or booklet that applicants can print.

National Resident Matching Program (NRMP)

www.nrmp.org

The National Resident Matching Program is a private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education (GME). Each year, the NRMP conducts a match that is designed to optimize the rank ordered choices of students and program directors.

When the NRMP opens, certify the number of positions your program will offer through the Match. Be sure to verify positions for special/preliminary residents as applicable to your program.

The NRMP is not an application service or a job placement service. Applicants must apply directly to residency programs in addition to registering for the Match. Most programs participate in the Electronic Residency Application Service (ERAS), which transmits residency applications to program directors and/or Administrators via the Internet. **Applicants and programs must register with both the NRMP and ERAS to participate in the Match.**

Before you begin scheduling applicant interviews for the Main Residency Match, we wish to remind you that Section 5.1 of the Match Participation Agreement among Applicants, the NRMP, and Participating Programs prohibits all of the institution's programs from discussing or offering positions to ineligible applicants. Prior to interviewing for or discussing any position, the program is required to first determine whether the applicant is eligible for appointment by using the Applicant Match History and/or contacting the NRMP.

The Applicant Match History in the Registration, Ranking, and Results (R3) System provides information about not only applicants' PGY-1 and/or PGY-2 match status, but also whether they have requested a waiver or been involved in a violation investigation. This year, you can use a bulk upload that allows you to verify the eligibility of multiple applicants at once. Create your

applicant list in ERAS, save the list to your desktop or another location, and upload the list as a text (.txt) file in the R3 System. You can conduct bulk searches over the course of the interview season and retrieve records from prior searches at any time. Remember, students currently enrolled in medical school will not be found in the Applicant Match History and are always eligible for appointment. The following is a step by step guide of the bulk history process:

HOW TO RUN A MATCH HISTORY REPORT IN NRMP USING A BULK LIST

1. If you don't want to include all of your ERAS candidates in the check, then in ERAS, apply a FILTER that will select only the candidates that you want to run a MATCH VIOLATION HISTORY for.
2. ERAS, choose FILE and then EXPORT
    a. Under SELECT APPLICANT, leave the ALL APPLICANTS IN RECORDSET selected
    b. Under AVAILABLE FIELDS, double click on these, in this order:
        i. AAMC ID Number
        ii. First Name
        iii. Middle Name
        iv. Last Name
    c. Click on NEXT
    d. Leave all of the default selections in the "CHOOSE THE FIELD DELIMETER…." box
    e. Click on the BROWSE button in the "EXPORT TO FILE" box and choose where you want to save the file and what you want to name it.
    f. Click FINISH and then OK
3. Open MICROSOFT WORD
    a. Choose FILE and then OPEN and navigate to where you saved the EXCEL file that you created above
    b. Double click on the EXCEL file to open it in WORD
    c. Choose FILE and then SAVE AS and leave the default SAVE AS TYPE as PLAIN TEXT.
    d. Rename the file if desired
    e. Click on SAVE and then OK
    f. Close WORD (if you don't, the upload will not work)
4. Go to the NRMP web site and LOG IN
    a. Click on APPLICANT MATCH HISTORY in the left menu choices
    b. Click on SEARCH FOR MULTIPLE APPLICANTS: BULK UPLOAD near the bottom of the page
    c. Click on the BROWSE button and navigate to where you just saved the WORD document as a ".txt" file.
    d. Double click on the TXT file (denoted by an icon that looks like a note tablet), NOT the EXCEL file that you created first.
    e. Click on CHECK APPLICANTS
    f. An APPLICANT HISTORY report will print for anyone who has one.

Directions for creating an applicant list in the PDWS for upload into the R3 System have been issued separately by ERAS.

If you have questions, please contact the NRMP Client and Technical Support Specialists at nrmp@aamc.org or 1-866-617-5837.

An institution may register one or several programs in the NRMP Main Residency Match. An institution that registers any of its programs in the Main Residency Match agrees to select senior students of U.S. allopathic medical schools only through the Matching Program or another national matching service, in accordance with the Match Participation Agreement. Program directors whose programs are enrolled by their institutions in the Main Residency Match also agree to select senior students of US allopathic medical schools only through the Matching Program in accordance with the Match Participation Agreement. Please refer to the NRMP website for detailed information.

NOTE: *Program Directors/Administrators should go in individually and register themselves yearly. Administrators can change quotas, enter the ROL and the SOAP Preference List but the Program Director must certify all lists. The use of the Program Director's login (legal signature) by anyone other than the director is a violation of the match agreement.*

The NRMP releases the results of the Main Residency Match in mid-March. More details regarding the schedule for Match activities can be found on the website www.nrmp.org.

Supplemental Offer and Acceptance Program (SOAP)

- SOAP is not a second match. It is a series of offers by programs.
- Applicants express preferences by applying to programs.
- Programs express preferences with lists of applicants.
- The R3 system offers positions to applicants in order of a program's preference list.
- Applicants can receive multiple offers in any round.

Program Participation in SOAP
Prior to Match Week, programs must elect whether to participate in the Supplemental Offer and Acceptance Program (SOAP) to fill their available positions during Match Week.

Positions offered and accepted during SOAP establish a *binding commitment* enforced by the Match Participation Agreement.

SOAP Procedures: Programs MUST accept applications *only* via ERAS.

- Applications will be "stamped" with the program types for which an applicant is eligible.

- Program directors cannot use phone, fax, email, or personal contacts until after an application has been received.

***Cannot* make offers outside SOAP during Match Week**

- **Programs cannot offer positions to ineligible applicants.**
- **Programs cannot "create" positions for unmatched applicants.**

Can opt out of SOAP, but *cannot* fill positions during Match Week
Unfilled programs: (All times are Eastern Standard Time)

- Learn filled/unfilled status at noon on Monday of Match Week
- Begin receiving ERAS applications at 2:00 p.m. Monday
- Can begin entering preference lists at 11:30 a.m. Tuesday
- First-round preference lists must be finalized by 11:55 a.m. Wednesday
- Can update preference lists until 5 minutes before the start of each round
- Preference lists are updated real-time in the R3 system
- Receive email notification when offer is accepted
- List of Unfilled Programs updated at start of each round

1. To set the SOAP participation indicator, log in to the R3 system using your AAMC ID number and password.

2. From the **Program Options Page**, click the **Program Information** link on the left menu bar. You must actively select **Yes** or **No** in response to the question "Will You Participate in SOAP?" Doing so will confirm your *SOAP* status on the **Program Options Page**.

   Soap participation status must be approved in the R3 system by the NRMP institutional official. In addition, only the NRMP institutional official can change the SOAP participation status of a program.

3. From the **Program Options Page**, click the **SOAP** link on the left menu bar to access detailed information, by day, about Match Week events and when information is disseminated by the NRMP.

4. Click the **Unfilled Programs** link to access the List of Unfilled Programs. The List is updated by the NRMP prior to the start of each SOAP round.

   For SOAP-eligible applicants, access to the List of Unfilled Programs is restricted by Match status. Applicants can access only the categorical, preliminary, and/or advanced programs for which they are eligible. Fully matched applicants cannot access the List.

5. Click the **My SOAP Programs** link to create your preference list. From the **Maintain SOAP Preference List** page, click the drop-down arrow to select your program.

6. Once you have selected your program, click the hyperlinked *Unfilled* indicator. If you have more than one unfilled program, create separate preference lists for each. The *Certification Status* field is updated real-time to inform you whether your preference list is certified for a SOAP round, a feature that is particularly helpful for directors with more than one program.

7. To search for applicants to place on your preference list, do **NOT** use the Search Applicant button that is located on the left menu bar. Rather, click **Search SOAP Applicants**. The **Search SOAP Applicants** link works just like the Search Applicant function for generating a rank order list: you can search using the AAMC ID number or name of the applicant. Simpler searches work best.

   Only SOAP-eligible applicants will present during a search, so you do not have to worry that you are placing candidates on your preference lists who are unable to begin training. If the applicant's name does not appear on the search page, click *Back to Search* to start your search again. Directions at the top of the search page inform you that applicants who are grayed out are unavailable to be placed on a preference list because they are ineligible for your program type (e.g., your program is preliminary but they are unmatched for advanced) or they accepted a position in another program during an earlier SOAP offer round.

8. Select the applicant(s) in whom you are interested by clicking the square next to the name. Click **Add to Preference List**. Continue in this manner until your preference list is complete.

   - To rearrange the order of applicants on your list, click on the name of the applicant and drag that applicant to the appropriate rank. The *Rank* indicator lets you know the order in which offers will be extended to applicants on your list.

9. Click **Certify List** on the **Maintain SOAP Preference List** page to ensure your preference list is used in a SOAP round. You are prompted to enter your unique password to confirm your awareness of the number of applicants on your preference list, your understanding that offers will be extended based on the order of applicants ranked, and your understanding that offers extended to and accepted by applicants constitute a binding commitment.

10. Click **Submit** to certify your preference list.

    Once a SOAP round commences, you can log into the R3 system to learn real-time the status of your offers. Each SOAP round lasts two hours; accordingly, applicants must accept or reject any offers within the two-hour time period. If an applicant rejects an offer or allows an offer to expire, that offer will not be extended again. As applicants accept positions, the R3 system

automatically sends confirming emails to the applicants and program directors. In each SOAP round, the R3 system will extend offers to as many applicants on your list as there are unfilled positions in your program.

Applicants who reject offers or who allow offers to expire move to the bottom of your preference list for the duration of SOAP.

- Applicants who accept offers remain at the top of your preference list for the duration of SOAP.
- Applicants who accept offers in other programs and thus no longer are eligible for an offer from your program move to the bottom of your preference list for the duration of SOAP and are listed with a status of *Unavailable*.

Remember: The rank order of applicants will change in each SOAP round. Once offers have been extended in a SOAP round, the number one rank on your list moves to the next available applicant on the list for the next round. Unless you make changes to your preference list, that applicant will receive the first offer during the next round of SOAP if your program has any remaining unfilled positions. **Again, you do not have to keep recertifying your list to go to the next round in SOAP unless changes are made.**

11. Click the **Uncertify List** button to make changes to your preference list. Changes can be made at any time up until 5 minutes before the start of a SOAP round. If your list is not certified by 5 minutes prior to the SOAP round, no offers will be made during that round. The R3 system will send you an email confirming your submission of a certified preference list.

    If at any time during SOAP you have a certified list with no available applicants, the **Maintain SOAP Preference List** page will reflect that status. If you have no available applicants on your preference list and you still have unfilled positions you wish to fill, you must uncertify your list to add additional candidates. When you click the **Uncertify List** button you are prompted to provide your password to confirm your understanding that uncertifying your list removes the program from SOAP rounds unless you re-certify your list in a timely manner.

    Your program's SOAP status on the **Maintain SOAP Preference List** page will show as *Filled* when you have no more unfilled positions.

Appointment Letters and Obligations

After the general announcement of results on Match Day, letters of appointment should be sent to all matched applicants. Each program and institution determines the specific format of the letters and the associated contracts pertaining to those appointments.

Applicants and programs are bound by the match results. Under the Match Participation Agreement signed at the time of registration, the listing of an applicant by a program on its rank order list and the listing of a program by an applicant on his/her rank order list establishes a binding commitment to offer/accept an appointment if a match results. Such appointments are subject to the official requirements and other published policies of the organization in effect on the date the program submits its rank order list and are contingent on applicants meeting all of the eligibility requirements imposed by those policies. Failure to offer or accept a matched position is a material breach of the Match Participation Agreement, and violators may be subject to penalties outlined in the Agreement and the NRMP's Violations Policy.

Applicants and programs may request a waiver of the match commitment if fulfillment of that commitment would cause serious hardship. Waivers must be requested from, and can be granted only by the NRMP. If the waiver is granted, an applicant may accept another position or participate in future NRMP matches, and programs may recruit for the vacant position. If the waiver is denied, the applicant and program are expected to honor the match commitment. Failure to do so is a material breach of the Match Participation Agreement and grounds for a violation investigation.

Things to consider:

After the Match and SOAP, you should send each incoming resident an employment packet. Listed below is the content of a typical packet. Contact your Graduate Medical Education office to coordinate the information being sent, to avoid duplication or confusion.

1. Program Administrators should be aware of special match situations such as couples matching, armed forces commitments, and visa requirements.
2. Print the Match schedule from the NRMP website.
3. Items to include in mailing(s):
    a. Welcome letter
    b. Background information sheet
    c. Benefits packet (medical, life, dental, disability)
    d. Requirements of current BLS and ACLS and schedule for ATLS training
    e. Contract
    f. Immunization request form
    g. Employment application, if required
    h. Request for Medical School Diploma or letter from the Dean disclosing graduation date

i. Hospital security agreement
j. Job description
k. Lab coat order forms

4. Contact the GME office regarding any foreign medical graduates you may have.
5. Check with program director and GME office to determine what additional materials need to be sent to incoming residents.

Recruitment Process Timeline

Below is a sample of what can occur during these months as it relates to the recruitment process and will vary from program to program.

April - August

- Medical students request residency program information. Programs mail residency brochures or refer medical students to their website.
- A representative from the program may choose to attend Medical School Recruitment Fairs.
- Install ERAS software/upgrades as they become available and/or gain access to the Web-based PDWS by invitation through your DIO.

August - **October**

- ERAS Post Office opens. Medical students begin to apply to surgery residency programs.
- Download and/or logon to the Web-based PDWS and review applications regularly.
- Register with the NRMP; indicate the number of categorical and preliminary positions the program is offering.
- If required to pre-screen for program director, mark candidates of interest.
- Complete NRMP History Search prior to sending invitation to interview.
- Use filter sorts based on your recruitment criteria.
- Prepare for and schedule interviews.
- E-mail interview confirmation, interview day agenda, parking information, hotel information, social events, etc.
- Schedule faculty for interviews.
- Prepare handouts: copy of resident contract, perks, and Confidentiality Disclosure forms if candidates attend M & M.

November - January

- Continue to download and/or logon to the Web-based PDWS and review applications.
- Conduct interviews.
- Hold ranking session (Some programs do this in February).

February

- Schedule and prepare for the final match meeting.
- Medical students are ranked in order of desirability by the program director, selection committee, and program Administrator. Rank lists are submitted and certified to NRMP in mid-February.

March

- Notification of matched medical students takes place mid-March.
- Contact your matched applicants.
- Send out employment and information packets.

April - June

- Follow up is a must to ensure that all employment materials are returned in a timely manner to either the program directly or to the GME office based on your institution's process.

Resident Employment Contracts

All residents in ACGME accredited residency programs must be provided with a written contract. Residents cannot participate in their residency program if a contract has not been issued. The contract is an agreement in which residents accept the responsibilities of their position along with the proposed salary and agree to comply with all institutional policies.

The ACGME specifies the contract format in the Institutional Requirements and requires each program to provide written policies concerning resident job descriptions, curriculum, salary, benefits, vacation, sick leave, maternity/paternity/adoption leave, sexual harassment, grievance procedures, and moonlighting. In some programs, the written policies are included as attachments to the contract. Other programs may provide these policies in the form of a house staff handbook or residency manual. Contracts may be mailed or hand delivered to residents. Your GME office can answer specific questions related to resident contracts. Each institution has its own contract version that must conform to the ACGME guidelines.

File materials:

1. Copy of resident contract for the academic year
3. Resident Rotation Schedule
4. Resident Curriculum
5. Resident Manual
6. Policies distributed by the GME office
7. Other documents as required by your institution

Things to consider:

1. The Graduate Medical Education Office (GME) of each institution should provide an ACGME compliant contract format as well as copies of the appropriate institutional policies.
2. The program Administrator may be required to personalize the contracts and distribute/mail them to each resident for signature.
3. Monitor the return of contracts and contact those residents who have not returned their copy.
4. Once the signed contracts are returned obtain appropriate signatures. After signatures, a copy is given to the resident, one is placed in the residency file, one is sent to GME, and one is sent to HR. Programs may vary on this disbursement.

Resident Orientation

Resident orientation is held at the beginning of each academic year. The incoming resident can be required to attend several orientations including an institutional orientation, a hospital orientation, and a department orientation, as well as certification courses such as ATLS, ACLS, BLS, and coursework such as knot tying, lap skills, or other types of labs. Refer to your past year's agenda for more information.

PROFESSIONAL ASSOCIATIONS

American Board of Surgery (ABS)

www.absurgery.org

The American Board of Surgery (ABS) is an independent, non-profit organization founded in 1937 for the purpose of certifying surgeons who have met a defined standard of education, training, and knowledge. Surgeons certified by the ABS, known as diplomats, have completed a minimum of five years of surgical training, and successfully completed a written (qualifying exam) and oral (certifying exam) examination.

Performance of certification examination results are published on their website. At minimum, for the most recent five-year period, 65% of the graduates must pass each the qualifying and certifying examination on the first attempt.

The ABS currently certifies surgeons in the following fields: general surgery, pediatric surgery, vascular surgery, surgical critical care, and surgery of the hand. The ABS is one of the 24 member boards of the American Board of Medical Specialties.

To apply to the American Board of Surgery for Board certification, the applicant must have a minimum of 850 cases in five years with 200 cases in the chief year; and 40 critical care cases with one patient in each category. In 2014, the ABS added 25 teaching assistant (TA) cases by completion of residency. In addition, residents must be FLS certified and have had an ACLS and ATLS certification during residency. In 2017, the ABS added the FES curriculum effective for the 2017-2018 and thereafter graduates, that must be obtained during residency. FES certification will need to be provided with ABS Board packet. The ACGME RRC for Surgery's requirement for the defined category criteria IS NOT required by the ABS.

Refer to the ABS website for the following topics:

About the ABS	Publications	Training Programs
News	Certification/Recertification/MOC	Links

Things to consider:

1. Upon annual notification by the ABS, update program information and the resident roster to include graduating residents.
2. Notify residents of the open period for completing the on-line Board application.
3. Supply the resident with his/her rotation schedules, as well as a list of all time off for each year of training. Resident needs to sign agreement with ACGME to allow the ACGME to electronically send his/her case data to the ABS.
4. Ensure program director reviews case logs and affixes signature to application.

5. Keep copies of all Board applications and procedures in resident file, as well as a list of all time off.

File materials:

1. Copies of resident ABS application and operative experience submitted
2. ABS Board passage reports
3. ABS correspondence
4. ABSITE results (may be kept in ABSITE file if preferred)

Timeline of ABS Communications

January

- ABSITE order confirmation sent via email, along with proctor manual and seating chart guidelines

February/March

- ABSITE results sent via e-mail to program directors and Administrators
- QE packets mailed in care of program to each graduating chief, with cover letter to program director

June/July

- Five-Year Summary Report of Candidate Performance (QE & CE) sent via e-mail
- Programs notified via e-mail to verify the satisfactory completion of the preceding academic year for their resident roster via the ABS website

August/September

- Programs notified via e-mail to update their resident roster for the current academic year via the ABS website
- General Surgery Residency Program Pass Rates updated on ABS website

September

- Report of Candidate Performance for calendar year (QE and CE) sent via e-mail; includes results of August QE

October

- Notification sent via e-mail that ABSITE orders may now be placed via the ABS website

December

- Deadline for placing ABSITE orders

Association of Program Directors in Surgery

www.apds.org

Association of Residency Administrators in Surgery

www.arasurgery.org

The Association of Program Directors in Surgery (APDS) was organized to provide a forum for the exchange of information and for discussion on a wide range of subjects related to post-graduate surgical education. Areas of focus include:

- the standards of surgery residency training programs,
- advice, assistance, and support to program directors on matters pertaining to surgical education and to accreditation,
- to encourage research into all aspects of the education and training of surgeons
- to represent the interests of program directors in the education and training of high quality surgeons to other organizations, individuals, and governmental agencies or regulatory bodies

The Association of Residency Administrators in Surgery (ARAS) was established as an educational resource, to provide a method for encouraging the exchange of ideas and a support network for persons in the position of managing surgery residency programs. The ARAS has an Executive Committee that oversees the planning of the annual spring meeting held in conjunction with the APDS. For new program Administrators, ARAS offers a mentor/mentee network to assist with the ins and outs of the job of managing surgical residency programs. ARAS supports and promotes the certification process of Training Administrators of Graduate Medical Education (C-TAGME).

Residency program administrators in surgery are eligible to become an Associate Member of the APDS. Upon acceptance as an associate member of APDS, you become a member of ARAS. Associate membership is obtained by completing an on-line application on the ARAS website, along with a current resume/CV, and a letter of support from your Program Director to the APDS office address listed below. Your information will be reviewed at the next business meeting of the APDS. The APDS holds business meetings twice a year, one in October and one in March/April at the annual conference. You will be notified of your membership status by the APDS office.

The APDS and ARAS hold a spring conference. The program includes workshops for new program directors and new program administrators, and presentations on other topics of interest and education. Program administrators are encouraged to attend the spring meeting of ARAS, as well

as submit ideas for workshops and presentations. Membership in ARAS is also strongly encouraged.

The APDS and the ARAS provide different types of communication to its members: the webpage (www.apds.org), ARAS website**,** www.arcsurgery.org, newsletters, and listservs.

Currently there are two listservs in operation. The first is apds@groupspaces.com for all program directors and administrators. This listserv was established by the APDS to disseminate information to a global distribution list composed of program directors and program administrators. It is a vital resource for discussion of issues and topics particular to managing surgical training programs, posting vacant positions, finding residents looking for positions, conducting surveys, and asking "how to" questions.

The second listserv is for administrators only. The ARAS listserv was designed for administrators who have questions or issues they would like to address directly with other administrators. Mail from this listserv will be sent from MailChimp on behalf of ARAS listserv. If you would like to post a question to the listserv, please contact the current ARAS President. The president or a member of the ARAS Executive Committee will send your message to the listserv.

If you are not currently signed on as a member of the APDS listserv, please contact Katie Thorn at apds@mindspring.com. If you wish to be added to the ARAS listserv, please contact the current ARAS president.

Visit the ARAS website for further information and helpful resources by going to www.arcsurgery.org.

Things to consider:

1. Ensure dues payments are processed.
2. Register for the annual spring meeting.
3. Make travel arrangements.
4. Obtain information on annual meetings.
5. Add the APDS & ARAS link to your *Favorites* list and visit the sites often.

Address:

APDS Headquarters Office
6400 Goldsboro Road
Suite 450
Bethesda, MD 20817-5846

OR

P.O. Box 342260
Bethesda, MD 20827-2260
Phone: (301) 320-1200, Fax: (301) 263-9025

Educational Commission for Foreign Medical Graduates (ECFMG)

www.ecfmg.org

The Educational Commission for Foreign Medical Graduates (ECFMG) is a private, non-profit organization. It is authorized by the U.S. Department of State to sponsor foreign medical physicians as exchange visitors in accredited programs of graduate medical education for training, or advanced research programs (involving primarily observation, consultation, teaching, or research). Exchange Visitors sponsored by ECFMG receive a Certificate of Eligibility for Exchange Visitor (J-1 Visa) Status (Form DS-2019). This document is used to apply for the J-1 Visa. Please note that a J-1 Visa must be renewed every year. Initial applications and re-applying for a J-1 Visa can be accessed via the ECMFG's website.

Through its program of certification, the ECFMG assesses the readiness of graduates of foreign medical schools to enter residency or fellowship training programs in the United States that are accredited by the ACGME. The ECFMG also offers a variety of other programs and services to foreign-educated physicians and members of the international medical community.

The following tools which can be found at the ECFMG website have been very informative and beneficial for those Administrators who work with international medical graduates (IMGs):

- **ECFMG *Information Booklet*** - updated annually, contains detailed information on ECFMG's program of certification and ECFMG's other programs and services for international medical students and graduates
- ***"ECFMG Certification Fact Sheet"*** – outlines basic information on ECFMG certification and steps necessary to begin the certification process
- ***"CVS ON-LINE"***- provides web-based access to ECFMG's Certification Verification Service. International medical graduates may use CVS ON-LINE to request that confirmation of their ECFMG certification status be sent to medical licensing authorities in the United States. Authorized contacts of U.S. medical licensing authorities, residency programs, and employers may use CVS ON-LINE to request confirmation of the ECFMG certification status of international medical graduates.
- ***"J-1 Visa Sponsorship Fact Sheet"* -** outlines the basic requirements for J-1 visa sponsorship as well as other general information regarding the J-1 Exchange Visitor Program
- ***ECFMG Reporter*** – by subscription, provides Administrators with e-mail updates and information on new developments, changes, etc.
- **J-1 (EVSP) Educational Tools** - offers PowerPoint tutorials and presentations addressing a number of IMG issues including ECFMG certification, J-1 visa applications and processing, general information about H-1B visas, etc.; to access the educational tools from the ECFMG

website, click on “EVSP-ECFMG - J-1 Visa Sponsorship” on the home page of the website, scroll down to and click on “Educational Tools” on the next, go to "Educational Tools for Program Administrators"

While overall responsibility for certification and visa issues belongs to the individual international medical graduate, your guidance in these areas can prove to be very helpful in making the transition from medical school to residency.

Things to consider:

1. Have a notebook with the above items for a quick reference.
2. Subscribe to the ECFMG reporter for e-mails on current or upcoming changes.
3. A copy of the DS-2019 should be kept in the resident's personnel file.
4. Remind J-1 Visa holders well in advance that reapplication is required for continuation in the residency program.
5. Ensure appropriate file materials are completed and submitted in a timely fashion.

As a note, some programs sponsor other types of visas such as the H1B Visa. You should speak to your GME office or HR office about other types of visas not sponsored by the ECFMG.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES
3624 Market Street
Fourth Floor
Philadelphia, PA 19104-2685
Phone: (215)386-5900, Fax: (215)387-9963

Surgical Training Administrators Certification (STAC)

Training Administrators of Graduate Medical Education (C-TAGME)

www.tagme.org

At the 2002 ARAS meeting, the membership agreed to explore the feasibility of Administrator certification. A task force was formed, called STAC (Surgical Training Administrator Certification). The task force spent a year working on a certification process and bylaws. In 2003, the results of STAC were presented at the ARAS spring meeting, and the idea and concept was adopted. From there, TAGME (Training Administrators of Graduate Medical Education) was formed for the purpose of developing and incorporating a certification process for all specialties. Please visit the TAGME web site at http://www.tagme.org/surgery.html for more information on the certification process.

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

Journal of Surgical Education
Program Administrators' Corner

General Surgery program administrators have been recognized by the Association of Program Directors in Surgery as viable and necessary members of the educational team, and have acknowledged their skills, knowledge, and abilities. The program administrators are challenged to continue to perform on a professional level and merit that recognition and acknowledgement. With thanks to Dr. Weigelt, editor of *Journal of Surgical Education*, program administrators now have a forum for publishing. He has created a section – Program Administrators' Corner – that features an article written by an administrator, and appears in every issue. This opportunity had its debut with the January/February 2006 issue.

Administrators do not need an advanced degree to be the first or primary author, nor do they need to be certified. Topics for the article are not limited. Adult education concepts, medical education ideas, research, and "how-to" articles are all welcome. For more information, click on *Journal of Surgical Education* on the ARAS website (www.arcsurgery.org).

ADMINISTRATIVE ROLES and RESPONSIBILITIES

The program administrator's position, responsibilities and job description varies among surgery programs. Many of us serve as mentors, counselors, and confidants not only to the residents and fellows but also to the faculty, program director and chairman. The program administrator is often the point person for institution administration, GME, and outside entities such as the RC for Surgery or the American Board of Surgery, and may be the overseer of the hospital and department policies and procedures, strategic planning and objectives within the Department of Surgery.

Administrative

1. Manage the daily, weekly, monthly, and yearly operations of the surgical residency program.
2. Coordinate specific activities related to the surgical residency program, including but not limited to accreditation, credentialing, scheduling, recruitment including dates, location, and participants, standing meetings, scheduling, travel, etc.
3. Perform administrative duties, for example:
    a. maintain resident files and portfolios
    b. document conference attendance
    c. maintain resident schedules for Medicare compliance and risk management
    d. monitor work hours
    e. monitor case acquisition data and reports
    f. perform human resource activities such as payroll, vacations, sick time, and CME paperwork

Budget

1. Prepare, manage and/or assist with the program's fiscal budget.
2. Review monthly expenditures, budget line items, and financial reports.
3. Approve and/or process invoices for program expenses.

Credentialing

1. Schedule residents for certification in BLS, ACLS, ATLS, FCCS (Fundamentals of Critical Care Support) and FLS (Fundamentals of Laparoscopic Surgery), and beginning 2017-2018 FES (Fundamentals of Endoscopic Surgery).
2. Prepare requested program surveys, i.e., FREIDA, GMETrack, ADS, ABS, ERAS, etc.

Scheduling

1. Schedule general surgery program related activities: teaching conferences, vacations, rotations, committee meetings, recruitment and milestone reviews
2. Schedule department events, e.g., retreats, orientation, graduation.

Special Events

Special events take place throughout the residency year and are different from program to program. They are an important factor in the overall effectiveness of the surgery residency program. Special events promote team-building, contribute to high morale, and demonstrate that the overall well-being of residents is important to the program. Events can be scheduled at your institution or off-campus.

Special events can encompass a broad spectrum of activities. The number of yearly events varies among programs depending on availability and funding. Special events can include: a party or barbeque, sports events, picnics, happy hours, holiday, etc. Most programs hold a Welcome Party/Reception for the incoming residents in late June or early July. A holiday party is typically scheduled in December. Some have a spring picnic or post-match gathering. In late May or early June, programs have a graduation dinner, resident appreciation dinner, and/or a resident research forum.

Alumni

To maintain a program's history and to continue the program's traditions, most surgery programs have some type of data base for tracking alumni. As your previous residents continue to develop their careers, the importance of communicating with them on a regular basis becomes more and more important. Your alumni will represent your program and be its voice in the community. Some programs charge alumni dues to be used for further enhancement of the program needs.

There are many ways to keep in touch with your alumni:

- invite the most recent graduates to the resident graduation ceremonies or the resident graduation dinner,
- provide CME educational programs,
- hold receptions at annual society program meetings such as the American College of Surgeons, regional and national conferences, or mail departmental or institutional publications.

Things to consider:

1. Check with your program or department to see if there is an alumni tracking mechanism in place.
2. If one is in place, contribute to the communication.
3. Check with your program or department to see what communication mechanism is being used.
4. Create a communication mechanism if one is not in place.

Certification Courses

Due to JCAHO guidelines, each hospital system and each state may have different requirements for certification. All residents should maintain certification in Basic Life Support (BLS) to include a pediatric component if available. Advanced Cardiac Life Support (ACLS) is also required along with Advanced Trauma Life Support (ATLS). All residents must have FLS certification upon graduation. For the 2017-2018 year, FES is also required upon graduation. Some programs may offer an ATLS Instructors Course or the Fundamentals of Critical Care Support course. Please check with your hospital regarding the length of the certification courses, re-certification, and length of certification. If your hospital does not offer ATLS training, refer to the American College of Surgeons' website at www.facs.org for courses in your area.

Resident Committees

Different institutions have different types of committees established to meet the needs of graduate medical education. They can include, but are not limited to, resident liaison, Patient Care Committee, Education Committee, Quality and Safety Committee, Trauma Committee, Program Evaluation Committee, and Research Committee. There should be at least one committee that includes faculty and residents to discuss and resolve resident concerns and issues.

Things to consider:

1. The Administrator may facilitate the committee meeting by scheduling dates, times, and location, ordering food and/or drinks, preparing an agenda and transcribing minutes.
2. Residents should be peer selected each year.

Resident Travel

Away Rotations

Rules for resident travel vary by institution and in some states there are mandated rules that the institution must abide by. Consult your institution's policies and procedures manual to learn more about travel documentation and requirements.

If the resident is traveling for an elective surgery rotation, there are certain conditions that must be met. The program director must approve the rotation, the goals and objectives, preceptor and

funding sources must be identified. In addition, the experience must comply with the ACGME and RRC requirements.

Things to consider:

1. Ensure that all funding is approved
2. Ensure paperwork is processed to allow the resident to complete the travel --
    a. elective rotation goals and objectives
    b. malpractice insurance
    c. licensing
    d. preceptor
    e. institutional agreement
    f. Program Letter of Agreement

International Rotation Application Process
Review Committee for Surgery

The following are required to accompany an application for an international rotation. When applying for an international rotation, a letter of request must be sent to both the American Board of Surgery (ABS) and the Executive Director of the Review Committee for Surgery at the following addresses:

Jo Buyske, MD
Associate Executive Director
American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, Pennsylvania 19103

Donna L. Lamb
Executive Director, Review Committee for Plastic Surgery, Surgery, Thoracic Surgery
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, Illinois 60654

- The letter must be co-signed by both the program director and the designated institutional official (DIO) providing the following:
- Name and location of international site
- Documentation that the resident has the appropriate license to practice in the country where the rotation will occur
- PGY level of the resident for whom the rotation is requested (international rotations cannot occur during the R1 or R5 years)

- Dates of the rotation
- Verification that the rotation is an elective
- Program's accreditation is "Continued Accreditation"
- A list of ABMS-certified faculty members (or faculty members with qualifications deemed acceptable in advance by the Review Committee) who will supervise the resident
- A statement of the competency-based goals and objectives of the assignment
- Educational Rationale - A statement describing what educational experience the international rotation provides for the resident that the primary institution or affiliates do not
- Verification there will be an evaluation of the resident's performance based on the stated goals and objectives
- A description of the clinical experience
- Type of center (governmental, non-governmental, private)
- Scope of practice of the host center
- A statement of the center's operative volume and type
- Verification that the experience will include an outpatient experience
- Verification that the resident will enter operative experiences in the ACGME Case Log System for credit
- Verification that salary, travel expenses, health insurance and evacuation insurance is provided by the sponsoring institution
- A description of the educational resources, including access to a library with reasonably current resources and/or reliable access to web-based educational materials
- A statement addressing physical environmental issues, including housing, transportation, communication, safety, and language
- A copy of the Program Letter of Agreement

The program will receive separate approval letters from the ABS and the Review Committee. Both approval letters must be received prior to implementation of international rotations.

Academic Year Timeline

This section provides an example of how to organize your monthly tasks and activities. This calendar reflects most required activities. It can serve as a reference and/or reminder. Since the administrator's responsibilities vary from program to program, we suggest that you tailor the sample to your needs, including, but not limited to: review of work hours, evaluations, file reviews and evaluation sessions between the program director and resident, mock orals, education committee meetings, annual program review meetings. The ACGME often refers to the frequency of an activity, but rarely gives a specific time for that activity. You are **STRONGLY** encouraged to customize this list with the above activities as your program schedules them.

Program administrators have found that organizing their activities in a calendar format, electronically, on paper or on a whiteboard, help them manage the complexities of the job. Whatever format you select, you will experience firsthand the advantage of using this helpful tool.

July

- Move residents up in PGY in ACGME Resident Case Log System
- Add incoming residents in the ACGME Resident Case Log System
- Set up resident portfolio for the new academic year
- Setup the evaluation system for the academic year. Promote residents and add in the interns.
- Update your program website with new interns and fellowship/job information for program graduates
- Start ADS update (residents, faculty, rotations, program information)
- Surgical Operative Log due to ACGME by August 1st
- Complete ACS candidate applications for incoming residents
- AMA/FREIDA update opens
- ABS previous year completion roster notification sent to programs (due in August)
- Order FES & FLS Vouchers for the Academic Year

August

ERAS – Only the DIO or their designee can grant program access to you. Therefore, if you do not receive your invitation to the Web-based PDWS, please contact your DIO. Once you have registered and successfully logged into the application, you will be able to invite other program staff, and perform your pre-season set-up (creating custom scores, statuses, and filters; scheduler set-up, etc.).

- ABS previous year completion roster due
- Faculty evaluation letters prepared and sent
- Ensure you have your interview dates set up for the fall recruitment

September

- ERAS post office opens 9/15; mark your calendar to download everyday
- Finish ADS update; usually due last week of September
- Discuss upcoming interview season (dates, who will interview, etc.)
- Make arrangements for interviewing sessions
- Start cursory review of applicants

October

- Continue reviewing ERAS applicants
- Start sending out invitations to interview
- Schedule room for ABSITE exam, order supplies, food, and drink
- Submit Medicare information for first quarter
- ABS current trainee roster notification sent; due in November
- MSPEs released in ERAS
- Set banquet/graduation date
- Schedule CCCs for end of Nov/Dec

November

- Interview season begins
- Send out interview invitations
- Send out interview confirmation e-mails
- Remind faculty and residents of interview dates
- Order ABSITE exams & Arrange for ABSITE payment per institution procedures
- Clinical Competency Committee (CCC) meetings (and continue into December)
- Schedule Rank Meeting for late January/February

December

- ABSITE payment DEADLINE
- Medicare tracking for the 2nd quarter
- Clinical Competency Committee (CCC) meetings (continued from November)
- Enter ACGME Milestones data (due early January)

- Mid-year resident evaluation/review with Program Director

Try to enjoy some time off around the holidays…you deserve it!

January

- Send ABSITE reminder; confirm ABSITE proctor(s)
- Receive ABSITE instructions
- Confirm NRMP quota
- Prepare candidate files for Rank Meeting
- ERAS registration for next academic year
- Submit request for travel approval for APDS/ARAS spring meeting
- Schedule Mock Orals

February

- Enter and **CERTIFY** rank list prior to deadline ** Certify by the Program Director**
- Discuss how any unfilled positions would be filled if needed
- Register, make travel and hotel reservations for APDS/ARAS spring meeting) for you and your program director (if required)
- Reserve rooms for department orientation (in June)
- ACGME resident/faculty survey preparation
- ABSITE results received

March

- Match Day and SOAP
- Send announcement of new interns to the Department
- Send welcome letter to incoming residents with employment package
- Send post-match survey
- Chief residents receive ABS application
- Review chief resident case logs for deficiencies
- AAMC GME (FRIEDA) updates are due
- ACGME resident/faculty survey opens (runs through May)
- Work on Visas (if applicable)
- Have all of your current residents sign their contracts for the upcoming academic year

April

- Follow up on incoming residents paperwork
- Start preliminary orientation schedule
- Start preliminary rotation schedule
- Review goals and objectives for next academic year
- Review and update resident manual
- Review and update departmental policies and procedures
- Schedule PEC for Annual Program Review, invite faculty, peer selected residents
- Prepare graduation certificates
- Order chief residents' gifts
- Prepare invitation list, mail invitations, arrange menu for banquet/graduation party
- ACGME resident/faculty survey active
- Schedule CCCs for May/June
- Remind chief residents of ABS application deadline
- Chief residents to submit Board application to program director for review and signature
- ABS application and payment deadline

May

- Send graduation dinner / ceremony invitations
- Review chief residents' case logs for deficiencies
- Mock Orals
- Confirm orientation schedule, participants, room location, etc.
- Finalize rotation schedule
- Order resident/faculty awards
- Prepare to close out ERAS
- Set interview dates for upcoming year
- CCC meetings (continue into June)

June

- Graduation ceremony
- Orientation
- Request forwarding addresses of graduating/departing residents
- Schedule final chief evaluation
- Prepare final RC operative logs for chief residents and preliminary resident(s) for submission to ACGME
- Clinical Competency Committee (CCC) meetings

- Enter ACGME Milestones data
- PEC meeting
- End of year resident evaluation/review with Program Director

APPENDIX

Acronyms

AACOM – American Association of Colleges of Osteopathic Medicine (http://www.aacom.org/)
The AACOM provides support and assistance to osteopathic medical schools and services as a unifying voice for osteopathic medical education.

AAMC – Association of American Medical Colleges (www.aamc.org)
The Association of American Medical Colleges is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools, nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers, and nearly 90 academic and scientific societies. Through its many programs and services, the AAMC strengthens the world's most advanced medical care by supporting the entire spectrum of education, research, and patient care activities conducted by America's medical schools and teaching hospitals. The AAMC also publishes "Academic Medicine."

ABMS - American Board of Medical Specialties (www.abms.org)
The American Board of Medical Specialties works in collaboration with 24 specialty Member Boards to maintain the standards for physician certification. Their focus is on improving the quality of health care to patients, families, and communities by supporting the continuous professional development of physician specialists.

ABS - American Board of Surgery (www.absurgery.org)
The American Board of Surgery is an independent, nonprofit organization that provides board certification to individuals who have met a defined standard of education, training and knowledge in the field of surgery. The ABS serves the public and the specialty of surgery by providing leadership in surgical education and practice, by promoting excellence through rigorous evaluation and examination, and by promoting the highest standards for professionalism, lifelong learning, and the continuous certification of surgeons in practice.

ABSITE - American Board of Surgery In-Training Examination

The ABS offers annually to general surgery residency programs the In-Training Examination, a multiple-choice exam designed to measure the progress attained by residents in their knowledge of applied science and management of clinical problems related to surgery. The ABSITE is furnished to program directors as an evaluation instrument to assess residents' progress.

ACA – Affordable Care Act
Health plans must provide coverage to children up to age 26 by allowing children to stay on a parent's plan.

ACCME - Accreditation Council for Continuing Medical Education (www.accme.org/)
This organization's mission includes identifying, developing, and promoting standards for quality medical education by physicians to maintain competence.

ACGME - Accreditation Council for Graduate Medical Education (www.acgme.org)
The ACGME is a private, non-profit organization that reviews and accredits graduate medical education (residency and fellowship) programs, and the institutions that sponsor them, in the United States. Its mission is to improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation.

ACLS - Advanced Cardiac Life Support
ACLS is an advanced, instructor-led classroom course that highlights the importance of team dynamics and communication, systems of care and immediate post-cardiac-arrest care. It is designed for healthcare professionals who either direct or participate in the management of cardiopulmonary arrest and other cardiovascular emergencies.

ACS - American College of Surgeons ("The College") (www.facs.org)
The ACS is a scientific and educational association of surgeons that was founded to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

ADS – Accreditation Data System (ADS)
ADS is an online service of the ACGME that allows authorized program directors of accredited graduate medical education programs to input limited amounts of program information to servers maintained by the ACGME or on its behalf. It contains critical accreditation data for all sponsoring institutions and programs and serves as an ongoing communication tool with programs and sponsoring institutions, as well as Residency Review Committee staff.

AHA – American Hospital Association (http://www.aha.org/)
AHA is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters.

AHME – Association for Hospital Medical Education (www.ahme.org)
AHME is a national, non-profit professional organization involved in the continuum of hospital-based medical education. It aims to promote improvement in medical education to meet health

care needs; serve as a forum and resource for medical education information; develop professionals in the field of medical education; and advocate the value of medical education in health care.

AMA - American Medical Association (www.ama-assn.org)
The mission of the AMA is to promote the art and science of medicine and the betterment of public health. The AMA works to enhance the delivery of care and enable physicians and health teams to partner with patients to achieve better health for all.

AMSA – American Medical Student Association (www.amsa.org)
AMSA is the oldest and largest independent association of physicians-in-training in the United States. It is a student-governed, national organization committed to representing the concerns of physicians-in-training.

AOA – American Osteopathic Association (www.osteopathic.org)
The AOA is the accrediting agency for all osteopathic medical schools and has federal authority to accredit hospitals and other health care facilities.

AOA Honor Medical Society – (http://alphaomegaalpha.org/)
Alpha Omega Alpha (AOA) is the national medical honor society and is dedicated to the belief that in the profession of medicine care will be improved for all by recognizing high educational achievement, honoring gifted teaching, encouraging the development of leaders in academia and the community, supporting the ideas of humanism, and promoting service to others. Election to AOA is a lifelong honor signifying a lasting commitment to scholarship, leadership, professionalism, and service.

APDS - Association of Program Directors in Surgery (www.apds.org)
The purpose of the APDS is to provide a forum for the exchange of information and for discussion on a wide range of subjects related to post-graduate surgical education. It maintains high standards of surgical residency training by improving graduate education and patient care. The APDS provides advice, assistance and support to program directors on matters pertaining to surgical education and accreditation, it encourages research in the education and training of surgeons and surgical subspecialties, and represents the interests of program directors to other organizations, individuals and governmental agencies or regulatory bodies.

APE – Annual Program Evaluation
The APE is a formal, systematic evaluation of a program's curriculum with the goal of improving the program. The results are used by the program to identify areas for improvement and track the efforts of the program to effect changes. The APE does not have to be submitted to the ACGME.

ARAS - Association of Residency Administrators in Surgery (www.arcsurgery.org)
ARAS is an organization established as an educational resource to foster the exchange of ideas, and support a network for persons in the position of managing surgery residency programs. ARAS also supports and promotes the certification process of training administrators of graduate medical education.

ATLS - Advanced Trauma Life Support
The ACS and its Committee on Trauma (COT) has worked to establish standards for the care of the trauma patient. This program provides systematic and concise training for the early care of trauma patients.

BLS - Basic Life Support
Basic Life Support (BLS) certification is a relatively short training course required of many health professionals to help revive, resuscitate, or sustain a person who is experiencing cardiac arrest or respiratory failure. The primary skills taught in the BLS course include basis mouth-to-mouth resuscitation and CPR.

CBE – Competency-Based Education
Outcome based instruction which focuses on the student's ability to apply basic and other skills in situations that are commonly encountered.

CCC – Clinical Competency Committee
The CCC is a required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program. Members of the CCC are appointed by the program director and are responsible for preparing and ensuring the reporting of milestone evaluations semi-annually to the ACGME and making recommendations to the program director for resident progress.

CE – ABS Certifying Examination
The Certifying Examination (CE) is the last step toward board certification. It is an oral exam consisting of 3 consecutive 30-minute sessions, each conducted by a team of 2 examiners. The CE's purpose is to evaluate a candidate's clinical skills in organizing the diagnostic evaluation of common surgical problems and determining appropriate therapy. Emphasis is placed on candidates' ability to use their knowledge and training to safely, effectively and promptly manage a broad range of clinical problems. Candidates must successfully complete the ABS Qualifying Examination (QE) prior to taking the CE.

CK – Clinical Knowledge
A portion of the licensing exam that assesses the ability to apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision.

CLER – Clinical Learning Environment Review
As a component of the Next Accreditation System (NAS), the ACGME has established the CLER program to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites. CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care.

CME – Continuing Medical Education
Ongoing educational activities after the completion of residency.

CMSS – Council of Medical Specialty Societies (www.cmss.org)
The main purpose of this organization is to provide a forum for collaboration to influence policy, medical education and accreditation from a broad, cross-specialty perspective.

COGME – Council on Graduate Medical Education
A federal agency that provides ongoing assessment of physician workforce trends, training issues and financing policies.

COMLEX – Comprehensive Osteopathic Medical Licensing Examination
COMLEX provides a pathway to licensure for osteopathic physicians. The exam assesses medical knowledge and clinical skills considered essential for osteopathic physicians to practice medicine without supervision.

CPT - Current Procedural Terminology
CPT code is a medical code set maintained by the AMA. The CPT code describes medical, surgical and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations and payers for administrative, financial and analytical purposes. CPT coding is similar to ICD-9 or ICD-10 coding except that it identifies the services rendered rather than the diagnosis. CPT codes are used in the ACGME Case Logs to record resident surgical experience.

CRC or CRCC – Council of Review Committee Chairs
Consists of all current chairs of review committees and two ACGME directors. This group's purpose includes monitoring innovations in graduate medical education, sharing notable practices, applying quality parameters, standardizing processes and procedures.

CRCR – Council of Review Committee Residents
An advisory body concerning resident matters, GME, and accreditation.

CS – Clinical Skills
Using standardized patients, this provides an assessment of the ability of examinees to apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision.

DEA – Drug Enforcement Administration
The federal agency that enforces laws and regulations related to controlled substances.

DFA – Department of Field Activities
Responsible for scheduling and conducting accreditation site visits.

DIO – Designated Institutional Official
The individual in a sponsoring institution with the authority and responsibility for all of the ACGME-accredited GME programs.

ECFMG - Educational Commission for Foreign Medical Graduates (www.ecfmg.org)
Through its program of certification, the Educational Commission for Foreign Medical Graduates (ECFMG®) assesses the readiness of international medical graduates to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

EMR – Electronic Medical Record
A computerized medical record created in an organization that delivers care, such as a hospital or physician's office.

ERAS - Electronic Residency Application Service (www.ama-assn.org)
ERAS is a service of the AAMC by which medical students apply to residency programs through their medical schools. All medical students, including international students, must apply through ERAS for residency. International students access this program through the ECFMG office.

FCVS – Federation Credentials Verification Service
The agency provides a permanent, lifetime repository of primary-source verified core credentials for physicians and physician assistants.

FERPA - Family Educational Rights and Privacy Act
Protects the privacy of student education records at schools that receive funds under an applicable program of the U.S. Department of Education.

FLS – Fundamentals of Laparoscopic Surgery (http://www.flsprogram.org)
FLS is a comprehensive web-based education module that includes a hands-on skills training component and assessment tool designed to teach the physiology, fundamental knowledge, and

technical skills required in basic laparoscopic surgery. The ABS now requires residents to be FLS certified upon graduation.

FREIDA Online – Fellowship and Residency Electronic Interactive Database
FREIDA Online is an online database maintained by the AMA of accredited graduate medical education programs, both residency and fellowship programs, in the United States and Puerto Rico. It lists information for the more than 9,800 graduate medical education programs accredited by the ACGME, as well as over 100 Board-approved combined specialty programs, such as internal medicine/psychiatry. It can be used to search for programs by specialty in a particular state or geographic region as well as to determine specific aspects about any given program (number of first-year spots, salary, years of training, etc.)

FSC - Fundamentals of Surgery Curriculum (www.facs.org/education)
The FSC is a highly interactive, case based, online curriculum that addresses the essential content areas that all surgical residents need to master in their earlier training years. Developed by the ACS Division of Education, the curriculum includes over 99 simulated case scenarios in which residents are asked to recognize and assess symptoms and signs, order appropriate tests and procedures, evaluate data, and initiate appropriate actions.

FSMB - Federation of State Medical Boards (www.fsmb.org/)
Organization representing the 70 medical and osteopathic boards of the United States and its territories, promotes excellence in medical practice, licensure, and regulation, to protect the public.

GME - Graduate Medical Education
GME refers to any type of formal medical education pursued after receipt of the M.D. or D.O. degree in the United States. Post-doctoral education prepares physicians for practice in a medical specialty. Primary focus is on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty. This learning process prepares the physician for the independent practice of medicine in that specialty.

The single most important responsibility of any program of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients. A resident takes on progressively greater responsibility throughout the course of a residency, consistent with individual growth in clinical experience, knowledge and skill.

GMEC - Graduated Medical Education Committee
This group is required to establish and implement policies and procedures regarding the quality of education and the work environment for all residents in the institution.

HHS - US Department of Health & Human Services (www.hhs.gov)
The principal federal agency that protects the health of all Americans and provides essential human services, especially for those unable to help themselves.

HIPPA – Health Insurance Portability and Accountability Act
HIPPA is a U.S. law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

HRSA - Health Resources and Services Administration (www.hrsa.gov)
The primary federal agency for improving access to health care services for uninsured, isolated or medically vulnerable people.

IHI - Institute for Healthcare Improvement (www.ihi.org)
This organization provides training in quality improvement, patient safety, teamwork, leadership, and patient-centered care.

IMG – International Medical Graduate
A graduate from a medical school outside the United States and Canada (and not accredited by the Liaison Committee on Medical Education). IMGs may be citizens of the United States who chose to be educated elsewhere or non-citizens who are admitted to the United States by US Immigration authorities. All IMGs should undertake residency education in the United States before they can obtain a license to practice medicine in the United States even if they were fully educated, licensed, and practicing in another country.

IRB - Institutional Review Board
The committee formally designated to approve, monitor, and review biomedical and behavioral research involving humans.

IRC - Institutional Review Committee
This group sets accreditation standards for institutions, provides peer evaluation to assess compliance with the published educational standards, and confers an accreditation status.

IRIS - Interns & Residents Information System
The computer system used by CMS to handle reimbursement requests from provider hospitals for the costs associated with training residents and fellows.

ITE - In-training Exam
Formative examination that evaluates a resident's progress in meeting the educational objectives.

JGME - Journal of Graduate Medical Education (www.jgme.org)
Periodical published to promote critical inquiry among the graduate medical education community.

JC - Joint Commission on Accreditation of Healthcare Organizations (www.jointcommision.org)
The organization responsible for accrediting and certifying healthcare organizations in the United States.

LCME - Liaison Committee on Medical Education
Sponsored by the AMA and AAMC, this body is recognized as the accrediting authority for medical education programs leading to the MD degree in the United States and Canada.

LON – Letter of Notification
The official communication from a Residency Review Committee (RRC) that states the action taken following a site visit or other request.

MSPE – Medical Student Performance Evaluation
The MSPE or Dean's Letter evaluates a medical student's performance during his or her academic career relative to his or her peers.

NAS - Next Accreditation System
Outcomes-based evaluation system requiring residency programs to demonstrate that residents have the core competencies and clinical skills to deliver quality patient care and respond to developments in health care delivery.

NBME - National Board of Medical Examiners (www.nbme.org)
This independent, not-for-profit organization serves the public through its high- quality assessments of healthcare professionals.

NRMP - National Resident Matching Program (http://www.nrmp.org)
NRMP, also called The Match, is a U.S.-based private, non-profit organization created to help match medical school students with residency programs. The purpose is to provide a uniform time for both applicants and programs to make their training selections without pressure.

OSCE - Observed Standard Clinical Examination
A method of testing clinical skill performance and competence using standardized patients.

PD – Program Director
The physician designated with the authority and accountability for the operation of the residency/fellowship program.

PDSA – Plan Do Study Act
A four part method for discovering and correcting assignable causes to improve the quality of processes and action-oriented learning.

PDWR - Program Director's Web Review
This provides programs with remote access to review ERAS application supporting documents remotely via the Internet.

PDWS - Program Director's Workstation
The software used by participating residency programs to receive, sort, review, evaluate, and rank applications.

PEC – Program Evaluation Committee
Appointed by the program director, the PEC's responsibilities include planning, developing, implementing and evaluating education activities of the program. The PEC should review and make recommendations for revision of competency-based curriculum goals and objectives, address areas of non-compliance with ACGME standards, and review the program's APE to improve the program.

PGY - Post Graduate Year (PGY)
Each PGY level corresponds to a year spent in a residency program. It is used to stratify responsibility in most training programs and to determine salary. The grade of the resident is denoted with a numeral after the PGY designation, such as PGY-3 for a third-year resident.

PLA – Program Letter of Agreement
A written document that addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education.

QE – ABS Qualifying Examination
The Qualifying Examination (QE) is offered annually as the first of two exams required for board certification. The exam consists of approximately 300 multiple-choice questions designed to evaluate a surgeon's knowledge of general surgical principles and applied science. Successful completion of the QE is a requirement for admission to the CE.

RC - Review Committee or **RRC** - Residency Review Committee

This committee is a component of the ACGME whose purpose is to review training programs for adherence to program requirements. The RC determines the status of accreditation for training programs.

SCORE - Surgical Council on Resident Education (http://surgicalcore.org)
The SCORE an innovative, nonprofit initiative to provide residents and residency programs with high-quality educational materials and a structured program for self-learning in all areas of general surgery. The content of the portal is aligned with the SCORE Curriculum Outline, a list of topics to be covered in a five-year general surgery residency.

SESAP - Surgical Education and Self-Assessment Program (www.facs.org)
The Surgical Education and Self-Assessment Program (SESAP®) was developed by the ACS Division of Education to promote excellence in surgery through acquisition and application of evidence-based surgical knowledge. SESAP offers problem-based multiple-choice questions and evidence-based explanations of answers, as well as supporting references from current literature.

SOAP - Supplemental Offer and Acceptance Program (http://www.nrmp.org)
SOAP replaces the "Scramble" and provides a uniform process for obtaining appointments during Match Week. Unfilled programs that have elected to participate in SOAP offer positions to SOAP-eligible unmatched applicants through the R3 system, and positions offered and accepted constitute a binding commitment under the Match Participation Agreement.

SOL - Surgical Operative Log (www.acgme.org)
This acronym is no longer being used in formal writing, but is used in conversation regarding case data reports. This is now called the Resident Operative Case Experience Report. During the five year general surgery residency training each resident must maintain a Resident Operative Case Experience Report. This is a summative record of all the procedures performed by a resident during residency, including both operative and non-operative procedures.

SV – Site Visitor
A representative of the ACGME who conducts an on-site review of a residency training program.

USMLE - United States Medical Licensing Examination (www.usmle.org)
The United States Medical Licensing Examination (USMLE) is a three-step examination for medical licensure in the United States and is sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners® (NBME®). The USMLE assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care. Each of the three Steps of the USMLE complements the others; no Step can stand alone in the assessment of readiness for medical

Glossary of Terms

Program Administrators are encouraged to print the glossary of terms found on the ACGME website and included here.

Academic Appointment: An appointment to a faculty category (e.g. professor, Associate Professor, Adjunct Clinical Instructor, etc.) of a degree-granting (e.g. BS, BA, MA, MD, DO, PhD, etc.) school, college, or university.

Accreditation: A voluntary process of evaluation and review based on published standards and following a prescribed process, performed by a non-governmental agency of peers.

Accreditation Data System (ADS): The WebADS is an online service of ACGME that allows authorized program directors of accredited graduated medical education programs to input limited amounts of Program Information data to servers' maintained by the ACGME or on its behalf.

Applicant: An M.D. or D.O. invited to interview with a GME program.

Assessment: An ongoing process of gathering and interpreting information about a learner's knowledge, skills, and/or behavior.

At-Home Call: Same as Pager Call. A call taken from outside the assigned site. Time in the hospital, exclusive of travel time, counts against the 80 hour per week limit but does not restart the clock for time off between scheduled in-house duty periods. At-Home Call may not be scheduled on the resident's one free day per week (averaged over four weeks).

Categorical Resident (also see "Graduate Year 1"): A resident who enters a program with the objective of completing the entire program.

Certification: A process to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality care in a particular specialty.

Chief Resident: Typically, a position in the final year of the residency (e.g., surgery) or in the year after the residency is completed (e.g., internal medicine and pediatrics).

Citation: A finding of a Review Committee that a program or an institution is failing to comply substantially with a particular accreditation standard or ACGME policy or procedure.

Clarifying Information: A Review Committee may request clarifying information that specifies information to be provided, including a due date for the clarifying information.
Clinical: Refers to the practice of medicine in which physicians assess patients (in person or virtually) or populations in order to diagnose, treat, and prevent disease using their expert judgment. It also refers to physicians who contribute to the care of patients by providing clinical decision support and information systems, laboratory, imaging, or related studies.

Clinical Competency Committee: A required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program.

Clinical Learning Environment Review (CLER): The ACGME Clinical Learning Environment (CLER) provides the profession and the public a broad view of sponsoring institution's initiatives to enhance the safety of the learning environment and to determine how residents are engaged in the patient safety and quality improvement activities.

Clinical Responsibility/Workload Limits: Reasonable maximum levels of assigned work for residents/fellows consistent with ensuring both patient safety and a quality educational experience. Such workloads, and their levels of intensity, are specialty-specific and must be thoroughly examined by the RRCs before inclusion in their respective program requirements.

Clinical Supervision: A required faculty activity involving the oversight and direction of patient care activities that are provided by residents/fellows.

Combined Specialty Programs: Programs recognized by two or more separate specialty boards to provide GME in a particular combined specialty. Each combined specialty program is made up of two or three programs, accredited separately by the ACGME at the same institution.

Common Program Requirements: The set of ACGME requirements that apply to all specialties and subspecialties.

Competencies: Specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs. These include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Complement: The maximum number of residents or fellows approved by a Residency Review Committee per year and/or per program based upon availability of adequate resources.

Compliance: A program's or institution's adherence to a set of prescribed requirements.

Conditional independence: Graded, progressive responsibility for patient care with defined oversight.

Confidential: Information intended to be disclosed only to an authorized person; that an evaluation is deemed confidential does not imply that the source of the evaluation is anonymous.

Consortium: An association of two or more organizations, hospitals, or institutions that have come together to pursue common objectives (e.g., GME).

Continued Accreditation: A status of "Continued Accreditation" is conferred when a Review Committee determines that a program or sponsoring institution has demonstrated substantial compliance with the requirements.

Continuity Clinic: Setting for a longitudinal experience in which residents develop a continuous, long-term therapeutic relationship with a panel of patients.

Continuous time on duty: The period that a resident or fellow is in the hospital (or other clinical care setting) continuously, counting the resident's (or fellow's) regular scheduled day, time on call, and the hours a resident (or fellow) remains on duty after the end of the on-call period to transfer the care of patients and for didactic activities.

Core Faculty: All physician faculty who have a significant role in the education of resident/fellows and who have documented qualifications to instruct and supervise. Core faculty devote at least 15 hours per week to resident education and administration. All core faculty should evaluate the competency domains; work closely with and support the program director; assist in developing and implementing evaluation systems; and teach and advise residents.

Core Program: See "Specialty Program"

Designated Institutional Official (DIO): The individual in a sponsoring institution who has the authority and responsibility for all of the ACGME-accredited GME programs.

Didactic: A kind of systematic instruction by means of planned learning experiences, such as conferences or grand rounds.

Duty Hours: Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent on in-house call, and other scheduled

activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

ECFMG Number: The identification number assigned by the Educational Commission for Foreign Medical Graduates (ECFMG) to each international medical graduate physician who receives a certification from ECFMG.

Elective: An educational experience approved for inclusion in the program curriculum and selected by the resident in consultation with the program director.

Essential: (See "Must")

External moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Extraordinary Circumstances: A circumstance that significantly alters the ability of a sponsor and its program s to support resident education.

Extreme Emergent Situation: A local event (such as a hospital-declared disaster for an epidemic) that affect resident education or the work environment but does not rise to the level of an extraordinary circumstance as defined in the *ACGME Policies and Procedures, Section 20.00*.

Faculty: Any individuals who have received a formal assignment to teach resident/fellow physicians. At some sites appointment to the medical staff of the hospital constitutes appointment to the faculty.

Fatigue management: Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety and enactment of appropriate countermeasures to mitigate the fatigue.

Fellow: A physician in a program of graduate medical education accredited by the ACGME who has completed the requirements for eligibility for first board certification in the specialty. The term “subspecialty residents” is also applied to such physicians. Other uses of the term "fellow" require modifiers for precision and clarity, e.g., research fellow.

Fellowship: see “subspecialty program”

Fifth Pathway: One of several ways that individuals who obtain their undergraduate medical education abroad can enter GME in the United States. The fifth pathway is a period of supervised clinical training for students who obtained their premedical education in the United States, received undergraduate medical undergraduate abroad, and passed Step 1 of the United States

Medical Licensing Examination. After these students successfully complete a year of clinical training sponsored by an LCME-accredited US medical school and pass USMLE Step 2, they become eligible for an ACGME-accredited residency as an international medical graduate.

Fitness for duty: Mentally and physically able to effectively perform required duties and promote patient safety.

Focused Site Visit: A focused site visit assesses selected aspects of a program or sponsoring institution identified by a Review Committee (see ACGME Policies and Procedures, Section 17.30).

Formative Evaluation: Assessment of a resident/fellow with the primary purpose of providing feedback for improvement as well as to reinforce skills and behaviors that meet established criteria and standards without passing a judgment in the form of a permanently recorded grade or score.

Full Site Visit: A full site visit addresses and assesses compliance with all applicable standards and encompasses all aspects of a program or sponsoring institution (see ACGME Policies and Procedures, Section 17.30).

Graduate Medical Education: The period of didactic and clinical education in a medical specialty which follows the completion of a recognized undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty, also referred to as residency education. The term "graduate medical education' also applies to the period of didactic and clinical education in a medical subspecialty which follows the completion of education in a recognized medical specialty and which prepares physicians for the independent practice of medicine in that subspecialty.

Graduate-Year Level: Refers to a resident's current year of accredited GME. This designation may or may not correspond to the resident's particular year in a program. For example, a resident in pediatric cardiology could be in the first program year of the pediatric cardiology program but in his/her fourth graduate year of GME (including the 3 prior years of pediatrics.) Also referred to as 'post graduate year' or 'PGY".

In-House Call: Duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

Initial Accreditation: A status of "Initial Accreditation" is conferred when a Review Committee determines that an application for a new program or sponsoring institution substantially complies with the requirements. Initial accreditation is considered a developmental stage.

Innovation: Experimentation initiated at the program level which may involve an individual program, a group of residents (e.g., PGY1 residents) or an individual resident (e.g., chief resident).

Institutional Review: The process undertaken by the ACGME to determine whether a sponsoring institution offering GME programs is in substantial compliance with the Institutional Requirements.

Integrated: A site may be considered integrated when the program director a) appoints the members of the faculty and is involved in the appointment of the chief of service at the integrated site, b) determines all rotations and assignments of residents, and c) is responsible for the overall conduct of the educational program in the integrated site. There must be a written agreement between the sponsoring institution and the integrated site stating that these provisions are in effect. This definition does not apply to all specialties. (See specific Program Requirements)

Intern: Historically, a designation for individuals in the first year of GME. This term is no longer used by the ACGME.

Internal Moonlighting: Voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the resident is in training or at any of its related participating sites.

International Medical Graduate (IMG): A graduate from a medical school outside the United States and Canada (and not accredited by the Liaison Committee on Medical Education). IMGs may be citizens of the United States who chose to be educated elsewhere or non-citizens who are admitted to the United States by US Immigration authorities. All IMGs should undertake residency education in the United States before they can obtain a license to practice medicine in the United States even if they were fully educated, licensed, and practicing in another country.

In-Training Examination: Formative examinations developed to evaluate resident/fellow progress in meeting the educational objectives of a residency/fellowship program. These examinations may be offered by certification boards or specialty societies.

Joint Commission (TJC): Formerly known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO, which evaluates and accredits health care organizations in the United States.

LCME: Liaison Committee on Medical Education, which accredits programs of medical education leading to the M.D. in the United States and in collaboration with the Committee on Accreditation of Canadian Medical Schools (CACMS), in Canada.

Letter of Notification: The official communication from a Review Committee that states the action taken by the Review Committee.

Master Affiliation Agreement: A written document that addresses GME responsibilities between a sponsoring institution and a major participating site.

Medical School Affiliation: A formal relationship between a medical school and a sponsoring institution.

Must: A term used to identify a requirement which is mandatory or done without fail. This term indicates an absolute requirement.

National Resident Matching Program (NRMP): A private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education in the United States. Five organizations sponsor the NRMP: American Board of Medical Specialties, American Medical Association, Association of American Medical Colleges, American Hospital Association, and Council of Medical Specialty Societies.

Night Float: Rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus.

Notable Practice: A process or practice that a Review Committee or other ACGME committee deems worthy of notice. Notable practices are shared through the ACGME website or other ACGME publications to provide programs and institutions with additional resources for resident education. Notable practices do not create additional requirements for programs or institutions.

One Day Off: One (1) continuous 24-hour period free from all administrative, clinical and educational activities.

Ownership of Institution: Refers to the governance, control, or type of ownership of the institution.

Pager Call: A call taken from outside the assigned site.

PDSA (Plan-Do-Study-Act): A four part method for discovering and correcting assignable causes to improve the quality of processes; the method may be applied to individual learning, courses, programs, institutions, and systems, in repeated cycles.

Pilot: An ACGME-approved project, which is initiated by the Review Committee and involves several residency/fellowship programs that elect to participate.

Preliminary Positions:

> **Designated Positions**: Positions for residents who have already been accepted into another specialty, but who are completing prerequisites for that specialty (see Program Requirements for Surgery).
>
> **Non-Designated Positions**: Positions for residents who at the time of admission to a program have not been accepted into any specialty (see Program Requirements for Surgery).

Primary Clinical Site: If the sponsoring institution is a hospital, it is by definition the principal or primary teaching hospital for the residency/fellowship program. If the sponsoring institution is medical school, university, or consortium of hospitals, the hospital that is used most commonly in the residency/fellowship program is recognized as the primary clinical site.

Probationary Accreditation: An accreditation status is conferred when the Review Committee determines that a program or sponsoring institution that has failed to demonstrate substantial compliance with the requirements.

Program: A structured educational experience in graduate medical education designed to conform to the Program Requirements of a particular specialty/subspecialty, the satisfactory completion of which may result in eligibility for board certification.

Program Director: The one physician designated with authority and accountability for the operation of the residency/fellowship program.

Program Evaluation: Systematic collection and analysis of information related to the design, implementation, and outcomes of a resident education program, for the purpose of monitoring and improving the quality and effectiveness of the program.

Progress Report: A Review Committee may request a progress report that specifies information to be provided, including a due date for the report. The progress report must be reviewed by the sponsoring institution's Graduate Medical Education Committee, and must be signed by the designated institutional official prior to submission to the Review Committee.

Program Letter of Agreement (PLA): A written document that addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education.

Program Merger: Two or more programs that combine to create a single program. One program may maintain continued accreditation while accreditation is voluntarily withdrawn from the other program or programs. Alternatively, both programs may be withdrawn and a new program may be established.

Program Year: Refers to the current year of education within a specific program; this designation may or may not correspond to the resident's graduate year level.

Required: Educational experiences within a residency/fellowship program designated for completion by all residents/fellows.

Resident: Any physician in an accredited graduate medical education program, including interns, residents, and fellows.

Residency: A program accredited to provide a structured educational experience designed to conform to the Program Requirements of a particular specialty.

Review Committee Executive Director: Appointed by the ACGME Chief Executive Officer, is a chief staff person for a Review Committee and is responsible for all administrative matters of the Review Committee.

Review Committee, Residency Review Committee: The function of a Review Committee is to set accreditation standards and to provide a peer evaluation of residency programs and fellowships
(or, in the case of the Institutional Review Committee, to set accreditation standards and to provide a peer evaluation of sponsoring institutions).

Rotation: An educational experience of planned activities in selected settings, over a specific time period, developed to meet goals and objectives of the program.

Scheduled duty periods: Assigned duty within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Scholarly Activity: An opportunity for residents/fellows and faculty to participate in research, as well as organized clinical discussions, rounds, journal clubs, and conferences. In addition, some members of the faculty should also demonstrate scholarship through one or more of the following: peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or participation in national committees or educational organizations. (See Common Program Requirements)

Shall: (See must)

Should: A term used to designate requirements so important that their absence must be justified. A program or institution may be cited for failing to comply with a requirement that includes the term 'should'.

Site: An organization providing educational experiences or educational assignments/rotations for residents/fellows.

> **Major Participating Site**: A Review Committee-approved site to which all residents in at least one program rotate for a required educational experience, and for which a master affiliation agreement must be in place. To be designated as a major participating site in a two-year program, all residents must spend at least four months in a single required rotation or a combination of required rotations across both years of the program. In programs of three years or longer, all residents must spend at least six months in a single required rotation or a combination of required rotations across all years of the program. The term "major participating site" does not apply to sites providing required rotations in one year programs. (see "Master Affiliation Agreement")
>
> **Participating Site**: An organization providing educational experiences or educational assignments/rotations for residents/fellows. Examples of sites include: a university, a medical school, a teaching hospital which includes its ambulatory clinics and related facilities, a private medical practice or group practice, a nursing home, a school of public health, a health department, a federally qualified health center, a public health agency, an organized health care delivery system, a health maintenance organization (HMO), a medical examiner's office, a consortium or an educational foundation.

Specialty Program: A structured educational experience in a field of medical practice following completion of medical school and, in some cases, prerequisite basic clinical education designed to conform to the Program Requirements of a particular specialty; also known as 'core' programs.

Sponsoring Institution: The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, an educational foundation).

Clarification: When the sponsoring institution is a non-rotation site the major associated hospital is the participating rotation site. Additionally, for multiple ambulatory medical sites under

separate ownership from the sponsoring institution one central or corporate site (and address) must represent the satellite clinics (that are located within 10 miles of the main site).

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

Subspecialty Program: A structured educational experience following completion of a prerequisite specialty program in GME designed to conform to the Program Requirements of a particular subspecialty.

> **Dependent Subspecialty Program**: A program that is required to function in conjunction with an accredited specialty/core program, usually reviewed conjointly with the specialty program, usually sponsored by the same sponsoring institution, and geographically proximate. The continued accreditation of the subspecialty program is dependent on the specialty program maintaining its accreditation.

Suggested: A term along with its companion "strongly suggested," used to indicate that something is distinctly urged rather than required. An institution or program will not be cited for failing to do something that is suggested or strongly suggested.

Summative Evaluation: Assessment with the primary purpose of establishing whether or not performance measured at a single defined point in time meets established performance standards, permanently recorded in the form of a grade or score.

Transfer resident: Residents are considered as transfer residents under several conditions including: moving from one program to another within the same or different sponsoring institution; when entering a PGY 2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school). Before accepting a transfer resident, the program director of the 'receiving program' must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director. The term 'transfer resident' and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

Transitional-Year Program: A one-year educational experience in GME, which is structured to provide a program of multiple clinical disciplines; its design to facilitate the choice of and/or preparation for a specialty. The transitional year is not a complete graduate education program in preparation for the practice of medicine.

Transitions of care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.

Unannounced Site Visit: A site visit that is unannounced due to the urgency of an issue(s) that needs immediate review. A program may receive up to three weeks' notice of unannounced site visits.

Withdrawal of Accreditation: A Review Committee determines that a program or sponsoring institution has failed to demonstrate substantial compliance with the requirements.

Warning: If a program or sponsoring institution does not demonstrate substantial compliance, a Review Committee may warn a program or sponsoring institution if it determines areas of non-compliance may jeopardize its accreditation status.

American Board of Medical Specialties
(www.abms.org)

General Certificates	Subspecialty Certificates
ABAI	American Board of Allergy and Immunology
ABA	American Board of Anesthesiology
ABCRS	American Board of Colon and Rectal Surgery
ABD	American Board of Dermatology
ABEM	American Board of Emergency Medicine
ABFM	American Board of Family Medicine
ABIM	American Board of Internal Medicine
ABMGG	American Board of Medical Genetics and Genomics
ABNS	American Board of Neurological Surgery
ABNM	American Board of Nuclear Medicine
ABOG	American Board of Obstetrics and Gynecology
ABOP	American Board of Ophthalmology
ABOS	American Board of Orthopaedic Surgery
ABOTO	American Board of Otolaryngology
ABPATH	American Board of Pathology
ABP	American Board of Pediatrics
ABPMR	American Board of Physical Medicine and Rehabilitation
ABPS	American Board of Plastic Surgery
ABPM	American Board of Preventive Medicine
ABPN	American Board of Psychiatry and Neurology
ABR	American Board of Radiology
ABS	American Board of Surgery
ABTS	American Board of Thoracic Surgery
ABU	American Board of Urology

ASSOCIATION of RESIDENCY ADMINISTRATORS in SURGERY

National/Regional Surgical Organizations

AAPS	American Association of Plastic Surgeons
AAVAS	American Association of Veterans Administration Surgeons
ABA	American Burn Association
APSA	American Pediatric Surgical Association
ASSH	American Society for Surgery of the Hand
ASCRS	American Society of Colon and Rectal Surgeons
ASMS	American Society of Maxillofacial Surgeons
ASPRS	American Society of Plastic and Reconstructive Surgeons
ASTS	American Society of Transplant Surgeons
ASA	American Surgical Association
ATA	American Thyroid Association
AAS	Association for Academic Surgery
ASE	Association for Surgical Education
APDS	Association of Program Directors in Surgery
CACS	Canadian Association of Clinical Surgeons
CAGS	Canadian Association of General Surgeons
CSA	Central Surgical Association
EAST	Eastern Association for the Surgery of Trauma
ESS	Eastern Surgical Society
ISCVS	International Society for Cardiovascular Surgery
MSA	Midwest Surgical Association
NESS	New England Surgical Society
NPSA	North Pacific Surgical Association
PCSA	Pacific Coast Surgical Association
PVSS	Peripheral Vascular Surgery Society
SCVS	Society for Clinical Vascular Surgery
SSAT	Society for Surgery of the Alimentary Tract
SVS	Society for Vascular Surgery
SAGES	Society of American Gastrointestinal Endoscopic Surgeons
SCS	Society of Clinical Surgery
SHNS	Society of Head and Neck Surgeons
SSO	Society of Surgical Oncology
STS	Society of Thoracic Surgeons
SUS	Society of University Surgeons
SESC	Southeastern Surgical Congress
SSCS	Southern Society of Clinical Surgeons
SSA	Southern Surgical Association

STSA	Southern Thoracic Surgical Association
SWSC	Southwestern Surgical Congress
SSS	State Surgical Society
SIS	Surgical Infection Society
WSA	Western Surgical Association
WTSA	Western Thoracic Surgical Association