

# **SUPERVISION OF POSTDOCTORAL TRAINEES POLICY:**

## **Department of Surgery**

### **I. OBJECTIVES**

The Department of Surgery subscribes to the philosophy that the most effective learning environment for post-graduate medical trainees is one that provides (a) graded responsibility for residents and fellows in patient care decision-making under adequate supervision, (b) supervisor feedback to residents and fellows concerning their diagnostic and management decisions, and (c) an appropriate balance of education and patient care responsibility with the patient's right to expect a healthy, alert, responsible and responsive physician dedicated to delivering effective and appropriate care.

### **II. PRINCIPLES**

- A.** In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care. This information is located in EPIC, the electronic medical record.
- B.** Clinical responsibilities must be conducted in a carefully supervised and graduated manner, allowing housestaff to assume progressively increasing responsibility in accordance with their level of education, ability, and experience.
  - 1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident or fellow must be assigned by the program director and faculty members after assessment of relevant competencies
  - 2. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific criteria or milestones.
  - 3. Senior residents or fellows should be given the responsibility for supervising junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- C.** Supervision of residents and fellows should foster humanistic values by demonstrating a concern for each housestaff member's well-being and professional development.

1. Supervision must include timely and appropriate feedback and residents and fellows must be provided with rapid, reliable systems for communicating with supervising faculty. Faculty must be available within 30 minutes for patient care activities that are critical and/or require operative intervention.
  2. Supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility.
- D. Faculty members functioning as supervising physicians should delegate portions of care to residents and fellows, based on the needs of the patient and the skills of the resident or fellow. Residents, fellows and faculty members should inform patients of their respective roles in each patient's care.
- E. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

### **III. LEVELS OF SUPERVISION**

To ensure oversight of resident supervision and graded authority and responsibility, the following terms apply:

- A. **Direct Supervision** – the supervising physician (senior resident, fellow or faculty member) is physically present with the resident and patient.
- B. **Indirect Supervision:**
1. **with direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
  2. **with direct supervision available** – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- C. **Oversight** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

## VI. SPECIFIC REQUIREMENTS

### *A Indirect supervision is allowed for:*

#### **a. Patient Management Competencies**

1. evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
3. evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
4. transfer of patients between hospital units or hospitals
5. discharge of patients from the hospital
6. interpretation of laboratory results

#### **b. Procedural Competencies**

1. performance of basic venous access procedures, including establishing intravenous access
2. placement and removal of nasogastric tubes and Foley catheters
3. arterial puncture for blood gases

### *Direct supervision is required until competency is demonstrated for:*

#### **a. Patient Management Competencies**

1. initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS is required at the beginning of internship (2011))
  - i. The Trauma team chief resident or attending will be immediately available to review the care of critically injured patients
2. evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes.
  - i. PGY I competency will be determined by clinical observation of senior resident supervisors for not less than 4 weeks AND successful completion of a competency examination. Senior supervising residents at night have no other clinical responsibilities except to supervised PGY I residents. They are listed on QGenda. Once considered "competent" a PGY I resident may then work under indirect supervision with direct supervision available.
3. evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
  - i. Supervision for critically ill patients is provided by on-site ICU fellows or faculty. An ICU faculty member will be available to call within 5 minutes and will be onsite within 30 minutes when they are the scheduled ICU attending.
4. management of patients in cardiac or respiratory arrest (ACLS required)
  - i. all residents will be ACLS certified . The code team will provide initial management of any patient in cardiac or respiratory arrest and care will be transferred to a senior surgical person per JHH policy.

## **b. Procedural Competencies**

All procedural competencies will be supervised by a more senior resident (PGY II-V) or appropriately qualified and credentialed substitute, until the intern has been directly observed to be competent to perform the procedures below the number of procedures observed may vary except as noted below.

1. carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
  - i. An intern must be supervised until they have been certified for independence per JHH VAD policy.
2. repair of surgical incisions of the skin and soft tissues
3. repair of skin and soft tissue lacerations
4. excision of lesions of the skin and subcutaneous tissues
5. tube thoracostomy
6. paracentesis
7. endotracheal intubation
8. bedside debridement

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3. Guidelines for circumstances and events in which trainees must communicate with appropriate attending faculty members are separately listed.

B. The following site-specific faculty supervision requirements are applicable.

1. Inpatient Services: A patient care team that may include medical students, interns, residents and fellows, under the supervision of a faculty physician, shall care for patients admitted to the service. Decisions regarding diagnostic tests and therapeutics, although initiated by housestaff, shall be reviewed with the responsible faculty member during patient care rounds.

Patients shall be seen by the responsible attending and their care shall be reviewed at appropriate intervals. The attending shall document his/her involvement in the care of the patient in the medical record. Housestaff members are required to promptly notify the patient's faculty physician in the event of any controversy regarding patient care or any serious change in the patient's condition.(see separate specifics)

Faculty members or their designees (covering physicians) are expected to be available, by telephone or pager, for housestaff consultation 24 hours per day for their term on service, on-call day or for their specific patients.

2. Adult and Pediatric Emergency Departments:  
The Trauma, Acute Care and Emergency General Surgery Service will have an in-house faculty member at all times, with a published back-up faculty call schedules (QGenda)
3. Clinics and Consultation Services:  
In clinics and consultation services, a faculty member must review overall patient care rendered by housestaff.
4. Intensive Care Units:  
In intensive care units, housestaff decisions regarding patient care, including admission, discharge, treatment decisions, performance of invasive procedures and end-of-life decisions are to be discussed and reviewed by faculty.
5. Supervision of Housestaff in Operating Suites:  
In the operating suites, a surgical faculty member is responsible for the supervision of all operative cases. A surgical faculty member shall be present in the operating room with housestaff during critical parts of the procedure. For less critical parts of the procedure, a surgical faculty member must be immediately available for direct participation.

**V. MONITORING COMPLIANCE BY THE DEPARTMENT**

1. The quality of housestaff supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the housestaff's evaluations of their faculty and rotations, review of ACGME surveys and the GMEC's internal reviews of programs. During the Internal Reviews of programs, the GMEC shall request that each program provide a description of the procedures to ensure supervision in the program's clinical settings (including nights and weekends), an explanation as to how the program monitors compliance with its supervision policies, a description as to how the program becomes aware of and responds to exceptions or critical instances of breakdown of supervision and the mechanisms the program has in place to ensure accessibility and availability of faculty.
2. For any significant concerns regarding housestaff supervision, the respective program director shall submit a plan for its remediation to the GMEC for approval and the program director may be required to submit progress reports to the GMEC until the issue is resolved.

# Senior Supervisor Policy

## **When is a call required?**

When an intern receives notice from nursing staff about one of the conditions below, they must **immediately notify the senior resident assigned to supervise them** while they go to evaluate the patient, and **the supervision must be in person**:

- Hypotension/hypertension (SBP <90 or SBP >170)
- Oliguria (UOP<30ml/kg) or anuria
- Cardiac arrhythmias (HR >120 or HR <50 or dysrhythmias such as a-fib)
- Hypoxia (O2 sat <90%)
- Concerning change in respiratory rate
- Change in neurologic status
- Concern for compartment syndrome

Senior supervisors may be called for ANY concerns about a patient rather than only those on the list above. For problems not on the list, the intern is permitted to see the patient independently first and formulate an assessment. Routine updates (CT scans, lab results, etc.) should still be communicated to the service chief without the need to involve the senior supervisor resident. *Updates on issues requiring supervision should also be relayed to the service chief with the guidance of the senior supervisor resident.*

## **Who is the senior supervisor to call?**

There are several services at JHH without in-house senior coverage at night: the GI services (Eckhauser, Cameron Red/Gold, Cameron Green, Cameron Blue, MIS, Colorectal, and Handelsman GI; all covered by GI Fire at night), as well as Vascular, Transplant, Thoracic, and BEM. All issues requiring direct supervision for these services should be immediately relayed to the senior resident designated for in-house senior supervisor call (listed on New Innovations). This call is set up for all days in July/August when a PGY1 is covering overnight on one of the above services (i.e. Sunday through Friday). The hours for the senior supervisor call coverage are:

- Monday-Friday: 5PM to 5AM
- Sunday: 10AM to 5AM

**\*\*\*Senior supervisors must write their name/phone number on the board in Z6 at the beginning of their senior supervisor shift\*\*\***

**For Halsted, GPS, and Bayview there is already a senior level resident or fellow in the hospital, and the interns should relay all issues requiring direct supervision to the in-house senior resident/fellow. The senior resident/fellow must come to the bedside and supervise the intern's assessment of the patient for any of the conditions listed above.**

*During the daytime, including Sunday mornings before 10 AM, interns are supervised by the seniors on their teams or by the fellow or attending who works directly with that service. **Again, during the daytime, the senior resident/fellow on the service must come to the bedside and supervise the intern's assessment of the patient for any of the conditions listed above.***

### **How do interns achieve competency?**

In order to demonstrate competency, Dr. Lipsett will give a session on common clinical problems as well as a practical evaluation. These sessions will occur during the first module of intern labs in July (all interns must attend and will be assigned to one of these sessions). The final demonstration of competency will occur when the intern successfully passes a written intern competency examination (~20 questions). The deadline to pass the intern competency exam is **August 15th**.

The senior supervisor calls are scheduled to extend until Aug 31st, but of course most of the interns will have demonstrated competency before this. We encourage the interns to take the intern competency exam as soon as possible after attending the critical care lab session. This will offer the interns independence in evaluating patients, and also free up senior residents from taking senior supervisor call so that they can operate and participate in the activities of their services instead of being post-call the following day. **For senior residents, taking senior supervisor call means you must go home post-call the following day. If assistance is needed with arranging coverage/case coverage for your service on your post-call day, let Admin Chiefs know.**

## **Policy for Mandatory Calls to Faculty**

A resident or fellow must **ALWAYS** call the attending physician with any and all of these issues.

**Every surgeon (general surgery) will be called about these things, no exceptions.** This is intended to remove the burden from the resident or fellow about deciding whether or not to call. Any service can "add" individually to this list, but the central list for the residency and fellowships in our department will be these conditions.

**The resident or fellow must personally call an attending physician for the following indications:**

- 1. Admissions or new consults**
- 2. Transfer of a patient to a higher level of care, or a patient's death**
- 3. Refusal of planned interventions, patient or family conflict, patient desire to sign out AMA**
- 4. Medical error which has resulted in an adverse outcome, patient harm, or conflict**
- 5. If an elective invasive procedure is planned, an attending must be aware before the procedure is performed. If an emergency procedure is indicated/performed, an attending must be called as soon as it is possible to do so.**
- 6. Critical change in a patient's condition, and/or loss of pulses, new neurologic finding.**

An ICU resident will notify the ICU attending and call the senior resident/fellow listed as being on call for the service (the senior resident/fellow on the service is then expected to call their surgical attending as required above).

All new fellows and residents are notified of these "mandatory calls to faculty" rules at the start of each academic year.

### Thursday Morning Protected Educational Time for Residents

	Intern and Resident Didactics 6:30-7:30 am (All residents attend)			Grand Rounds 7:30-8:30 am (All residents and faculty)		Resident Skills Lab 9am – noon (Select PGY 1-3 residents each week, not everyone)		
	Coverage for EPIC secure chat/first call	Coverage for consults or traumas	First start OR case pre-op/consent	Coverage for EPIC secure chat/first call	Coverage for consults or traumas	Coverage for EPIC secure chat/first call	Coverage for consults or traumas	Coverage for first start OR cases
<b>Halsted</b>	APP (with Dr. Stevens as backup)	Dr. Stevens	Attending	APP (with Dr. Stevens as backup)	Dr. Stevens	APPs or other residents on service not assigned to lab	Other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Bayview</b>	One junior for the red team, one junior for the blue team, alternating weeks of coverage within the team	Post-call senior resident	Attending	One junior for the red team, one junior for the blue team, alternating weeks of coverage within the team	On-call senior resident	Other residents on service not assigned to lab	Other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>ICU</b>	ICU fellows or attending	n/a	n/a	ICU fellows or attending	n/a	Other ICU residents not assigned to lab	n/a	n/a
<b>Breast</b>	Attendings will cover their own patients	On-call breast attending	Attending	Attendings will cover their own patients	On-call breast attending	Other residents on service not assigned to lab	Other residents on service not assigned to lab	Other residents on service not assigned to lab *7:30 am GSS cases on Thursdays will NOT be covered by residents
<b>Endocrine</b>	Endocrine fellow (Dr. Morris-Wiseman if fellow on vacation)	Endocrine fellow (Dr. Morris-Wiseman if fellow on vacation)	Endocrine fellow (Dr. Morris-Wiseman if fellow on vacation)	Endocrine fellow (Dr. Morris-Wiseman if fellow on vacation)	Endocrine fellow (Dr. Morris-Wiseman if fellow on vacation)	Other residents on service not assigned to lab	Other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Cam Green</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Cam Blue</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Cam Red/Gold</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Handy GI</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>MIS</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Ravitch CR</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab

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	Coverage for EPIC secure chat/first call	Coverage for consults or traumas	First start OR case pre-op/consent	Coverage for EPIC secure chat/first call	Coverage for consults or traumas	Coverage for EPIC secure chat/first call	Coverage for consults or traumas	Coverage for first start OR cases
<b>Eckhauser</b>	GI Fire Night APP	GI Fire Night APP	Attending	APP	APP	APP or other residents on service not assigned to lab	APP or other residents on service not assigned to lab	Other residents on service not assigned to lab
<b>Thoracic</b>	APPs	APPs and fellows	APPs	APPs	APPs and fellows	APPs or other residents on service not assigned to lab	APPs or other residents on service not assigned to lab	Other residents/fellows on service not assigned to lab
<b>Vascular</b>	APPs	APPs to triage consults	Fellow	APPs	APPs to triage consults	APPs or other residents on service not assigned to lab	Other residents/fellows on service not assigned to lab	Other residents/fellows on service not assigned to lab
<b>GPS</b>	NPs	Fellow	Fellow	NPs	Fellow	NPs or other residents on service not assigned to lab	Other residents/fellows on service not assigned to lab	Other residents/fellows on service not assigned to lab
<b>Transplant</b>	Outside rotator (Fellow if no outside rotator)	Outside rotator (Fellow if no outside rotator)	Outside rotator (Fellow if no outside rotator)	Outside rotator (Fellow if no outside rotator) *APPs arrive at 8 am	Outside rotator (Fellow if no outside rotator)	APPs	Other residents/fellows on service not assigned to lab	Other residents/fellows on service not assigned to lab
<b>Howard County</b>	Attending	On call attending	Attending	Attending	On call attending	Attending	On call attending	Other residents on service not assigned to lab

### Notes:

1. If an attending is designated to be signed in as first call during protected time, residents will be responsible for signing themselves OUT as first call and signing the appropriate attending IN as first call just prior to didactics starting at 6:30 am.
2. When attendings are signed in as first call, they will triage all secure chat messages.
3. If a true patient care emergency (e.g. a patient needing to go to the OR as level 1 or a patient acutely decompensating on the floor), the attending may use their discretion to call the chief resident on service during protected time.
4. GI Fire Night APP for surg onc/colorectal/MIS services will retain all service pagers when day shift interns arrive for sign out at 5 am. The GI Fire Night APP will take over first call at 6:30 am, and hand off service pagers and first call responsibilities to the service APP at 7 am.
5. When APPs arrive at 7 am on surg onc/colorectal/MIS services, they will sign themselves IN as first call.

# Johns Hopkins General Surgery Pregnancy, Parental Leave, and Extended Sick Leave Policy for Residents

The Department of Surgery aims to provide all trainees a safe and supportive environment for reproductive health needs, pregnancy, and parental leave across the timeline from preconception to postpartum and return to work, regardless of age, gender, ethnicity, level of training, disability, or sexual orientation. This policy applies to all parents independent of birthing parent status, and applies to pregnancy, surrogacy, foster care, or adoption. In the event of any conflict between this policy and the applicable law, residents will be afforded all rights required by law.

The Department of Surgery also aims to provide a supportive environment for trainees in the event of extended personal or family illness, including those unrelated to reproductive health.

This document lays out best practices as determined by the Johns Hopkins Department of Surgery based on iterative input from faculty and trainees. Use of all available time is allowed and encouraged; however, this may extend training time if the leave is greater than that allowed by the American Board of Surgery (or other respective subspecialty boards, if applicable).

These policies and practices are outlined with the implicit understanding that:

- 1) All Department of Surgery members, including faculty, staff, trainees pursuing parenthood and trainees not pursuing parenthood who may be impacted by colleagues' absence, are invested in providing a supportive and safe environment for peers.
- 2) All trainees who require coverage for clinical duties to ensure their own safety and health are doing so in good faith and will exercise professionalism in providing advance notice, understanding that providing advance notice may not always be possible.
- 3) Not all coverage needs can be anticipated. Faculty, residency/fellowship program leadership, and trainees will work together to address leave and coverage needs not outlined in this document.

## I. Preconception and Fertility Preservation

Surgical training is long and coincides with peak fertility and child-bearing years for many residents. As a result, it is essential that training programs have policies in place to minimize the impact of surgical residency on the ability of trainees to have children during or after training. The Johns Hopkins Department of Surgery is supportive of residents pursuing elective (also known as planned) fertility preservation and assisted reproductive technology (ART) during clinical or research time. This includes, but is not limited to, egg or sperm cryopreservation and in vitro fertilization (IVF). By nature, procedures and treatments for fertility preservation or infertility are unpredictable, time consuming, and emotionally and physically demanding.

Therefore, it is the policy of the Department and our residency programs that residents:

- 1) Have time off to attend necessary appointments for consultations, lab draws, imaging studies, and procedures related to fertility preservation or ART; and
- 2) Can pursue this treatment with the expectation of confidentiality beyond working with the Program Director and Administrative Chief residents to help coordinate scheduling, as outlined in this policy.

Anticipated accommodations that will be made to facilitate fertility preservation and ART include:

- 1) Co-resident coverage for rounding and first start cases to allow time for early morning appointments
- 2) Days off (sick leave) for relevant procedures, recognizing that the time needed will vary depending on the procedure and physician recommendations, and that the unpredictable nature of ART/IVF may necessitate absence on short notice for procedures
- 3) Flexibility to leave clinic or the OR for medication administration as needed

- 4) Option to avoid 24-hr calls/night float if anticipated to adversely affect cycle

This policy is intended to mitigate stress associated with family planning and infertility treatment for surgical residents and applies to both male and female residents. Residents are encouraged, if they feel comfortable, to share information regarding upcoming infertility or ART treatments as soon as they anticipate that they might need coverage to the Program Director and/or the Administrative Chief residents.

## **II. Adoption**

Residents who might be considering adopting a child during residency are recommended to contact the General Surgery Residency Program Director as soon as accommodations might be anticipated. The Johns Hopkins Department of Surgery is supportive of residents pursuing adoption during clinical or research time, and understands that this process can be unpredictable, time consuming, and emotionally demanding.

Therefore, it is the policy of the Department and our residency program that residents:

- 1) Have time off to attend necessary appointments required for the adoption process (including but not limited to court appearances, meetings with lawyers, home visits, physicals, etc.) and
- 2) Can pursue this process with the expectation of confidentiality beyond the Program Director and the Administrative Chief residents to help coordinate scheduling.

Anticipated accommodations that will be made to facilitate residents in the process of adoption:

- 3) Co-resident coverage for rounding and cases (at any time of a shift) to allow time for appointments that might be hard to schedule outside of a working day,
- 4) Days off (personal days) for relevant appointments, home visits, etc. recognizing that the time needed will vary.

## **III. Early Pregnancy: 1<sup>st</sup>- 2nd Trimesters (through 28 weeks gestation)**

### Program Director(s)

We recommend that trainees contact the General Surgery Residency Program Director as soon as accommodations are desired. While the timing is entirely up to the resident, initiating this process as early as possible will help facilitate desired accommodations. Discussions about accommodations will remain confidential except as explicitly discussed. This applies to birthing and non-birthing parents and for trainees pursuing preconception treatments, fertility preservation, pregnancy, surrogacy, foster care, or adoption.

### Administrative Chiefs

We suggest informing the Administrative Chiefs as early as the resident feels comfortable to inform them of the due date and desired/anticipated schedule changes (such as call schedule changes and block schedule changes). The Administrative Chiefs (under the direction of the Program Director) will help facilitate schedule changes as needed based on the accommodations and leave plan arranged by the resident and Program Director(s). The Office of Institutional Equity will be enlisted to assist with reasonable accommodations as needed. These discussions will remain confidential to the fullest extent possible to allow for colleagues to be adequately informed of schedule changes.

## **Accommodations During the 1st and 2nd Trimesters**

### General OR Accommodations

Pregnant residents may require accommodations in the operating room to manage nausea, remain adequately hydrated, get consistent nutrition, and use the restroom. Residents are encouraged to inform the attending surgeon(s) on a given service ahead of the rotation for anticipated accommodations. The Program Director can help with this communication at the discretion of the resident. We encourage attending surgeons aware of a resident's pregnancy to encourage the resident to take regular breaks. Having a "back up" resident available to step in is helpful if available, but not required. Pregnant residents are encouraged to inform the rest of the team in the operating room of their pregnancy to minimize other unknown risks such as inhalation agents and the electrosurgical smoke plume.

### HIPEC Cases

**Pregnancy:** Resident may participate in the cytoreductive portion of the operation but should not participate in the infusion or closure afterwards. A mid-level or junior resident on service should join for the second half of the case, and the pregnant resident can cover other clinical duties.

**Lactation:** There is no clear data on HIPEC exposure and lactation. Overall, the risk is low when using the closed approach to infusion and all standard precautions are taken. The resident may discuss with the attending whether any additional precautions need to be taken. If desired, the resident is excused from the infusion and closure.

### Endoscopy/Fluoroscopy

Efforts should be made to minimize pregnant residents' radiation exposure, by adhering to ALARA principles and/or by avoiding portions of procedures involving fluoroscopy/endoscopy that are not critical to the educational process.

At the start of pregnancy, it is recommended that the trainee contact the Radiation Badge Office to obtain a second dosimeter which should be worn **under** the lead at the level of the abdomen during fluoroscopy/endoscopy cases. This will be monitored on a monthly basis to assess for fetal radiation exposure and can be done independently of the training program itself to maintain privacy.

### Other Oncologic Therapeutics

Some intralesional therapies used in surgical oncology clinics (such as oncolytic virus) carry hypothetical risk to immunosuppressed persons. As a general precaution, any person who may be pregnant should not be exposed directly to these agents as transmissibility or impact on the developing fetus has not been defined. Residents who are preconception, pregnant, or lactating may observe but should avoid handling these agents or performing any wound care to treated fields in the 7 days following therapy. Attendings administering these therapies should inform any trainees assisting with the care of intralesional treated patients that these restrictions exist.

### Call Schedule/Night Call

The data on miscarriage and preterm delivery suggest a small to moderately increased risk related to night shift work, heavy lifting, and prolonged standing. However, studies are severely limited by their observational nature. Given this, the program will make accommodations in the schedule to reduce night and 24-hour call for the pregnant resident **if requested** during the 1<sup>st</sup> trimester. The Office of Institutional Equity will be enlisted to assist with reasonable accommodations as needed.

### Prenatal Appointments

We support birthing and non-birthing parents to attend prenatal appointments, ultrasounds, and procedures for pregnancy, surrogacy, or adoption. The resident should provide advance notice of anticipated absences or accommodations when possible. The resident should inform their team and the attending surgeon at the start of the rotation or as soon as possible of any anticipated appointments. The resident should be excused with adequate time to travel to appointments and back. We recognize that additional appointments may be needed depending on the individual circumstance. Unanticipated visits should be communicated with the chief resident or attending, with the clear understanding that the pregnant resident is excused as needed to attend appointments. Appropriate communication with the chief resident or attending is expected. Residents should make an effort, when possible, to schedule appointments during less busy clinical or operative days to limit missed educational opportunities.

For services that have PA or NP support the residents should make individuals aware of any anticipated upcoming appointments as soon as possible to help facilitate coverage. Residents will not be expected to carry a service pager or be logged in and available on EPIC secure chat during these appointments.

## **IV. Late Pregnancy: 3<sup>rd</sup> trimester Accommodations**

### Call Schedule/Night Call

Birth parents with a scheduled block of nights past 30 weeks of pregnancy will have that block rescheduled by the Program Director to a different time period. For residents with scheduled blocks of nights during other portions of pregnancy, the resident may request moving blocks of nights to an alternate time in the schedule (for example, after returning to clinical work). This will be coordinated by the program to all extents possible.

Residents will not be scheduled for 24-hour in-house call after 30 weeks of pregnancy. Call shifts that would normally be 24-hours will be divided into two 12-hour shifts. Residents will not be scheduled for any in-house call shifts of any periods of time after 37 weeks of pregnancy. To reduce night home call, changes in the block schedule (for example, scheduling a rotation with multiple mid-level and senior residents towards the end of pregnancy) can be considered when the schedule allows.

### Prenatal Appointments

The same accommodations outlined in Section II for Early Pregnancy apply to the 3<sup>rd</sup> Trimester.

### Intraoperative Accommodations

The same OR accommodations outlined in Section II for Early Pregnancy apply to the 3<sup>rd</sup> Trimester, including General OR Accommodations, HIPEC Cases, and Endoscopy/Fluoroscopy.

### Delivery

We support and welcome any form of delivery based on the joint decision making between the pregnant resident and their medical provider, including spontaneous labor, induction, or C-section. We recognize that spontaneous labor may occur at any time and require unexpected backup.

### Managing Pregnancy Loss

Miscarriage is common during pregnancy, and unfortunately, more common for surgical residents. Miscarriage may require additional medical appointments or procedures. The program will coordinate coverage for any medical care that needs to be provided during this time.

In the event of a miscarriage, the resident should contact the Program Director and/or designated leave advisor for assistance with coordinating time off (sick leave and/or personal leave). The department expects and supports that residents will take time off with no clinical duties in the event of a miscarriage for physical and emotional health, regardless of the timing of when the miscarriage occurs during pregnancy and whether or not the resident had disclosed the pregnancy to program leadership before the miscarriage event.

## **V. Parental Leave and Postpartum Planning for Parental Leave**

The Department of Surgery supports both birthing and non-birthing parents, regardless of gender, to take as much time as desired for parental leave for pregnancy, surrogacy, adoption, or foster care up to a maximum allowed by state and federal policies with the following general considerations: 1) The American Board of Surgery, 2) Maryland (MD) State Programs/Benefits, and 3) Johns Hopkins University School of Medicine Benefits. These three organizations offer differing levels of protected time/funding and differ for birthing vs. non-birthing parents. Therefore, each resident will determine the right combination of leave length and types of leave for them based on their preferences, financial situation, and childcare situation.

The Department supports the American College of Surgeons recommendation of a minimum of at least 6 weeks of parental leave for all new parents regardless of gender, including both birthing and non-birthing

parents.

The Department encourages new parents to take additional leave beyond the recommended 6 week minimum as desired, understanding that this may require extension of training and a portion of this leave may be unpaid. Accommodations will be made whenever possible to allow a resident to enter or leave academic development time early to help facilitate that resident's desired duration of parental leave, although in some situations this may not be possible.

We also recognize that pregnancy and the post-partum period can be unpredictable and unanticipated changes may occur requiring modification of the resident's parental leave plan. The resident, to the best of their ability, should inform the program as early as possible of their desired leave time and any accommodations that may be made towards the end of pregnancy. To the extent possible, the earlier the resident notifies the program, the better prepared the program can be to meet the educational needs of the resident and ensure coverage for patient care.

The resident can seek assistance from the Program Director, Program Coordinator(s), and the GME office regarding what types of leave are available and the ABS Requirements. The resident is then entitled to take the desired length of parental leave in accordance with federal/state/Johns Hopkins University School of Medicine (JHUSOM) leave policies. Links to the JHUSOM GME policies can be found below:

<https://www.hopkinsmedicine.org/som/gme/residents-fellows#contracts-policies>

Specifically the policies below are applicable for extended and parental leave:

- Health Care and Sick Leave Policy for Postdoctoral Trainees (SOM)
- [JHU Postdoctoral Fellows policy](#)
- New Child Accommodations for Full-time Graduate Students and Postdoctoral Trainees (JHU)

Per the JHUSOM GME policies, the sum of health care and sick leave that will be granted with pay is a maximum of 13 weeks per training year and cannot be carried over from one training year to subsequent years.

American Board of Surgery (General & Vascular Surgery)

Except as outlined in the table below, the ABS requires 48 weeks per year of full-time clinical activity. The remaining four weeks of the year are considered non-clinical time that may be used for any purpose, such as vacation, conferences, interviews, etc. The exact ABS policies are listed in the table below but are also summarized for clarification in bullet points. **As a reminder, these policies enable a resident to complete their clinical training in 5 years and still be board eligible. Residents may always take additional leave if necessary or desired, but they will have to make up that clinical time (at the beginning/end of research years or in July/August at the end of their chief year) if they want to complete residency in 5 years and be able to sit for boards.**

\*copied from the ABS website on leave: <https://www.absurgery.org/resources/abs-policies/policy-leave/>

<b>ABS General Surgery Family Leave Policy</b>	Residents may take documented leave for 6 weeks to care for a new child, whether for the birth, the adoption, or placement of a child in foster care; to care for a seriously ill family member (partner, child, or parent); to grieve the loss of a family member (partner, child, or parent); or to recover from the resident's own serious illness.
<b>Additional Leave for Significant Life Events</b>	Residents may take an additional four (4) weeks off during the first three (3) years of residency, for a total of 140 weeks required, and an additional four (4) weeks off during the last two (2) years of residency, for a total of 92 weeks required. This allows for six (6) weeks of leave for significant life events while preserving two (2) additional weeks for vacation or other uses, as approved by the residency program. No additional ABS approval is needed for this option if taken as outlined. Residents are still required to complete a minimum of 48 weeks of Chief Resident rotations, however, with advance planning, some PGY-4 rotations may be counted towards this requirement.

<b>Extending Chief Year</b>	The ABS will permit, with advance approval, applicants to extend their final year of training through the end of August and still take that year's Qualifying Exam (QE). Upon completion of training, a letter of attestation will be required from the program director stating that the individual has met ABS requirements. The attestation letter must be received by the ABS before registration for a Certifying Exam date is permitted. In addition, prior approval from the RC-Surgery may be needed for the increase in complement.
<b>"5 in 6" years</b>	If permitted by the residency program, the five clinical years of residency training may be completed <b>over six academic years</b> . All training must be completed at a single program with <b>advance approval from the ABS</b> . In this option, an average of 48 weeks of full-time training is required in each clinical year as explained above. The first 12 months of clinical training would be counted as PGY-1, the second 12 months as PGY-2, and so forth. No block of clinical training may be shorter than one month (four weeks). Under this option, a resident may take <b>up to 12 months off</b> during the six-year training period. Use of the six-year option is solely at the program's discretion, and contingent on advance approval from the ABS. The option may be used for any purpose approved by the residency program, including but not limited to, family issues, visa issues, medical problems, maternity leave, external commitments, volunteerism, pursuit of outside interests, educational opportunities, etc.

General Surgery Residents at JHUSOM currently receive 3 weeks of vacation as a PGY1 and 4 weeks as a PGY 2-5 (divided normally into two 2-week blocks)

- Per ABS requirements, residents may take an additional 4 weeks off at one point during years PGY1-3, and an additional 4 weeks off at one point during PGY 4-5 (this is in addition to the 4 weeks of vacation that PGY 2-5 receive) without needing to make up any clinical time and still be eligible to sit for boards after graduation in June. These weeks do not need to be consecutive.
- Residents may combine weeks of their vacation to this 4-week block to have a consecutive time period of 6 weeks off.
- If residents are anticipating that they will want to complete their clinical training and be board eligible at the end of 5 years **AND** they might utilize more time than outlined above, they are encouraged to talk to the Program Director ASAP. The transition schedule when residents are returning from their research years can in some circumstances be pre-approved to count as additional clinical weeks if a resident feels they are likely to pursue extended leave after research.

#### Additional Leave Considerations

**No "Make-Up Call":** Residents taking protected leave time (FMLA) will not be required to "make-up" call missed during their scheduled leave. This applies particularly to call scheduled in addition to regular clinical duties such as trauma call coverage by senior residents and consult call coverage by junior residents. The program will communicate with affected residents the planned schedule changes. Residents can choose when to start the leave (i.e. does not need to be immediately after delivery for paternity leave or non-birthing parents).

Residency training extensions need to be pre-approved by the ABS.

Residents should notify the Johns Hopkins GME disability leave company of the date of birth and route within 24 hours of delivery, according to GME policy.

#### Postpartum Mental Health

We recognize the unique challenges, stressors, and mental health issues that can arise in the postpartum period for men and women, including fatigue, sleep deprivation, anxiety, and post-partum depression. Schedules will be modified as possible to allow residents returning from parental or medical leave – regardless of gender or

birthing status – to rotate on services with more scheduling flexibility, which have been identified for both junior and senior resident levels based on resident survey feedback.

Residents who may require additional leave for their postpartum mental health are strongly encouraged to do so.

#### **IV. Returning to Clinical Activity**

##### How/When to Express Your Anticipated Return to Work Date

We suggest you discuss various options for parental leave and returning to work with the Program Director, Program Coordinator, and/or Admin Chiefs as early as you feel comfortable discussing this. A second meeting should take place during the 3<sup>rd</sup> trimester to solidify an anticipated return to work date.

##### Requesting Changes to Anticipated Return to Work Date

The program understands that the birthing process and outcomes can be unpredictable. The program will work to be fluid and accommodating to each resident's individual circumstances. In the event that there is a change to your anticipated return to work date for any reason, please contact the Program Director who will aid in navigating that process.

##### Accommodations Upon Returning to Clinical Duties

As during pregnancy, it is expected that parents may require accommodations upon returning to clinical duties, and effort will be made to accommodate requests to start or not start on a particular rotation upon return to clinical duties.

##### Lactation

Our policy on lactation will be in accordance with the department's lactation task force guidelines. Residents may excuse themselves from non-critical portions of a case for lactation purposes. If there are any lactation related concerns, e.g. lack of access to refrigerator, lack of access to a private and clean place to pump, or discomfort in excusing oneself from clinical duties for lactation, please contact one of the designated leave advisors.

Current locations of lactation rooms relevant to general surgery residents: (full list can be found at <https://hr.jhu.edu/benefits-worklife/family-programs/new-expecting-parents/lactation-support/>). It should be emphasized that residents need to register to use and access to these lactation rooms in advance (the website states it might take a week or so to get access added to existing ID cards). The Department recommends submitting a lactation request (<https://hr.jhu.edu/benefits-worklife/family-programs/new-expecting-parents/lactation-support/register/>) as soon as residents anticipate they might wish to utilize these rooms in the future. The below list is not exhaustive of all lactation rooms but includes those that might be most pertinent to general surgery residents. A full list can be found at the link above.

#### **East Baltimore**

Johns Hopkins Outpatient Center (JHOC), Rm. LL231B

Zayed Tower, Rm. 6-013

Weinberg Building, Rm. 2339

Halsted, Rm. B-186

Bloomberg Children's Center (Vending), Rm. 4462

Green Spring Station Pavilion II, Suite 265

## **Bayview**

A Building, Rm. A118F

Burton, 1<sup>st</sup> Floor, Rm. 1437

Francis Scott Key Pavilion (Vending), 1<sup>st</sup> Floor, Rm P01-2-12D)

Francis Scott Key Pavilion, 5<sup>th</sup> Floor, Mamava Pod

## **Howard County**

\*\*Available upon request\*\* 2<sup>nd</sup> floor; 410-740-7830, contact Deb Schinner or Morgan Risley

### Wearable pumps

The Johns Hopkins GME Office is currently loaning out wearable breast pumps for up to 12 months after return to work from the birth of a child. Information below:

“Elvie Wearable Breast pumps will be available on a loaner basis. We recognize that standard breast pumps are more effective in expressing milk and are completely supportive of your taking time out from your clinical schedules to do so. However, we heard that sometimes you want other options too. For those of you in the OR or in procedural areas, you may not want to scrub out to pump. For others, a wearable breast pump may simply be more convenient. For that reason, we will offer loaner wearable breast pump to augment your use of your standard breast pump. Our expectation is that this will allow you more freedom to choose when and how you pump.”

Email Laura Hanyok ([lhanyok2@jhmi.edu](mailto:lhanyok2@jhmi.edu)) for more information.

### OBGYN and Pediatrics Appointments

The Department encourages residents to take time for postpartum and pediatric healthcare appointments. The process to request time off to attend appointments is the same as outlined in Section II for prenatal appointments. This notification process can be done directly to the Admin Chiefs by you or via the Program Director on your behalf. Additionally, as stated above, on services with PA or NP support the residents should make individuals aware of any anticipated upcoming appointments as soon of possible to help facilitate coverage. Residents will not be expected to carry a service pager or be logged in and available on EPIC secure chat during these appointments.

## **V. Coordination**

The policy for ensuring a safe and supportive pregnancy for new parents in the general surgery training program at Johns Hopkins has been segmented by the stage of pregnancy to better serve the needs of trainees during the pregnancy timeline. However, there are some overarching themes that are important to address throughout the entire process.

It is essential to ensure that the stated policies are in line with the current policies of the Johns Hopkins University School of Medicine, the American Board of Surgery, and other applicable organizations that oversee the certification of surgical trainees. Approval will be obtained by the Program Director from the American Board of Surgery when a resident requests extended leave to ensure that trainees are provided with accurate information and do not risk having their training/certification unknowingly delayed. The policies in this document

will be reviewed and updated periodically to reflect any changes in the policies of the aforementioned organizations. All residents must meet duty and work hour rules (no more than 80 hours/week averaged over 4 weeks, 1 day off in 7 averaged over 4 weeks).

**Training Sites**

It is the expectation of the Department, and the residency training program, that this policy is followed at all training sites where surgical residents rotate (Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, etc.).

### **Coverage**

This document identifies multiple instances for which expectant parents, new parents, those pursuing fertility preservation, or related treatments, will need time off for scheduled appointments or other accommodations. There are also unplanned instances in which residents may need additional time off for personal or family medical reasons. Non-birthing parents should also be afforded time off to be present with their partners during this time. This coverage will be arranged by the program in conjunction with the Admin Chief(s) and Program Director. Trainees are not expected to find their own *ad hoc* coverage for these events (planned or unplanned) in order to:

1. Eliminate the perception of trainees creating additional work for their colleagues
2. Normalize the culture of asking for help and coverage to ensure a safe and supported pregnancy
3. Encourage trainees to attend all of the necessary and recommended appointments to ensure a safe pregnancy

The Department intends to use all available departmental resources (within reason) to support residents who are participating in unexpected or extended coverage to ensure the safety and health of their colleagues on leave, including but not limited to:

1. Providing as much advance warning as possible for schedule changes related to coverage
2. Distributing schedule changes among clinical residents in a predictable, equitable, and transparent fashion
3. Devoting financial resources to physician and/or advanced practice provider moonlighter coverage to help fill coverage gaps where feasible and appropriate
4. Actively re-evaluating existing coverage strategies on an ongoing basis based on faculty, resident, and advanced practice provider feedback

	Detailed Examples	Potential Barriers and/or Pitfalls
<p><b>Providing as much advance warning as possible for schedule changes related to coverage for extended leave</b></p>	<p>Coverage for residents on extended leave anticipated before an annual block schedule is created will be accommodated without use of “at risk to be pulled” residents as possible (for example, by):</p> <p>1) limiting redundant junior or senior coverage on services that may have flexible resident assignments [e.g., Halsted, Transplant, BEM]</p> <p>2) by assigning fellows to services during anticipated senior resident leave to minimize educational gaps or unwanted repeat rotations for senior residents [e.g., Surgical Oncology Services, Halsted])</p>	<p>Advance warning is not always possible and must be balanced with valid concerns regarding the confidentiality of residents who are pregnant, in the process of adoption or fostering, undergoing elective fertility preservation or infertility treatment, or require other personal or family medical leave</p>
<p><b>Distributing schedule changes among clinical residents in a predictable, equitable, and transparent fashion</b></p>	<p>Junior and senior “at risk to be pulled” assignments will be established for at the time of initial schedule distribution each year. This will be denoted on the block schedule with an * next to the block.</p> <p>“At risk to be pulled” assignments will be equally distributed among residents to the extent possible, given expected variations in scheduling for each individual resident</p> <p>Unless explicitly requested by a covering resident, no “at risk to be pulled” assignment will be more than 2 weeks’ continuous duration</p> <p>Unless explicitly requested/agreed upon by the covering resident as part of a change in 4- or 6-week block schedules, no late-notice coverage reassignment will be more than 2 weeks’ duration</p> <p>Residents may have the opportunity to request rearranging “at risk to be pulled” assignments before the academic year begins if they are concerned about potential missed educational opportunities (e.g., subspecialty or out-of-institution electives)</p>	<p>“At risk to be pulled” assignments will unavoidably overlap with elective and less-rigorous rotations in which residents are less central to clinical care (e.g., endoscopy, Howard County, elective time)</p> <p>Even with “at risk to be pulled” assignments in place, there may still be circumstances in which changes to “non- at risk to be pulled” resident schedules are needed to provide coverage, either for resident health and safety or to maintain appropriate patient care</p>

<p><b>Using existing ad hoc case coverage mechanisms rather than resident reassignments when possible and appropriate</b></p>	<p>In scenarios in which coverage can be managed using ad-hoc case coverage rather than resident reassignments (e.g., for anticipated frequent appointments, to supplement junior or senior resident coverage on services with multiple residents), existing mechanisms will be used when appropriate to cover cases without disrupting existing block schedules</p> <p>This policy should also stand as first-line for coverage for short-term leave, frequent appointments, and last-minute unanticipated appointments</p> <p>Residents are encouraged to use these mechanisms to arrange for lactation/pumping breaks</p>	
<p><b>Physician and/or advanced practice provider moonlighter/ “additional shifts” coverage to help fill coverage gaps where feasible and appropriate</b></p>	<p>Junior resident coverage gaps (e.g., GI fire nights, BEM, Halsted, Bayview) may be appropriate to fill with a combination of “at risk to be pulled” residents and APPs to limit schedule disruption of junior residents on other services; appropriateness of this coverage solution will be decided on a service-by-service basis and may not be feasible if there is insufficient moonlighter/“additional shifts” coverage available</p> <p>Certain rotations with multiple senior-level residents who take in-house call (primarily Halsted, Bayview) may be feasibly covered by one fewer on-service senior resident if senior-level moonlighting/“additional shifts” coverage for overnight calls can be obtained 1-3 days per week; appropriateness of this coverage solution will be decided on a service-by-service basis and may not be feasible if there is insufficient moonlighter/“additional shifts” coverage available</p>	<p><b>Budgetary constraints may limit funding/feasibility of using moonlighting or “additional shifts” mechanism as a source of coverage</b></p> <p>Division Chiefs will need to approve the use of moonlighters/“additional shifts” coverage in their respective divisions</p> <p>APP/moonlighter/“additional shifts” coverage availability – <i>APPs and moonlighters/“additional shifts” coverage should not feel coerced to cover when it interferes with their personal or other academic/professional obligations</i></p> <p><b>If funding is available, current clinical residents MAY be eligible to provide call coverage for extended leaves and be compensated via the “additional shifts” mechanism. To qualify for “additional shifts” coverage, residents must have the same level of clinical responsibilities and supervision as they would have at their current PGY level. Any hours worked as “additional shifts” must be logged as such in New Innovations, and count towards duty hours. Residents working “additional shifts” must still remain in compliance with all ACGME duty hour rules.</b></p> <p><b>If funding is available, residents in academic development time (research residents) MAY be eligible</b></p>

		<p><b>to provide call coverage for extended leaves and be compensated via the moonlighting/“additional shifts” mechanism as long as they have medical liability coverage to do so. To qualify for moonlighting/“additional shifts”, research residents must have the same level of clinical responsibilities and supervision as they would during the routine clinical training they have completed to date (either PGY2 or PGY3, depending on whether they began academic development time after their PGY2 or PGY3 clinical year).</b></p> <p><b>Residents on J1 (but NOT H1B) visas are eligible to cover “additional shifts” or moonlight.</b></p>
<p><b>Actively re-evaluating existing coverage strategies on an annual basis based on faculty, resident, and advanced practice provider feedback</b></p>	<p>Feedback on resident coverage strategies will be elicited as part of chief resident exit interviews. Residents in their junior, senior, and academic development time will have the chance to provide structured feedback about the coverage process at the end of each academic year, whether or not they personally took leave or were involved in coverage for a co-resident on leave.</p>	<p>There will almost certainly be unintended consequences and unanticipated failures of these measures, and flexibility to alter these policies is understood to be both necessary and beneficial to optimizing resident health and safety. Resident preferences and needs may evolve over time in the same way residency training evolves, and active policies should reflect these changes.</p>

