

RESIDENCY MANUAL AND
CURRICULUM

2009-2010

ALBANY MEDICAL COLLEGE
DEPARTMENT OF SURGERY
DIVISION OF GENERAL SURGERY

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INTRODUCTION

“Let the surgeon be bold in all sure things, and fearful in dangerous things; let him avoid all faulty treatments and practices. He ought to be gracious to the sick, considerate to his associates, cautious in his prognostications. Let him be modest, dignified, gentle, pitiful, and merciful; not covetous nor a extortionist of money; but rather let his reward be according to his work, to the means of the patient, to the quality of the issue, and to his own dignity.”

Guy De Chauliac, 1360

You have chosen to enter a career in surgery, and no educational experience will be more gratifying than the successful completion of your training. As a practitioner, you will find that there is no profession in the world that carries more responsibility than that of surgeon. Through your actions, patients will survive or die, be relieved or suffer, be satisfied or angered. Success in your future career will be determined by your training as a resident and continued self-education as a practitioner. Years from now, you will find that your undergraduate experiences in college and education in medical school will prove far less important than knowledge and skills you are about to acquire in residency.

The education of surgical residents is in the midst of significant change. The strict Halstedian format of surgical residency has giving way to a format dictated by the changing patterns in the delivery of surgical care, , societal expectations as well as the exploding information base on which care is predicated.

The material contained in this manual reflects the philosophical and procedural guidelines established by the American Board of Surgery and the Residency Review Committee for Surgery. **It is your responsibility to become familiar with these tenets and to continue to do so throughout the training period.** As particular regulations or emphases change you will be so notified.

A basic science curriculum is provided. This will be a guide to the topics covered in the basic science lecture series. A clinical curriculum is also provided. This will be a guide to topics in clinical surgery that will be covered in the clinical science didactic sessions. In addition, a set of goals and objectives for each clinical rotation is provided. This will clarify the learner objectives for various clinical areas to which you are assigned throughout the five years of the Training Program. Please review these objectives at the beginning of the rotations in each of the clinical areas. These objectives will also be emailed to you prior to beginning the rotation

In the section on credentialing, you will find the skills that should be mastered during the residency. You should become credentialed in most of these procedures at least by the end of the PGY-2 year.

Although the program will provide very adequate clinical training and didactic sessions for the complete education and training of a surgeon it is primarily the resident's responsibility to participate in the educational and training aspects of the residency as directed by the ABS and RRC. This manual is your guide in completing this task.

Questions regarding this information or any RRC requirement, may be directed to the Program Director or Program Coordinator.

STRUCTURE OF PROGRAM

Categorical Residents

Four categorical residents are accepted into the Program and will track thru the PGY-1 to PGY-5 years. Given acceptable clinical and academic performances all four residents are expected to complete the Chief Residency experience (PGY-5). One or two years of basic science or clinical research may be arranged commencing at the end of the PGY-2 training year. This leave must be arranged with the Program Director one year prior to the intended absence.

Each Junior Resident (PGY1 and 2) will rotate for one month periods thru all of the primary, secondary and tertiary areas in general surgery as well as plastic surgery, and cardiothoracic surgery. Goals and objectives for each clinical rotation can be found in this manual. These are provided to guide both the resident and rotation coordinator in what is expected both cognitively and procedurally from each clinical rotation.

Each Junior Resident (categorical) can expect rotation assignments to the following clinical areas:

PGY 1&2

ER

ICU

General Surgery (1&2)

Acute Care Surgery

Transplant

Vascular Surgery

Veterans Administration Medical Center

Plastic Surgery

Pediatric Surgery

Breast Surgery/ Endocrine Surgery (SCC)

Minimally Invasive Surgery/Endoscopy (simulator lab experience)

Each Senior Resident (PGY 3&4) will rotate through the following principle areas:

PGY-3

General Surgery - VAMC

Minimally Invasive Surgery- AMC

Acute Care Surgery - AMC

Pediatric Surgery-AMC

Transplant Surgery- AMC

PGY-4

Colo-rectal and Oncologic Surgery-AMC

General Thoracic Surgery - SPH

Vascular Surgery – AMC

General Surgery/Transplant Surgery- AMC

Chief Residents will be assigned as follows:

General Surgery 1/Transplant Surgery (serves as administrative chief)

General Surgery 2 Colorectal and Oncologic Surgery - AMC

Acute Care Surgery -AMC

Minimally Invasive, Vascular, Pediatric Surgery

OFFICE EXPERIENCE

The residency review committee has emphasized the importance of resident involvement in all aspects of care of the surgical patients. To quote, "Doing the operation is not surgical education". The resident must be involved in initial patient evaluation, pre-admission workup, admission procedures, pre-operative, and post-operative care, as well as post-discharge evaluation and care. Only in this way can a resident gain insight and skill in all those aspects of the delivery of surgical care required of the contemporary surgeon.

To this end, residents at **all levels** are required to participate in all aspects of patient care and to document the same. The RRC will disallow resident case experience which does not reflect this ongoing involvement. **The RRC has emphasized this point in regard to all residents at all levels of training.**

AMCH

It is an RRC requirement that all categorical and designated preliminary residents spend at least one half day each week in the offices of the surgeons with whom they work on a given rotation. As compliance with this regulation has not been met in the past Dr. Conti has developed a schedule of attendance for each level resident on each of the AMC services. If you assigned to a given service you **must** (note the emphasis and underlining) attend office hours with the named physician. Do not forget to complete the revised office attestation sheet and attach a list of patients seen with the names of patients with whom you were involved indicated by highlighting or underlining. Return these forms to the program coordinator as soon after the encounter as possible.

G1/Transplant

Junior residents – Thursday AM (new transplant patients for evaluation) with Dr. Conti
PGY4- Tuesday PM (access clinic)- alternates w Dr Beyer at SCC
PGY5 – Thursday AM with Dr. Stain, or PM with Dr. Hena

G2

Junior resident 1- Thursday AM with Dr. Lee
Junior resident2- Wed. PM with Dr. Valerian
PGY4 – all day Monday with Drs. Lee and Valerian
PGY5- all day Monday with Dr. Nigam

ACS

Junior resident 1–Thursday 11-3 with Dr. Bonville
Junior resident 2 – Wed. PM with Dr. Hesham
PGY3 Monday PM Dr. Rosati
PGY5 Wed PM with Dr. Rosati

Peds Surg

Junior resident – Tues AM with Dr. Whyte
PGY3 – Thursday with Dr. Whyte
PGY5 – Tuesday AM with Dr. Whyte

MIS

PGY3 - all day Tuesday and Thursday AM with Dr. Singh
PGY5 – Thursday AM with Dr. Singh

Vascular Surgery

Junior resident 1 – Friday AM with Dr. Shah
Junior resident 2 – Friday PM with Dr. Shah
PGY4 – Tuesday PM with Dr. Shah

South Clinical Campus

Monday- Dr. Hena OR, if no cases, Pietrocola office
Tuesday – Pietrocola OR all day
Wednesday – Pietrocola office all day
Thursday – Beyer OR
Friday – Private surgeons OR

General Thoracic Surgery

PGY4 will attend all office hours of Dr. Moores

Veterans Hospital

PGY 3, 2 and 1 assigned will attend all clinics scheduled

ATTESTATION OF OFFICE INVOLVEMENT

I, _____, acknowledge that I have seen,
(print name)

examined and discussed the indicated patients on the date indicated below.

(resident signature)

(date seen)

RESIDENTS: Please complete this form for each office activity you attend. Attach by staple the list of patients provided by the office staff. Return to Angelica Gana as soon as office hours are completed.

Tracking of Specialty Surgery Experiences

The RRC requires “participation in the overall management of patients with common problems in Urology, Gynecology, Neurological Surgery, Orthopedics, Burns and Anesthesia. **Formal rotations in these areas are not provided.** You will, however, have experiences in all of these areas during rotations to the Emergency Medicine Department, the Surgical Intensive Care Unit and while performing consultations on the wards. **It is extremely important that you document these experiences.**

Spread sheets will be provided so that you may tabulate these experiences throughout the five years of residency. A reduced sample follows. Additional copies may be obtained from the residency office.

Once you have completed one sheet please return it to the office for inclusion in your file. These forms will likely be reviewed by the RRC at the time of the site visit.

Experiences in specialty surgery should include (but are not limited) to the following:

Anesthesia

- 1) Endotracheal and nasotracheal intubations
- 2) Awake and rapid intubations
- 3) Assessment of suitability for general anesthesia with consideration of co-morbid factors
- 4) Assessment of post anesthetic problems, routine PACU assessment and care
- 5) Selection and use of local anesthetics
- 6) Use of neuromuscular blockade
- 7) Management of suspected malignant hyperthermia

Gynecology

- 1) Complete gynecologic assessment including history, physical exam
- 2) Evaluation of pelvic mass
- 3) Evaluation for ectopic pregnancy
- 4) Evaluation of pelvic inflammatory disease
- 5) Establishing a differential diagnosis for pelvic and abdominal pain
- 6) Evaluation and management of pregnant patient with abdominal pain

Burns

- 1) The management of minor second and third degree burns
- 2) Resuscitation of the severely burned patient
- 3) Wound management of the severely burned patient
- 4) Transfer of severely burned patient to appropriate facility

Neurosurgery

- 1) Evaluation and management of head injuries
- 2) Evaluation and management of cervical spine
- 3) Evaluation and management of increased intracranial pressure
- 4) Evaluation of patients in all states of consciousness
- 5) Performance of lumbar puncture
- 6) Evaluation of disc disease

Orthopaedic

- 1) Care of patients with acute trauma to musculoskeletal system in various settings
- 2) Care of patients with closed extremity fractures

- 3) Care of patients with open extremity fractures (debridement, reduction, fixation)
- 4) Immobilization techniques (casts, splints, etc.)
- 5) Care of dislocations
- 6) Care of compartment syndromes
- 7) Care and evaluation of minor orthopaedic problems (sprains, etc.)
- 8) Care of patient with back pain
- 9) Care of patient with pelvic fracture

Otolaryngology

- 1) Complete examination of head and neck with indirect laryngoscopy
- 2) Evaluation of airway problems
- 3) Evaluation of neck mass
- 4) Evaluation and treatment of epistaxis
- 5) Evaluation and treatment of facial trauma
- 6) Cricothyroidotomy
- 7) Intubations

Urology

- 1) Evaluation of patient with hematuria
- 2) Evaluation of patient with stone disease
- 3) Evaluation of patient with GU trauma (kidney, bladder, urethra)
- 4) Evaluation of patient with pelvic fracture and bladder/urethral injury
- 5) Evaluation of patient with blunt abdominal trauma with injury to GU system
- 6) Evaluation of patient with scrotal trauma, mass, pain, etc.

RESIDENT OPERATIVE RECORD

It is necessary for each resident to record each and every operative case. Ward or office procedures are exempted. Every case done in the operating room must be recorded. This tabulation must be submitted to the American Board of Surgery as you apply to sit for the Qualifying examination. The data is also submitted to ACGME RRC as evidence of your technical training as a General Surgeon. The data is reviewed by the Program Director at twice monthly intervals to insure a balanced and appropriate operative experience. The RRC tracks certain cases as DEFINED CATEGORY CASES. You must meet certain target numbers in these defined categories. These are listed below for your review. Please be aware that these are minimum numbers. Also provided is a listing of National Program Data. This lists the number of defined category cases required to achieve a given percentile of experience.

A word of warning is in order. Ideally, finishing Chief Residents should have approximately 1000 cases for total resident case experience over five years with under 350 in the chief year. Operative experience above this level indicates to the RRC that deficiencies in other important areas of surgical education must exist in the training program.

Each finishing chief must have performed at least 500 MAJOR cases during the 5 year resident experience. At least 150 must be performed during the Chief year. The following distribution is meant to set a **minimum**:

Soft Tissue and Breast	25
Head and Neck	24
Alimentary Tract	72
Abdomen	65
Liver	4
Pancreas	3
Vascular (other than aortic)	44
Vascular (aortic)	10
Endocrine	8
Trauma	30 (Includes operative and non-operative care of trauma patients)
Thoracic	15
Pediatric	20*
Plastics	5
Endoscopy	85 (50 colonoscopies, 35 upper endoscopies including PEG's)
Laparoscopic	85 (60Basic–cholecystectomy, appendectomy etc. and 25 Advanced)
Total Major	500
Total as Chief	150

You can see by the above that the RRC mandates a managed resident case experience. Too many cases in a given category is as undesirable as to few.

- see Pediatric Surgery section for details (*)
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Please note – as of July 2009 all applicants to the American Board of Surgery MUST produce evidence that they have completed ACLS, ATLS and FLS. There is no requirement to be currently certified at the time of application for examination

Please note that the ABS requires 25 critical care cases (not 20) – see below

We currently use the ACGME Case Log Reporting System. Input of cases into that system is the responsibility of the resident. **Please be concurrent in your record keeping.** It will serve you well in the final analysis. This Operative Log will serve many purposes as you transition from resident to practitioner. It is in your best interest to be accurate, complete and contemporaneous.

To enter cases:

- 1) Go to www.acgme.org
- 2) Click on “data collections systems” (left side of screen)
- 3) Click on Resident Case Log System
- 4) Click on Log In
- 5) Your user ID is your initials (first and last name only) in lower case letters followed by your four digit beeper number (no spaces)
- 6) The password is the same your user ID
- 7) Click on Case Entry Tab
- 8) Click on Procedure – add
- 9) Complete all boxes – for case ID use medical record number
- 10) To find an appropriate CPT code click on search (if you know the code you may skip this step and #11)
- 11) Type in a concise description of the case
- 12) Type in the appropriate CPT code in box
- 13) Click select
- 14) Put a check mark in the box next to “selected cpt code” for credit
- 15) Check or uncheck “involved trauma” box
- 16) Put a brief outcome statement in box
- 17) Click SAVE

As far as role assignment is concerned, only a chief resident may select “SURGEON CHIEF”, all other residents should select “SURGEON JUNIOR”. If you have only served as a first assistant as a junior resident, choose “FIRST ASSISTANT”. Seniors should not choose this option. Seniors and Chiefs may choose “TEACHING ASSISTANT” if you have served in that role. This would apply to a limited variety of cases only and only after you have met and exceeded the targets.

It is possible to record more than one CPT code for a given patient encounter. The code that is used as the primary CPT code will generate the credit for the case. Additional codes will record additional procedures performed at the time of the primary procedure. This is desirable as it creates a complete record of your experience and may be useful in the future to the program in adjusting your operative log.

THE CREDENTIALING PROCESS FOR RESIDENTS

The Hospital and the Residency Program require that each resident become credentialed in the performance of routine invasive procedures performed outside the operating room. Once a resident is so credentialed, he/she may perform an invasive procedure under the INDIRECT supervision and with the permission and approval of the attending surgeon. Of course, the patient must give permission for the procedure.

Following you will find a copy of the “POLICY OF THE ALBANY MEDICAL CENTER”. You should review this policy. You will be asked to sign this form at orientation attesting to your knowledge of and agreement with this policy.

Following you will also find a list of the procedures for which credentialing is available. The procedure for credentialing is as follows:

Procedure Name	Credential Target
Arterial Blood Gases	6
Arterial Catheter	6
Bladder Catheter	6
Central Venous Cath-Jugular	6
Central Venous Cath-Other	6
Central Venous Cath-Subclavian	6
I & D of Abscess	6
Lumbar Puncture	6
Nasogastric Intubation	6
Orotrachial Intubation	6
Paracentesis	6
Pulmonary Artery Catheter	6
Suture Simple Wound	6
Thoracentesis	6
Tube Thoracostomy	6
Venous Catheter	6
Flexible Sigmoidoscopy	6

- 1) Go to www.new-innov.com/suite
- 2) Institution password is AMC (all caps)
- 3) Type in user name – your first initial and last name, all lower case, no spaces.
- 4) Repeat your user name as password-if you choose to change a password don't forget to record it in a safe place.
- 5) Go to procedure logger at the left of the screen and click on it.
- 6) Click on log in the pull down menu.
- 7) Click on add new-the procedure screen will come up-you must complete all of the required fields.
- 8) Under group and procedure, check all procedures.
- 9) Go to the right and using the pull down menu, select the procedure you are seeking credit for.
- 10) A diagnosis is not required.
- 11) Select location.
- 12) Select role.
- 13) Select your supervisor.

- 14) Complete patient ID using.
- 15) Complete gender.
- 16) Complete date of birth of the patient
- 17) You may write a brief list of complications if any
- 18) Then click on save and clear.

TRACKING FOR SURGICAL CRITICAL CARE EXPERIENCE

The RRC mandates that residents track (using the ACGME website) both critical care experience and the care of patients with non-operative trauma.

- 1) Each resident will develop a log of **at least twenty five(note the change in numbers)** critical care patients who best represent the broad scope of critical care index management. These patients must be distributed over the 5-year residency experience.
- 2) Each of the patients listed on the log should include management of **at least two of the seven categories listed in #3.**
- 3) The completed logs should include experience, with **at least one patient in all seven of the following essential categories.**

- a) Ventilatory Management (>24 hours on ventilator)
- b) Bleeding (non-trauma patient >3 units)
- c) Hemodynamic Instability
- d) Organ Dysfunction/Failure (etiology/mode of management)
- e) Dysrhythmias
- f) Invasive Line Management and Monitoring
- g) Nutrition

Please use the following codes. You may use one or **more than one** code for each patient for each date.

99292V	Ventilatory Management (>24 hours on Ventilator)
99292B	Bleeding (non-trauma patient >3 units)
99292H	Hemodynamic Instability
99292O	Organ Dysfunction/Failure (etiology/mode of management)
99292D	Disturbance of cardiac rhythm
99292I	Invasive Line Management and Monitoring
99292P	Parenteral/enteral Nutrition

PEDIATRIC SURGERY CASES

Twenty Pediatric surgery cases are required in the following categories:

- 8 Inguinal and/or umbilical hernias
- 6 Appendectomy procedures (open or laparoscopic)
- 6 Additional procedures

TRACKING OF NON-OPERATIVE TRAUMA

The tracking of non-operative Trauma usesn CPT 99199. All data elements for identifying the patients encounter must be included.

The essential criterion for receiving credit for the management of non-operative trauma is that the patient had to be admitted to a special care unit (e.g. SICU). The resident who takes credit for the patient

management would be the most senior resident on the Trauma Service involved with the patient. AT LEAST TWENTY NON-OPERATIVE TRAUMA EXPERIENCES ARE REQUIRED. THESE MUST BE DRAWN FROM ALL FIVE YEARS OF RESIDENCY. It is important that you exceed this minimum

BREAST CASES AND SENTINEL NODE BIOPSIES

When entering breast cases into the ACGME log please code ALL lumpectomy with axillary dissection cases as code 19162 – exc bx/quadrant with axillary sampling. This is the ONLY way you will get defined category credit for these cases as the RRC code for partial mastectomy does not track to defined category credit.

To record a sentinel lymph node biopsy use CPT code 38525 and select breast as the option. You may also record exc bx/quadrant with axillary dissection(19162) for the same patient if a lumpectomy was performed in tandem. You must choose to receive credit for the sentinel node biopsy portion by checking the box. Although you will not be given credit for the lumpectomy portion it will be entered into the data base for retrieval at a later time if needed.

DEFINED CATEGORIES

The following list, by defined categories, includes all those cases considered Major by the RRC and eligible for inclusion on defined category tabulation. An asterisk identifies those cases that are to be excluded from this tabulation.

HEAD AND NECK

Resection of Lesions:
Lips
Tongue
Floor of Mouth/Buccal Mucosa
Parathyroidectomy
Resection of other Salivary Glands
Radical Neck Dissection
Resection of Mandible or Maxilla
Tracheostomy
Includes:
Thyroidectomy
Parathyroidectomy
Trauma to Area
Carotid Vasc. Procedures
Plastic
Pediatric Procedures

BREAST

*Biopsy
Simple Mastectomy
Modified Radical Mastectomy
Radical Mastectomy
Excisional Biopsy or Quadrant Excision with
Axillary Sampling
Breast Reconstruction

ALIMENTARY TRACT

Esophagus:

Esophagectomy
Esophago-gastrectomy
Antireflux Procedure
Esophageal Bypass Procedure
Repair of Perforation (esophageal disease)
Other Operations for Esophageal stenosis
Esophageal Diverticulectomy

Stomach:

*Gastrostomy (all types)
Gastric Resection, Partial
Gastric Resection, Total
Vagotomy, Truncal/Selective with Drainage or Resection
Repair of Perforation (gastric disease)
Proximal Gastric Vagotomy, Highly Selective
Gastric Reduction for Morbid Obesity (all types)

Small Intestine:

Enterolysis
Enterectomy
Repair of perforation (duodenal disease)
Repair of perforation (small bowel disease)
Ileostomy (not associated with colectomy)
Diverticulectomy

Large Intestine:

Appendectomy
Colostomy (all types)
Colostomy closure
Colectomy partial
Colectomy total or subtotal with ileostomy
Colectomy with ileo-anal pull-through
Colectomy with continent reconstruction
Abdomino-peritoneal resection
Repair of perforation (colon disease)

Ano-Rectal:

Hemorrhoidectomy (all types)
Sphincterotomy/sphincteroplasty
Drainage procedures for anorectal abscess
Repair of anorectal fistula
Other operations for anal incontinence
Repair of rectal prolapse
Pilonidal cystectomy

ABDOMEN

General:

Exploratory laparotomy exclusive of trauma
Drainage of intra-abdominal abscess
Pelvic exenteration
Major retroperitoneal/pelvic lymph node disease

Liver:

Lobectomy or segmentectomy
Wedge resection or open biopsy
Liver transplantation
Drainage of liver abscess
Repair traumatic injury

Biliary Tract:

Drainage of pancreatic abscess
Resection, distal
Resection, whipple
Resection, total
Pancreaticojejunostomy
Repair Traumatic injury

Spleen:

Splenectomy for disease
Staging Laparotomy

Hernia:

Inguinal-femoral (all types)
Ventral

SKIN AND SOFT TISSUE

Major Lymphadenectomies
Major Excision and Repair/Graft for Skin
Neoplasm
Radical Excision of Soft Tissue Tumor
Other Major

VASCULAR

Aneurysms:

Repair of Infrarenal Aorta, Emergent (ruptured)
Repair of Infrarenal Aorta, Elective
Repair of Suprarenal Aorta, Emergent (ruptured)
Repair of Suprarenal Aorta, Elective
Repair of Iliac, Emergent (ruptured)
Repair of Iliac, Elective
Repair of Femoral, Emergent (ruptured)
Repair of Femoral, Elective
Repair of Popliteal, Emergent (thrombosed)
Repair of Popliteal, Elective

Cerebrovascular:

Carotid Endarterectomy, Bypass, or Repair
Vertebral Endarterectomy, Bypass, or Repair
Direct Repair of Aortic Arch Branches

Peripheral Obstructive:

Aorto-iliac-femoral Endarterectomy, Bypass
Femoral-popliteal-tibial Endarterectomy, Bypass

Intra-Abdominal Obstructive:

Celiac/Superior Mesenteric Axis
Endarterectomy
Renal Artery Endarterectomy, Bypass, or Repair

Upper Extremity (Axillary, Brachial):

Direct Repair of Graft (not vascular access)

Extra-Cavitary Bypass Procedures:

Axillary-Femoral
Femoral-Femoral

Portal Decompression Procedures:

Portacaval Shunt
Splenorenal Shunt, Proximal or Distal
Mesocaval Shunt

Miscellaneous Vascular:

*Stripping or Ligation of Varicose Veins
Embolectomy or Thrombectomy, arterial or graft
Embolectomy or Thrombectomy, venous
Operations for Venous Ulceration
Sympathectomy, Cervical or Lumbar
Transuminal Angioplasty
Operations for Lymphedema
Repair Traumatic Injury

Vascular Access Procedures:

Shunt
Fistula
Graft
Insertion Peritone-venous or Indwelling venous
Catheter

Amputations:

*Digit
Transmetatarsal
Below Knee
Above Knee
Arm

ENDOCRINE

Thyroidectomy, Partial or Total
Parathyroidectomy
Adrenalectomy
Pancreatic Endocrine Procedure
Other Major

HAND

Soft Tissue Repair or Graft
Tendon Repair or Transfer
Nerve Repair
Replantation

THORACIC

Exploratory Thoracotomy
Repair of Daphragmatic Hernia
Excision of Mediastinal Tumor
Pneumonectomy
Lobectomy or Segmental Resection of Lung
Wedge Resection of Lung
Thoracic Outlet Decompression Procedure
Open Drainage of Empyema
Pericardiectomy
Pacemaker Insertion
Cardiac Procedures
Other Major

TRAUMA SURGERY

Drainage of Sub- or Extra-dural Hematoma
Reduction and Stabilization of Maxillofacial
Esophageal Trauma,
Closure/Resection/Exclusion
Duodenal Trauma, Closure/Resection/Exclusion
Small Bowel Trauma,
Closure/Resection/Exclusion
Colon Trauma, Closure/Resection/Exclusion
Repair of Tendon or Nerve
Neck Exploration for Trauma
Exploratory Thoracotomy
Exploratory Laparotomy (except negative lap)
Splenectomy or Splenorrhaphy
Repair And Drainage for Injury
Hepatic Resection for Injury
Drainage of Pancreatic Injury
Resection of Pancreatic Injury
Closed reduction of Fracture
Open Reduction of Open/Closed Fracture
Debridment and Reduction of Open Fracture
Debridment and Suture of Major Wounds
Repair of Bladder Injury
Repair of Ureteral Injury
Repair of Resection for Kidney Trauma
Repair of Thoracic Aorta,
Innominate/Subclavian
Repair of Carotid or other Major Neck Vessels
Repair of Abdominal aorta or Vena Cava
Repair of Peripheral Vessels

ORTHOPAEDICS

Open Operations on Bone or Joints
Repair or Transfer of Tendon/Nerve
Prosthetic Joint Replacement
Arthroscopy
Other Major

OTHER PROCEDURES

Endoscopy
Laryngoscopy
Bronchoscopy
Mediastinoscopy
Sclerotherapy for Esophageal Varices
Esophago-gastro-duodenoscopy
Peritoneoscopy
Endoscopic Retrograde
Cholangiopancreatography
Sigmoidoscopy, Rigid or Flexible
Flexible Colonoscopy
Choledochoscopy
Cysto-Urethroscopy
Other Endoscopy

MISCELLANEOUS

Removal of Skin Moles, Small Tumors, etc.
Removal of Subcutaneous Small Tumors, Cysts
Repair of Minor Wounds and Grafts
Sclerotherapy for Peripheral Venous Disease
Banding Incision of Thrombosed Hemorrhoid
Lithotipsy
Other Procedures

Patient Care Management-Primary
Responsibility
Critical Care Patients
Multiple Organ Trauma Patients (operation not
required)

Anesthetics Given
General, Inhalation
Regional/Spinal

DIDACTIC CONFERENCES

The RRC stresses the importance of a defined curriculum in both basic and clinical surgical science. Didactic sessions are provided in both areas. In addition, traditional hospital based conferences are available for resident participation. Required conferences are indicated. Attendance is mandated. Attendance will be taken at all required conferences. Absence is permitted ONLY for formal vacation time and by excuse of the Program Director.

A) **Grand Rounds** – is held every Thursday at 7:00 AM in ME-700. . This conference will include Departmental Grand Rounds on the first Thursdays of most months, invited guests, faculty lectures and learning sessions on elements of the competency curriculum .

B) **Resident Didactic Sessions** –are held from 8:00 – 9:00 AM in ME 700 . Please consult the schedule of topics. This conference covers required topics in basic surgical biology and topics in clinical general surgery. Reading assignments will be made from standard texts and from the SCORE curriculum of the ABS. Journal Club will also be scheduled for this hour at intervals throughout the year. Please consult the teaching day schedule. It is imperative that you read the assigned material prior to the conference. The assigned material will be reviewed by discussion and the completion of a series of review questions.

C) **Monday Conference- 4PM, MS 316** - On alternate Mondays residents will present interesting cases for discussion. A faculty member is assigned as mentor. Rather than a formal lecture this should be an interactive session involving medical students and residents at all levels in a clinical discussion of an interesting disease entity and its surgical solution.

This conference alternates with a Board Review Course for PGY2-5 residents (Dr. Hesham). PGY1 categorical and Preliminary residents will meet on the alternate Mondays to participate in the Fundamentals of Surgery Curriculum of the ACS. These sessions begin on September 14th, 2009. During July the Chief Residents will conduct a “Nuts and Bolts” course for incoming interns.

D) **Mortality and Morbidity Conference** – is held at 5:00 PM each Thursday in Huyck Auditorium. Deaths and complications drawn from the previous week’s clinical activities will be reviewed. This will include all cases from AMCH. The senior resident from each service will present the significant complications and unexpected deaths occurring on the service to which he/she is assigned. Pertinent x-ray films should be provided and a power point presentation of the case should be prepared. The residents should be prepared to speak knowledgeably and succinctly on each case of significance to be discussed. The presenter must have reviewed the evidence based information available on the topic of discussion. The conference is run by the administrative chief resident and a panel of faculty that functions as a component of the Quality Assurance process for the Division of General Surgery. **Each presenting resident must complete a” Practice based improvement log” available from the residency office.**

E) **Critical Care Course; Basic Surgery Course** – A course in Surgical Critical Care is provided for all incoming and returning Junior residents. This will be held on Thursday mornings from 7AM-9AM in ME700 during July and August.

F) **Trauma Conference** – is conducted on a biweekly basis on the first and third Wednesday each month from 8:00 – 9:00 AM in ME-700. This conference involves both case presentations and didactic sessions. All residents on the Trauma Service are required to attend. All other residents are encouraged to do so, time permitting.

G) **Vascular Surgery Conference** – is held on a weekly basis on Friday mornings at 8:00 AM in the Radiology Education Conference Room (FB-18). This conference consists of case presentations from the VA Hospital, AMCH, and Ellis Hospital. The attending Vascular Surgeons who participate in the residency program attend. Cases are presented by the residents on Vascular Surgery and then discussed, at length, by the attendings. It is important that the residents responsible have a presentation prepared and

bring all pertinent x-rays and angiograms. **All residents on Vascular Surgery and all residents assigned to the VA Hospital are required to attend.** All other residents are encouraged to attend, time permitting.

H) **Journal Club** – The chief resident, in consultation with Dr. Carl Rosati, will choose 3 articles for discussion. These will include both basic science and clinically oriented papers. Journal Club will be held on certain Thursdays at 8AM in ME 700. Please refer to the Conference schedule for dates and the assigned literature topic area for consideration.

During Journal Club, we will review a sample of articles from the surgical literature. In addition, we will discuss research design, statistical usage as well as critical thinking in Surgery. Journal Club is provided, in addition to, and not to replace, your reading of the mainstream surgical literature. Reading habits you develop during the residency will stay with you the rest of your professional life. Residents should review on a monthly (and timely) basis the following Surgical Peer Reviewed Journals:

Journal of American College of Surgeons
Surgery
Annals of Surgery
Archives of Surgery
American Journal of Surgery

I) **VA Hospital** – Mortality and Morbidity Conference and Grand Rounds occur on Tuesday at 7:30 AM in the 6th floor conference room. This conference is **mandatory** for all resident staff. Each senior resident at the VA will be expected to give one Grand Rounds Presentation during the rotation.

CURRICULUM FOR RESIDENT TRAINING IN GENERAL SURGERY

THESE TOPICS WILL BE ADDRESSED IN A TWO-YEAR CYCLE – As all of the aspects of these topics cannot be covered, the resident must supplement with self-directed reading on the topic prior to topic focused sessions.

Year One

Principles of Pre and Operative Surgical Care

Preoperative Preparation of the Patient
Systems Approach to Preoperative Evaluation
Preoperative Considerations
Potential Causes of Intraoperative Instability
Principles of Operative Surgery
The Operating room Environment
Surgical Devices and Energy Sources
Outpatient Surgery – special considerations

Surgical Infections / Antimicrobials

Surgical Site Infections
Specific Surgical Infections
Pathogens in Surgical Infections
Antimicrobials

Complications in Surgery

Surgical Wound Complications
Complications of Thermal Regulation
Pulmonary Complications
Cardiac Complications
Renal/Urinary Tract Complications
Endocrine Gland Dysfunction
Gastrointestinal Complications
Hepatobiliary Complications\ Neurologic Complications
ENT Complications

Critical Assessment of Surgical Outcomes

Applications of Outcomes Research
Data Sources
Is the Study Valid?
Is the Study Focused on the Right Outcome Measure?
Is the Intervention Cost Effective?
Critical Assessment of Studies of Surgical Quality

Molecular and cell biology (BS)

Human Genome
Recombinant DNA Technology
Cell Signaling
Cell Division Cycle
Apoptosis
Human Genome Project
Novel Treatment Strategies
Ethical, Psychological and Legal Implications

The Esophagus

History
Embryology
Anatomy
Physiology
Neuromuscular Disorders
Diseases of the Esophagus
Acquired Conditions
Benign Tumors and Cysts
Carcinoma
Unusual Malignant Tumors
Paraesophageal Hernias

The Stomach

Anatomy
Physiology
Peptic Ulcer Disease
Stress Gastritis
Gastric Neoplasia
Misc. Gastric lesions

The Small Intestine

Embryology
Anatomy
Physiology
Motility
Endocrine Function
Immune Function
Obstruction

Inflammatory Diseases
Neoplasms
Diverticular Disease
Misc. Problems

Patient Safety Issues

History
The Patient Safety Problem
The Science of Safety and Joint Cognitive Systems
Safer Surgical Systems

The Appendix

Embryology and Anatomy
Appendicitis
Neoplasms of the Appendix

Shock, Fluids and Electrolytes(BS)

Body Water and Solute Composition
Acid-Base Balance
Extracellular Fluid Distribution
Cellular Aerobic Function and Dysfunction
Physiologic Control of Perfusion Pressure
The Surgeon's Response to Shock
Hypovolemic Shock
Cardiogenic Shock
Shock and Adrenal Insufficiency

The Colon and Rectum

Embryology
Anatomy of Colon, Rectum and Pelvic Floor
Physiology of the Colon
Bowel Preparation Before Surgery
Diverticular Disease
Colonic Volvulus
Colonic Obstruction and Pseudo-Obstruction
Inflammatory Disease of the Colon
Infectious Colitis
Colonic Ischemia
Neoplasms of the Colon and Rectum
Pelvic Floor Dysfunction and Constipation
Laparoscopic Approach to Colonic Diseases

Anal Diseases

Embryology, Anatomy and Physiology
Disorders of the Anal Canal
Pelvic Floor Disorders
Common Benign Anal Disorders
Neoplastic Disorders of the Anal Canal

The Resident as Clinical Teacher

The Liver

History
Anatomy and physiology
Infectious Diseases
Neoplasms
Hemobilia
Viral Hepatitis and the Surgeon
Anatomy, Physiology and Pathophysiology of Portal Hypertension
Evaluation of the patient with Cirrhosis
Variceal bleeding
Acutes and the Hepatorenal Syndrome
Encephalopathy

Metabolism and Nutrition(BS)

Metabolic Adaptations in Catabolic States and Regulation of Nitrogen Balance
Fundamental of Artificial Nutrition
Practical Approaches to Artificial Nutrition
Controversies in Artificial Nutrition
Novel Approaches

The Biliary tract

Anatomy
Physiology
General Considerations in Biliary Tract
Pathophysiology
Benign Pathophysiologic Conditions
Malignant Biliary Diseases

Informed consent- informed refusal – autonomy and diminished capacity

The Exocrine Pancreas
Anatomy
Embryology and Histology
Congenital Anomalies
Physiology
Pancreatitis
Chronic Pancreatitis
Benign Exocrine Tumors
Malignant Pancreatic Tumors
Pancreatic and Pancreaticoduodenal trauma

Wound Healing (BS)

Tissue Injury and Response

Wound Healing Phases
Abnormal Wound Healing
Fetal Wound Healing
Wound Dressings
What's in the Future of Wound Healing

The Spleen

Splenic Anatomy
Splenic Function
Splenectomy for Benign Hematologic conditions
Splenectomy for Malignancy
Splenectomy for trauma and Misc. Conditions
Late Morbidity After Splenectomy
Laparoscopic Splenectomy

Tumor Biology and Markers(BS)

Epidemiology
Tumor Biology
Carcinogenesis
Tumor Markers

The Thyroid

History
Anatomy
Physiology of the Thyroid
Disorders of Thyroid Metabolism
Benign Thyroid Diseases
Workup and Diagnosis of a Solitary Thyroid Nodule
Thyroid Malignancies
Surgical Approaches to the Thyroid and Adjacent Structures

The Parathyroids

History
Calcium Physiology
Anatomy
Diagnosis and Clinical Features
Hypercalcemic Crisis
Hypoparathyroidism
Primary Hyperparathyroidism
Secondary Hyperparathyroidism in Renal Failure
Tertiary Hyperparathyroidism
Inherited Parathyroid Disease
Parathyroid Carcinoma

Endocrine Pancreas

History
Embryology
Histomorphology of Islets

Endocrine Physiology
Islet Cell Tumors
Medical Therapy for Islet Cell Tumors
New Horizons

The Adrenals

History
Anatomy and Embryology
Normal Histopathology
Biochemistry and Physiology
Inborn Errors of Metabolism – Congenital Adrenal Hyperplasia
Adrenal Insufficiency
Diseases of the Adrenal Cortex
Diseases of the Adrenal Medulla
The Incidentally Discovered Adrenal Mass
Metastasis to the Adrenal
Technical Aspects of Adrenalectomy

MEN Syndromes

Type I
Type II

Conveying Bad News and creating emotional support

Statistics I(BS)

Statistics II(BS)

Transplantation Immunology(BS)

Conceptual Approaches to Immunosuppressive Therapy
The Cells Involved
Cell-Cell Interactions
Major Histocompatibility Locus-Transplantation Antigens
Clinical Immunosuppression
Xenotransplantation
Tolerance
Horizons of Transplantation

Melanoma

Epidemiology
Precursor lesions
Clinical Management – Biopsy
Histologic features
Staging
Surgical Management of the primary lesion
Management of Lymph Nodes
Distant metastasis

Non- Melanoma Cutaneous Malignancies

Soft Tissue Sarcomas

Predisposing Factors and Molecular Genetics
Pathologic Evaluation
Clinical Evaluation and Diagnosis
Evaluation of extent of disease
Staging
Management
Treatment of Recurrent Disease
Prognostic Factors and Results
Long Term Follow-up

Transplantation of Abdominal Organs

Renal Transplantation
Liver transplantation
Pancreatic Transplantation
Islet Cell Transplantation
Intestinal Transplantation
Ethical Considerations

Morbid Obesity

Epidemiology
Pathophysiology and Associated Medical Problems
Medical vs. Surgical Therapy
Preoperative Evaluation and Selection
Operative procedures
Postoperative Care and Follow-up
Results
Complications
Reoperative Surgery
Controversies on Bariatric Surgery

Surgery in the Elderly

Aging and Surgery
Physiologic Decline
Preoperative Assessment
Specific Considerations

Head and Neck Diseases

Normal Histology
Epidemiology

Carcinogenesis

Staging
Clinical Overview
Anatomic Sites
Tracheotomy
Vocal Cord Paralysis
Reconstruction

Anesthesia (BS)

Pharmacologic Principles
Equipment and Monitoring
Preoperative Evaluation
Selection of Techniques and Drugs
Airway Management
Regional Anesthesia
Conscious Sedation
Postanesthesia Care
Pain Management

ENTALA – Obligations and responsibilities in providing care for unstable patients

Burns

Pathophysiology of Burns
Initial Treatment
Inhalation Injury
Wound Care
Minimizing Complications
Nutrition
Outcomes
Electrical Burns
Chemical Burns

Discussing Maloccurrence with patient and family

History of Surgery.

Importance
Relationship of Surgery and Medicine
Before the 19th Century
19th Century Advances
What We Learn From War – WW1, WW2, Korea, Viet Nam

Two Year Curriculum Cycle – Year Two

Management of Acute Trauma

Epidemiology
History
Trauma
Prehospital Care
Transportation
Hospital Care
Rehabilitation
Prevention and Injury Control
The Surgeon's Role
Initial Management
Management of Specific Injuries

Emergent Care of Musculo/Skeletal injuries

Epidemiology
Terminology
Fixation Principles
Patient Evaluation
Initial Management
Orthopedic Emergencies
Common Long Bone Fractures

Surgical Critical care

CNS
Cardiovascular System
Respiratory System
Acute Renal Failure
Gastrointestinal System
Hepatic Dysfunction
Endocrine System
Hematologic System
Sepsis and Multisystem organ failure

The Breast (BS)

Breast – Benign Disease
Anatomy
Development and Physiology
Abnormal Development and Physiology
Diagnosis of Breast Disease
Breast Imaging
Benign Breast Tumors and Related Diseases
Breast – Cancer
Identification and Management of High-Risk Patients
Pathology of Breast Cancer
Staging of Breast Cancer

Surgical Treatment of Breast Cancer
Chemo and Hormonal Therapy for Breast Cancer

Trauma to the neck

Trauma to the Thorax

Non-Penetrating Abdominal Trauma

Penetrating Abdominal trauma

Growth and Development(BS)- O'Leary

Pediatric Surgery

Newborn Physiology
Fluid, Electrolytes and Nutrition
Extracorporeal life support
Trauma
Lesions of Neck
Alimentary Tract
Abdominal Wall
Genitourinary
Congenital Diaphragmatic Hernias
Chest Wall Deformities
Bronchopulmonary Malformations
Hepatobiliary
Childhood Solid Tumors
Fetal Surgery

Chest Wall, Pleura and Mediastinum

Anatomy and Embryology
Deformities
Infections
Thoracic Outlet Syndrome
Trauma
Tumors
Cysts
Misc. Problems

Lung

Anatomy
Pulmonary Function Tests
Operative Risk
Congenital Lesions
Cancer – primary and metastatic
Trachea

Emphysema
Diffuse Lung Disease
ARDS
Infections
Hemoptysis
Pulmonary Embolism
Bacterial Infections

Congenital Heart Disease

History
Adult Problems
Anatomy, Embryology and Diagnosis
Overview of lesions
Current Practice of Surgery for Congenital Defects

Acquired heart disease- Coronary

Anatomy
Normal physiology and circulation
Pump Function
CAD
Ischemic Injury of the Heart
Clinical Presentations
Indications for Surgery
Operations
Outcomes and Surveillance
Alternatives

Acquired heart Disease - Valvular

History
Diagnostics
Mitral Disease
Aortic Disease
Operative techniques
Outcomes
Prosthetic Valves

Endothelial Biology in Health and Disease(BS)

Vascular Diseases of the Thoracic Aorta

Anatomy, Embryology and Anomalies
Aortic Disease – Etiology
Diagnostic imaging
Thoracic Aortic Aneurysms
Thoracic Aortic Dissections
Surgical Results
Endovascular Repair
Emerging Techniques

Cerebrovascular Diseases

Epidemiology of Stroke
Etiology of Stroke
Carotid Disease and Pathophysiology
Clinical Manifestations
Risk Stratification
Indications
Diagnostic Tests used
Endarterectomy
Other strategies

Aneurysmal Disease
History
Classification
Pathogenesis
Abdominal Aortic Aneurysms
Iliac Artery Aneurysms
Popliteal Aneurysms
Visceral Aneurysms
Renal Artery Aneurysms

Peripheral Vascular disease

Pathophysiology
Acute Thrombotic Disease
Chronic Occlusive Disease
Chronic Visceral Ischemia

Venous/lymphatic diseases

Anatomy
Primary Venous Insufficiency
DVT of lower Extremity
DVT Upper Extremity
Anatomy , Embryology and Function of Lymphatic System
Pathophysiology
Differential Diagnosis
Therapy
Chylothorax
Chyloperitoneum
Tumors of Lymphatic Origin

Access and Ports

Vascular Access
Peritoneal Dialysis

Female Reproductive Biology (BS)

Diseases of the Female Genital tract

Pelvic Embryology and Anatomy
Reproductive Physiology
Clinical Evaluation

In-Situ and Invasive diseases
Alternatives to Surgery
Technical Aspects of Surgery

Surgery in Pregnancy

Physiologic Changes in Pregnancy
Radiologic and Anesthetic safety
Prevention of Preterm Labor
The Acute Abdomen in Pregnancy
MIS in Pregnancy
Breast Masses
Biliary Disease
Endocrine Disease
Alimentary Tract Disease
Trauma

Skin and Subcutaneous Tissues (BS)

Plastic Surgery Principles

General Principles
Head and Neck – Congenital and Craniofacial
Trunk and Genitalia
Extremities
Breast
Aesthetic Surgery

Hand Surgery

Basic Anatomy
Examination and Diagnosis
Principles of Treatment
Trauma
Infections
Injection Injuries and Compartment Syndromes
Tenosynovitis
Nerve Compressions
Soft Tissue Tumors
Congenital Problems
Arthritis
Contractures

Urology I and II

Neurosurgery I and II

Ambulatory surgery for minor problems

Unexpected disasters and their management

**Emerging Technology – Informatics,
Electronics and Robotics**

* eight competency topics to be added to above

QUALITY ASSURANCE (QA)

Quality Assurance is a general term that refers to an expanding component of medical care and encompasses “credentialing” (the tracking of individuals in their performance of specific identified procedures), “delineation” (the granting of the ability to perform the procedure with limited or no supervision), documentation of the quality of care, reviewing patient care outcomes (especially death and complications), investigating “incidents” (various unexpected problems or outcomes, many of concern to the State Department of Health as well as the AMC Risk Management Office), conducting “screens” and “reviews”, all to improve the “quality of patient care”. Significant hospital and State resources are devoted to these various efforts and they will significantly affect you during your training and practice. The following sections deal with the various aspects of Quality Assurance.

A. QUALITY ASSURANCE AND PROCEDURE CREDENTIALING

Quality assurance and procedure credentialing have become very important, and the Policy of the Albany Medical Center can be found in this manual. This policy must be reviewed by all surgical residents, and this review must be confirmed by the resident’s signature on the “Resident Review and Confirmation” sheet. This will be signed at General Orientation.

CREDENTIALING PROCESS

The Hospital and Residency program require that a resident become credentialed in the performance of routine invasive procedures performed outside the operating room. A resident may be delineated by the Program Director to perform these procedures without supervision. Delineated residents may also supervise other non-credentialed residents in the performance of these procedures.

All incoming residents in the Department of Surgery will be subject to a credentialing process.

A resident may be delineated to perform the following procedures without supervision: history, physical examination, venipuncture (with permission of that patient).

B. DEATHS AND COMPLICATIONS

A list of deaths and complications is submitted weekly by each Service and is the responsibility of the Senior Resident on that service. They are due each Wednesday morning and cover the previous week. Residents should create a tabulation of deaths and complications using Microsoft Access – this can then be emailed or delivered on disc to the Program Coordinator. Quality Assurance information is somewhat protected in that it is not “discoverable” in civil liability litigation; However, it may be discoverable in criminal cases. Therefore, all such narrative information should be carefully and thoughtfully considered.

C. THE MEDICAL RECORD

It is a fact of medical life that the unexpected and unfortunate will occur in medical care. A wide variety of adverse or unexpected occurrences are reportable under law to the State Health Department, as well as other agencies. That these are reportable does not necessarily indicate negligence or any deficiency by any party. This data is collected at Albany Medical Center by the office of Risk Management. Similar offices are found in all of the teaching hospitals of the program. What is a reportable occurrence? Basically, it is any unexpected occurrence that could or has affected patient care, especially those that will increase length of stay, will require an additional procedure for correction and currently includes nosocomial infections. Some judgment is required in the decision as whether to report an occurrence. If you are in doubt, please fill out the occurrence form, available at all nursing stations, and contact a representative from Risk Management (on call 24hours a day through the hospital page operator).

If a significant “incident” occurs, complete documentation describing what happened and the patient’s subsequent condition should be entered into the patient’s medical record. An “occurrence form”, available at all nursing stations, should be completed for the Risk Management Department. Specific reference to the filing of an “occurrence form” should not appear in the medical record. The “occurrence form” should be filled out immediately and the Risk Management person on call should be contacted. Many incidents must be reported to the Department of Health within 24 hours or the hospital is liable for significant sanctions and fines imposed by New York State. Your failure to document an incident properly could have significant consequences for all.

In documenting the incident in the patient’s record, it is important to be complete and accurate. **DO NOT BE DISHONEST UNDER ANY CIRCUMSTANCE.** However, be aware of the legal implications of what you are writing. There are often several ways to say the same thing, and you should record the information in an objective way, which will not be subject to misinterpretation. Record observations rather than conclusions. For example, if you were to find a patient on the floor, do not assume the patient has fallen out of the bed, but, rather document that the patient was found on the floor. When documenting the incident in the chart, anticipate important questions that may be raised in the future and address these points clearly and objectively. ***THINK BEFORE YOU WRITE!***

D. 405.4 STAFF SUPERVISION

It is a New York State requirement that residents receive direct supervision of their activities. A board eligible or board certified surgeon will be in house 24 hours a day, every day. This surgeon serves as the surgical resident supervisor.

The surgical supervisor is expected to be available to supervise the activities of all in-house surgical (general and specialty) residents. Should an emergent situation arise and the attending surgeon of record not be immediately available, the supervisor is expected to participate in the immediate care of this patient as supervisor of the resident involved and as a surrogate for the attending surgeon of record. The supervisor and resident must communicate with the attending of record such an event immediately following resolution of the event. This role includes resident activities in the Critical Care Unit, on patient care units and the Emergency Room.

POLICY OF THE ALBANY MEDICAL CENTER

No house officer can perform any procedure on any patient unsupervised unless the house officer has been credentialed and granted specific privileges for the performance of such a procedure. All other procedures must be performed under the direct visual supervision of a physician so credentialed and so granted privileges for such a procedure. Failure to adhere to this policy will result in appropriate disciplinary action that may include dismissal of that house officer from the Residency Program.

All clinical chiefs will certify in writing to the Institutional Quality Assurance Committee and thus through the appropriate channels to the Governing Board of the Albany Medical Center that this policy has been clearly enunciated to all medical students and all house officers on each and every change of rotation. Failure of a clinical chief to adhere to this policy will result in the communication of this failure directly to the Committee for Patient Care of the Board of Directors and thus to the entire Board of Directors of the Albany Medical Center for appropriate disciplinary action

DEPARTMENT OF SURGERY ALBANY MEDICAL CENTER CLINICAL PROCEDURES POLICY	
RESIDENT REVIEW AND CONFIRMATION	
Name of Resident: _____	
All Surgical Residents rotating on the Surgical Services will review this policy; confirm that by signature that he/she has read and understands that attached policy for resident credentialing.	
Date: _____	Signature: _____

(You will sign this form at orientation)

WORK HOURS LIMITATION

Both the ACGME and the New York State Department of Health monitor the work hours of resident trainees. A tired resident is not a safe resident and a tired resident is not a good learner. The institution's Graduate Medical Education Department also mandates compliance with these work hour regulations.

405.4 WORK HOURS RULES FOR ALBANY MEDICAL CENTER HOSPITAL

- 1) All residents are limited to a work-week of 80 hours. This includes any activity within the Institution: that is both patient care and educational activities. This 80-hour limit, is to be averaged over a four week period with no greater than 10% variance in any one week.
- 2) The work day begins at 6:00 AM for all residents and ends at 6:00 PM (Monday – Friday). A particular service may require a junior resident to work staggered shift (ie. 8:30 AM – 8:30 PM) should patient volume and service needs so demand. This needs to be approved by the Residency Office. **There must be a 10 hour rest period following each shift worked. There are no exceptions to this rule.**
- 3) Each resident will have at least one 24-hour period each week free of all residency duties. This must be reflected in the call schedule.
- 4) For senior residents – the workday begins at 6:00 AM and ends at 6:00 PM (Monday – Friday). Five hours are allowed for weekend rounds. This leaves an additional 15 hours available for additional in-hospital activity.
- 5) A senior “night-float” is assigned from 5:00 PM – 6:00 AM. This senior resident will cover all consultations from the emergency room (including traumas), all patient care issues in the ICU as referred by resident and attending staff and all problems with patients on the wards as referred by the junior resident on call. This resident will make appropriate contact with the PGY5 or PGY4 in house and in turn the responsible attending surgeon being consulted or of record. This resident, in general, will not go to the operating room but will refer issues involving specifically referred patients to the service specific chief resident at home. All trauma patients or general surgery patients not specifically referred to a named attending will be cared for by the PGY5/PGY4 resident in house in concert with the Surgical Attending in house. The “night float “ will communicate directly with the PGY4/5 in house regarding these patients. The senior “night float” will have one 24-hour day per week with no clinical responsibilities reflected on the call schedule.
- 6) The Chief Resident must also abide by the 80-hour limit. Each Chief Resident will be scheduled for one 24-hour period of non-work each week. Chief residents assigned to the Acute Care Surgery Service will take in house call every third night along with designated PGY4 residents.. Following this assigned duty that resident must leave the hospital for a 24 hour period. The other Chief Residents assigned to other services will take call from home yet abide by all of the work hours regulations. Any return to the hospital for patient care must accommodate a resident rest period of at least ten hours after the normal work shift has ended (6PM) or will require a return home for at least a **ten hour period** before resuming daytime patient care responsibilities.
- 7) There will be one junior resident in the house after 6:00 PM. This resident will cover Acute Care Surgery and all General Surgery Services through the night. After a debriefing at 6:00 AM, this resident is dismissed for a 12-hour period of non-work.

8) New York State allows a three hour time period following a work shift for the transfer of patient information from the departing resident to the resident assuming patient care responsibility. Although this is included in the calculation of the 80 hour work week it is excluded from the 24 hour continuous work rule. On Thursday morning two of these hours (7-9 AM) will be used for resident education.

WORK HOURS RULES FOR THE VETERANS ADMINISTRATION MEDICAL CENTER

For the current academic year, one senior resident and two junior residents will be assigned to the VAMC full time. The workday should commence at 6:30 AM and end at 6:30 PM. Residents are limited to an 80-hour work week. Each resident must have one scheduled 24-hour period each week free of all clinical duties. Senior residents will take call at night from home. We will provide an additional junior resident to the call schedule to maintain the q3 night call schedule. Returns to the Hospital for patient care must fall with the 80-hour limit.

Each junior resident will take call every 3rd night. This in-house call will end at 6:30 AM. After a brief transfer of information (no greater than 1 hour) the resident will depart the facility for a 24-hour day off duty. Each junior resident will have one in three weekends without clinical duties.

When a Senior Resident elects a Vacation period while assigned to the VAMC, no senior resident coverage will be provided. It is expected that the attending staff will provide appropriate supervision and coverage of the junior resident activities.

When a junior resident selects a vacation period while assigned to the VAMC, the senior resident will take night call for the junior, care being taken to ensure that the senior has no greater than an 80-hour work week and has one 24-hour day that week with no hospital duty.

WORK HOUR RULES FOR ST. PETER'S HOSPITAL

As this rotation is a mentorship, the general rules apply

-80 hour work week limit

-One 24 hour period free of all clinical duty each week

-As call is from home, the return to hospital time is counted in the 80 hour limit

-If return to hospital time exceeds four hours, there must be a 10 hour interval before return to the hospital.

COVERAGE

A schedule of rotations for each resident is prepared each spring. Resident may NOT independently arrange for rotation changes. Such changes will be approved only rarely and must be arranged through the Residency Office.

A) The Chief Administrative Resident is responsible for decisions regarding daily work schedules, resident operating room responsibility, vacation coverage, call schedules and individual resident problems during the course of the year. Any such problems should be directed to the Chief Administrative Resident

B) Hospital on-call coverage will be assigned by the Chief Resident at each hospital. The schedule will appear during the last week of the month and is final unless changed by the Chief Resident. Any change

in the schedule MUST BE APPROVED BY THE CHIEF RESIDENT IN ADVANCE. The Chief Resident has the authority to rearrange the schedule at any time as needs dictate.

C) It is the responsibility of the junior residents assigned to a service to work up all elective admissions to that service. In addition, the senior resident on a service is to provide for senior level coverage for Sunday rounds on the service. The “weekend” begins at noon Saturday.

D) It is the responsibility of the service that is to be cross-covered that evening or weekend to notify the covering resident of any problems before leaving the hospital. It is also the responsibility of the service to stabilize any problems before leaving. It will be necessary to “sign out” to the cross coverage team “in person”. This will ensure continuity and quality care for the patient.

E) Junior residents who have daytime assignments to non-general surgery services will be included in the general surgery night call schedule as needed. Designated preliminary junior residents assigned to the parent specialty will take call with that specialty (for Neurosurgery this includes Neurology). At all other times they will be included in the general surgery night call schedule as needed.

MEDICAL STUDENTS

Third and fourth year medical students are an integral part of the team on the surgical service. Students should be assigned a limited number of patients (3-4 for junior students ; 4-6 for senior students) and should pre-round on these patients, anticipate care needs, present patients on rounds and discuss patient progress or complications. They should be involved in all aspects of ongoing care of these patients.

Third year students have an assigned call obligation on either Friday (6PM -6AM) or Saturday (6AM-6AM) with dismissal after 24 hours on call. The schedule for this call obligation will be developed by the Clerkship Coordinator, Mrs. Engel.

Senior medical students on selective/elective have in-house call responsibilities every fourth night. Call ends at 10 PM for students. These responsibilities are to be taken seriously by the student and resident staff alike. The Chief Surgical Resident at each hospital is responsible for the On-Call Schedule for the senior medical students. No change in this schedule may be made without prior approval of the Chief Surgical Resident. It is understood that the duration of the student rotation extends only from 6:00 AM on the first day of the rotation, to 6:00 PM on the last Friday of the rotation. The student is not required to take call for the last weekend of the rotation.. Remember, hospital policy states that medical student orders cannot be taken off by nurses until a resident physician countersigns them. If you have an order that needs to be carried out expeditiously, either write it yourself or co-sign the student’s order immediately.

POLICY ON HARASSMENT OF MEDICAL STUDENTS

Medical Students pay dearly for the privilege of working with you. They give you the opportunity to think and act as an educator. **Inattention to or abuse of medical students will not be tolerated.**

The rules of good behavior should guide all resident activities: with faculty, with students, with nursing staff and, of course, with patients and families. Although correction and criticism is an integral part of the students learning experience, we must all be careful to avoid any behavior that could be considered

harassing. Treat others as you would like to be treated. Mentoring is an important aspect of all professions. Your opportunity to mentor students is a privilege.

Any student complaint regarding harassing behavior will be taken with great concern by the Course Director and the Chairman. Students are instructed to bring any complaint of substance to the course Director, in private, for discussion. If both agree, the issue will be brought forward to the Chairman and the College's Committee on Harassment, if appropriate.

Be aware that harassing behavior will not be tolerated and may be cause for summary dismissal.

VACATION

A. Residents are allowed three weeks of vacation time per year (one week equals Monday through Sunday). When possible, the Sunday before will be included in the vacation time.

Vacations must be taken only as three separate weeks. One week must be taken during each trimester (August 1 – November 30) (December 1 – March 30) (April 1 – June 15)

B. No vacation time may be carried over into the following year and no additional salary will be paid in lieu on vacation time not taken.

C. Vacation selection for interns will occur after the organizational meeting in July. PLEASE BE PREPARED TO MAKE YOUR CHOICES AT THAT TIME. DO NOT MAKE PLANS OR BUY PLANE TICKETS UNTIL THE EXACT DATES OF VACATION HAVE BEEN CONFIRMED. Retuning residents will select vacation dates late in June of the previous year.

D. Vacations on Specialty Services: (CT and Plastic Surgery)

1. Require the approval of the chief resident on that service. The permission should be obtained in writing, in advance.
2. Only one week may be taken on each specialty rotation.

E. Vacation on General Surgery Services:

1. No Junior Resident may take vacation on the Vascular Surgery Service.
2. Only one resident at the VA may take vacation at any one time.
3. Residents must notify both the attending staff as well as fellow resident staff on a service (at the beginning of the rotation) of a planned absence.
4. Two junior residents assigned to AMCH may take vacation at a time. Only one senior resident or Chief from AMC may be away at on time. Coverage at the Chief level must be arranged by the resident planning to be absent. The coverage must be approved by the Program office.
5. Senior residents on “night float” may not take vacation during that assignment.
6. Junior residents on night float may not take vacation during that assignment.

F. Vacations may **Not** be taken:

1. During July 1-15 (PGY-1 Categorical Residents may not take vacation in July)
2. During the last two weeks in June. Categorical Residents may not take vacation during the entire month of June. No terminal leave will be allowed.
3. During the weeks encompassing Christmas and New Year’s (adjustment in coverage will be attempted to provide some holiday time for everyone) December 22 – January 5.
4. During the last full week in January (ABSITE EXAM – Jan 26th)
4. During the ICU rotation during July, October, November, May and June for preliminary residents. Categorical residents may take one week only during the two month rotation.. Once you have selected the week Dr. Socaris must be notified immediately. Be warned!
5. During the week of the ACS meeting to allow for resident participation (seniors only) (October 12-16, 2008)
6. During the oral exam week (PGY 3, 4, and 5 only) (April 7, 2010)
7. During Junior rotation on vascular surgery
- 8) When assigned as night float

9. Senior residents may not take vacation while on the General Thoracic Rotation at St. Peter's Hospital

Vacation Policy for non-General Surgery PGY 1 and 2 residents while on the General Surgery Services

As we have many residents visiting from other GME programs we will need to establish a fair and equitable policy for vacation assignments.

Neurosurgery residents spend only two months with us and will not be allowed to take any vacation during this time (VA and SICU)

ENT residents are out of our schedule to do specialty work for a total of three months –Only two weeks of vacation from the General Surgery schedule is allowed.

Urology residents are designated preliminary residents .Since they are out of our schedule for a total of four months (Urol x2, Plastics and Elective) they must take one of their three vacation weeks during these times off general surgery

Plastic Surgery – the PGY 1 spends five months with us –One week of vacation may be taken while on general surgery

- the PGY2 spends only four months with us . Only one week of vacation may be taken while on the while on General Surgery
- the PGY 3 is with us for most of the year and may take the three weeks during the time with us.(2009-10)

Ortho – each resident is with us for only 6 months – each resident will be allowed one week vacation while on General Surgery rotations.

G. The vacation schedule and on-call coverage schedule will be integrated by the chief administrative resident in coordination with the senior resident assigned to the VA Hospital, subject to the final approval of the Program Director.

H. Interview time for fellowship application will be limited. PGY4 or 5 residents needing time for interviews may have 4 days for this activity. Any days in excess must be taken as vacation.

I. Vacation during the Emergency Medicine Rotation is allowed. You must notify the Chief Resident in EM of your selected vacation dates immediately following the selection process. The call schedules in EM are made up 3 months in advance. Be Warned!!!

J. Travel to Conference: Chief Residents may attend the ACS Fall Meeting. Occasionally, a Board Review Course may be attended by a designated resident.. All conference attendance must be approved in advance by the Residency Office. Of course, any resident presenting a paper at any conference may attend that conference with financial support of the Department. A three day absence will be permitted for formal presentations. Arrangements must be made by the Residency Office and notice should be given in a timely manner.

Policy on Resident travel reimbursement

Should you wish to go to a national or regional meeting with the support of the training program the following rules apply:

All planning must go through the General Surgery Residency Coordinator

She will make appropriate airline reservations after checking with you for preference. This will be done through our in house travel agency.

You should make your hotel reservation and secure it with a credit card.

During your trip you should collect all receipts for hotel, food and misc. expenses (taxis etc).

Upon your return please submit all receipts. You will need a copy of your credit card bill that reflects these expenses. This can be obtained on line. Do not wait for the bill to arrive by mail.

Timely submission of all of these receipts will help speed the processing of your reimbursement.

There is a summary of institutional policy in this regard on file in the residency office. A detailed policy is also available. **Be forewarned!**

LEAVE OF ABSENCE

Brief leave of absence for illness, family or personal reasons can be arranged with the program director. Formal and significant leave of absence must be arranged in advance (if possible) with the Program Director. This residency program requires 60 months of clinical activity for a resident to qualify for recommendation to the American Board of Surgery. Any significant leave of absence must be remedied before recommendation to the American Board of Surgery can be considered.

FMLA is available . This is unpaid leave for a family medical situation or maternity. Benefits continue during this period.

The American Board of Surgery will accept 46 weeks of surgical training in one of the first three years of residency and 46 weeks of training in one of the last two years of training.

As of 2008 the ABS permits six week's of maternity leave – including the three weeks allowed for vacation. Residents may borrow vacation time from future years **to extend** their maternity leave. You must have completed at least 54 months of clinical surgical experience, with no fewer than 36 months devoted to the essential content areas of surgery as defined.

If there are questions in this regard ask before you act!

“MOONLIGHTING” POLICY

PLEASE NOTE: “MOONLIGHTING” IS **NOT PERMITTED** AT ANY LEVEL OF THIS TRAINING PROGRAM.

JOB DISCRIPTION FOR GENERAL SURGERY RESIDENTS AND DISCRIPTION OF LINE OF SUPERVISION

Chief Resident

The Chief residents supervise all care of all patients admitted to the General Surgery services at the Albany Medical Center Hospital. Generally, the Chief Resident is involved directly in the care of the most critically injured or ill and complex surgical patients. This involvement should consist of pre-operative evaluation and preparation, participation in the operating room as surgeon or assistant, and provision of peri- and post operative care. The Chief Resident must also arrange to see this patient for post-discharge follow up. The day to day care of these patients should be directed by the chief resident under the immediate supervision of the attending surgeon of record. The chief resident will maintain appropriate communications with the attending surgeon and any more junior residents assisting in the care of this patient. Night coverage for these patients will be supervised by the chief resident in consultation with the Senior night float resident. In addition, the Chief Resident is responsible for supervision of all senior and junior residents in their patient care activities and will round with them as appropriate. Chief residents will maintain contact with the junior residents assigned to the Emergency Room and be available as a resource to the junior residents assigned to the SICU. The attending staff of the ER and SICU have a primary supervisory responsibility.

In addition, the Administrative Chief Resident responsibilities include:

- 1) Establishing a monthly call schedule – providing for vacations and 405 compliance.
- 2) Preside at all resident didactic activities.
- 3) Review the OR schedule and make case assignments.

Senior Resident

Generally, the Senior Resident will have the day to day responsibility of organizing and running the clinical service to which he/she is assigned. He is responsible for all aspects of patient care for all patients admitted to his service. The Senior Resident assigned to that service will continue to follow all patients on that service that reside in the SICU, in concert with the chief resident, SICU attending and the surgeon of record. Senior residents serving as night float will provide oversight of junior residents on call covering the wards, the SICU and the ER. Written surgical consultation on off-service patients and in the ER will be provided when requested and subsequently discussed with the chief resident and the appropriate surgical attending before making recommendation for care. Senior night float will communicate with the chief resident regarding any new admission, consultation or any complex patient care issue of an established patient. Communication with the attending surgeon of record should follow.

Junior Resident

The junior resident is responsible for all patients admitted to the service to which he is assigned. This includes a complete admission history and physical examination, appropriate charting and record keeping, the collection and collation of laboratory and imaging data, development of a care plan, all in discussion with the senior resident covering that patient and the chief resident if necessary. The junior resident will round with the senior, chief and attending surgeon, as appropriate, to disseminate information in regard to patient progress.

Please be aware that there is an in house supervisory surgeon available immediately 24 hours a day. If your normal supervisors are unavailable, you may call this person to provide supervision.

VA

No chief resident is assigned to the VA. The senior and junior resident lines of responsibility are as described above. The attending surgeon staff provide immediate supervision for all residents.

SPH

As only a senior resident is assigned to the Thoracic Surgery Service at SPH, Dr.'s Moores, attending surgeon, serves as the direct and immediate supervisor.

ALBANY MEDICAL CENTER RESIDENT (HOUSE STAFF) JOB DISCRPTION

JOB TITLE: RESIDENT (HOUSE STAFF)
STATUS: FULL TIME EXEMPT
SALARY: PGY-LEVEL DEPENDENT

Primary Function:

To acquire post-graduate training in a clinical setting in medicine or dentistry. The resident must be able to demonstrate the knowledge and skills necessary to provide appropriate care to the age of the patients served. The ability to assess data reflective of the patient's status, interpret the appropriate information needed to develop a treatment plan, and provide the care needed, must be demonstrated.

The program in graduate medical education will prepare the resident for practice in a medical specialty and will focus on the development of the clinical skills and professional competencies. The program, based at Albany Medical Center and its affiliates, will utilize both inpatient and ambulatory settings.

Duties and Responsibilities

- Functions as a physician or dentist resident performing duties involving direct patient care as identified in the curriculum of the specific training program under the direction of the residency training program director. The amount of supervision is dependent upon the level of experience of the resident.
- Attends lectures and seminars as outlined in the curriculum of the residency program.
- Participates in continuous quality improvement activities of clinical service as assigned by the program director.
- Performs the responsibilities and scope of practice as delineated in each residency program curriculum outline.
- Performs all duties in accordance with Albany Medical Center's bylaws, policies and procedures, in addition to those approved by the Graduate Medical Education Council.

Supervision

The resident's professional development will rely primarily on learning acquired during the process of providing patient care under supervision. Residents are indirectly and directly supervised by a licensed member of the Albany Medical Center or affiliated hospital faculty as mandated by the Accreditation Council on Graduate Medical Education (ACGME). All clinical decisions made by junior and senior residents are subject to the supervision and review of the faculty.

The resident will assume progressively greater responsibility for patient care throughout the course of the residency program, consistent with his/her individual growth in clinical experience, knowledge and skill. As the trainee demonstrates increasing competence, he/she will be granted increasing independence of practice and judgment.

Education, Experience and Special Skills

The resident must be one of the following:

- a graduate of a medical school in the U.S. or Canada which is accredited by the Liaison Committee on Medical Education (LCME); or

- a graduate of an osteopathic school accredited by the America Osteopathic Association; or
- a graduate of a medical school outside the U.S. or Canada who is certified by the Educational Commission for Foreign Medical Graduates (ECFMG) OR has a full and unrestricted license to practice medicine in a U.S. Licensing jurisdiction; or
- a graduate of a Fifth Pathway program.

In addition, the program from which the resident has graduated must be acceptable to the New York State Department of Education and the ACGME.

Program Directors/Department Chairmen shall, on a annual basis, make a judgment as to reappointment based on evidence of progressive scholarship and professional growth of the resident as demonstrated by his/her ability to assume graded and increasing responsibility for patient care.

Once accepted into a postgraduate training program, the resident progresses through the program as successful completion of each post graduate year of training is verified by the program director through regularly occurring performance evaluations. The level of responsibility is increased progressively as the resident successfully advances through the training program.

Special skills and specific responsibilities are dependent upon the resident's level of experience within the program curriculum. Program lengths vary depending upon accreditation and board eligibility requirements. Upon completion of the residency program, the resident should be prepared to undertake independent medical practice. Residents in a specialty typically also complete training requirements for certification by a specialty board.

Visa/Citizenship Requirements

If not a citizen of the United States, the resident must be the holder of an appropriate visa status, which specifically allows him/her to be work authorized. Currently, the only visa acceptable for graduate medical education at Albany Medical Center is the J-1.

The Competency Initiative

As of July 2002, the ACGME has mandated that each residency training program insure trainee competence in various areas of clinical practice. The General competencies for Surgery are iterated below.

General Competencies

Residents must become competent in the following six areas at the level expected of a surgical practitioner. Training programs must define the specific knowledge, skills, and attitudes required and provide the educational experience for residents to demonstrate:

- 1) Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
Surgical residents must:
 - a) Demonstrate manual dexterity appropriate for their training level.
 - b) Be able to develop and execute patient care plans.
- 2) Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of this knowledge to patient care.
Surgical residents are expected to:
 - a) Critically evaluate and demonstrate knowledge of pertinent scientific information.
- 3) Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
Surgical residents are expected to:
 - a) Critique personal practice outcomes.
 - b) Demonstrate recognition of the importance of lifelong learning in surgical practice.
- 4) Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals.
Surgical residents are expected to:
 - a) Communicate effectively with other health care professionals.
 - b) Counsel and educate patients and families.
 - c) Effectively document practice activities.
- 5) Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
Surgical residents are expected to:
 - a) Maintain high standards of ethical behavior.
 - b) Demonstrate a commitment to continuity of patient care
 - c) Demonstrate sensitivity to age, gender and culture of patients and other health care professionals.
- 6) Systems-Based Practice as manifested by actions that demonstrate an awareness of and response to the larger context and system of health care and effectively call on system resources to provide optimal care.
Surgical residents are expected to:
 - a) Practice high quality, cost effective patient care.
 - b) Demonstrate knowledge of risk-benefit analysis.
 - c) Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

The following graphic displays each area of competency required, the way in which we will insure your exposure to this area and our methods of evaluation of competency in these areas.			
Competency	Description	Instruction method **	Evaluation methods
Knowledge	- Critically evaluate and demonstrate knowledge of pertinent scientific information	Clinical topic interactive sessions, ward teaching rounds, chart stimulated case conferences, Journal club (using readers guide), evidence-based web-sites provided, journals and texts provided Selected Reading in General Surgery, Best Resident, ACS Surgery, Board review sessions	- Faculty end of rotation evaluation - ABSITE, Mock Oral Exams - Ongoing contact with faculty wards, office, OR - Stimulated Chart reviews - Ward teaching rounds - Board Review Sessions - Clinical sessions, Q and A sessions
Patient Care Skills	- Must demonstrate manual Dexterity - Must develop and execute Patient care plans	Operating room experience, case logs, procedure credentialing system, MIS dry lab, Simulators, LAP101 CD, animal labs, ACS Video library, daily supervision by more senior residents and faculty, chart stimulated case reviews, SICU course, Introduction to Surgical Care Course, ward teaching rounds, Morbidity and Mortality conference, practice Based improvement logs	- Evaluation of simulator performance - FLS Program of SAGES - Ward teaching rounds evaluation by faculty - End of rotation 360 evaluations - Operative skills checklists - Chart Stimulated case reviews by faculty - Mortality and Morbidity conference - Resident portfolio
Interpersonal and communication Skills	- Communicates effectively with other health care professionals - Counsels and educated patients and families - Effectively documents practice outcomes	Interactive sessions on communication skills, "Giving Bad news", discharge planning/ social work sessions, daily discharge planning, faculty role modeling one-on-one in office Weekly chart review by PD and Chief Admin Resident with feedback	- OSCE (pgy1,3) - 360 evaluations - Patient evaluation, outpatient form and inpatient satisfaction surveys, PD chart review with Admin. Chief with feedback - Observation by faculty mentors - Resident portfolio
Professionalism	- Maintain high standards of ethical behavior - Demonstrates knowledge of risk-benefit analysis - Demonstrate sensitivity to age gender, culture of patient and other health care professionals	Ethics curriculum, ethicist at M and M conference, sessions on advanced directives and informed consent , one-on-one role modeling in office Clinical topic sessions, chart stimulated reviews, Mortality and Morbidity conference, Risk management case study (pgy2,4) Sessions on cultural and ethnic diversity, discharge planning/ social work module, speaker from the Committee on Physicians Health, and Office of Professional Conduct NYSDOH.	- OSCE (pgy1,3) - 360 evaluations - Patient office evaluation - Discharged patient surveys - Mock oral exam and ABSITE - Risk management case study reviewed by PD - Report of DP/SW mentor
Practice-Based learning	- Critique personal practice and outcomes - Demonstrates recognition of Importance of lifelong learning In surgical practice	Resident portfolio, Practice Based Improvement Log, Chart stimulated reviews, Mortality and Morbidity Review, Mid-term feedback discussion, one-on-one discussions in office setting, ward teaching rounds Clinical and basic science sessions, Journal Club discussions, ABSITE and Mock Oral Prep sessions	- Mid rotation feedback forms - Evaluation of chart stimulated case reviews - PBL and I M and M forms - Resident portfolio - Evaluation of Journal club participation (form submitted)
System Based Practice	- Practice high quality and Cost effective care - Demonstrate knowledge of risk-benefit analysis - Demonstrate an understanding of the role of different specialists and other health care providers in overall patient management	Assignment of residents to QIT and other hospital committees, interactive sessions on health care delivery systems, payers, cost Discussion at M and M, Journal Club, QIT meetings, chart stimulated reviews, risk management case study (pgy2,4) Session with discharge planning/social work Legal issues and malpractice	- Discharge planning/social work module evaluation - Resident portfolio review - Risk-management module evaluation - 360 evaluation of office and inpatient practice - QIT and Committee participation , projects' and activities reviewed (Portfolio) - Chart stimulated reviews evaluation - Practice based improvement logs

Resident Portfolio

A Resident Portfolio is a tool that the ACGME and the RRC for Surgery suggest as the best way to track resident activities in the areas of competency listed above. This tool is available for your use on New Innovations. Your entries into this data base must be contemporaneous to be an effective learning and evaluation tool. The Program Director will review your portfolio from time to time. Failure to keep this log up to date will be considered as a lack of professionalism on your part.

Please enter information in the following categories:

Narrative entries

- 1) Monthly case study with EBLitt search- additional reflection of epidemiology and impact of the disease on the health care system (K, PC, PBL)
- 2) Monthly growth and development as a surgeon
 - Includes - Interpersonal and communication skills (IPC)
 - Team building strategies (SBP, IPC)
 - Patient safety (P, PC, PBL)
 - Self critique, faculty feedback, mid- rotation feedback (P, PBL)
- 3) Discharge planning case study –(SBP)
- 4) Monthly QIT and Hospital committee participation and project development (PC, P, IPC)
- 5) Reflection on ABSITE deficiencies and remediation plan, actions, litt review etc. (K, PBL)
- 6) Reflection on mock oral exam deficiencies, plan, actions, litt review etc. (K, IPC, PBL)

Imports - by resident or program coordinator

- 1) Journal club article preparation work sheet, slides etc (resident) (K, PBL)
- 2) Technical skills assessment form (coordinator) (PC)
- 3) PBL M and M form (coordinator) (PC, K, and PBL)
- 4) FLS certification (coordinator) (PC)
- 5) Quarterly letter of evaluation (K, PC, IPC, P, PBL, SBP)
- 6) Evaluation of resident (PGY2) participation in student tutorials (K, PC, IPC)
- 7) Report of Mentor – discharge planning (coordinator)
- 8) Report of mentor – Risk Management (coordinator)

Listings

- 1) Independent reading log (K)
- 2) SESAP and similar self study programs (K)
- 3) Computer assisted study (K, PBL)
- 4) Competency series attendance and topic (Choose one or more appropriate competency areas addressed-see teaching day schedule)
- 5) Publications, presentations, abstracts, posters and ongoing research project(s) (K, PC, PBL)
- 6) Use of Simulation center log /endo/lap-in hours or fraction thereof (PC, P)
- 7) Dry/animate labs attended- date, times, place (PC)
- 8) Completion of ACS skills curriculum (PC)
- 9) Completion of SCCM course (K, PC)
- 10) Completion of ACLS (K, PC)
- 11) Completion of ATLS (basic, Instructor level) – dates, place (K, PC, P)
- 12) Completion of Addiction Module – (K, PC, SBP) Trauma/ACS service activity PGY1 or2
- 13) Completion of Organ Procurement module and OSCE – (PC, IPC, P)- Transplant service activity – PGY1 or 2

- 14) Good Citizenship – (P) Memberships in societies etc
 - Community service
 - Patient evaluations (coordinator)
 - Medical record and discharge summary completion (Coordinator)
- 15) Completion of discharge planning experience (SBP, PC) PGY2 activity
- 16) Completion of Risk Management Module (PC, SPB, PBL) PGY 2 and 4 activity
- 17) Completion of Practice Management CD (SBP)
- 18) Completion of CD Communicating with patients about errors and adverse outcomes, Disclosing surgical errors vignettes (IPC, P)
- 19) Completion of CD Ethical issues in Clinical Surgery and Ethical Issues for Residents (P, PC, SBP)
- 20) Completion of Bariatric Surgery Primer (K, PC, IPC, SBP)
- 21) Completion of Breast Disease Curriculum (K, PC, IPC<PBL)
- 22) Completion of participation in student tutorial experience (PGY2) (K, PC, IPC)
- 23) Completion of OSCE – Communication and Interpersonal skills (P, IPC) – PGY 1,3

**Practice-Based Improvement Log
General Surgery Residency
Albany Medical Center**

Each resident will complete a practice-based improvement log entry on each patient he/she presented at the Morbidity and Mortality Conference for whom he/she was the responsible resident (operating or admitting surgeon). The resident will discuss his/her practice-based improvement log entries at his/her next formal evaluation meeting with the program director.

Resident:

PGY:

M & M Conference Date:

Date of Report:

Patient Data

M & M Case Report:

Effect of Complication on Patient's Outcome

Check the most appropriate description of the effect of the complication on the patient's outcome

- Outcome not affected by incident
- Minor, resolves or requires simple bedside procedure or antibiotics (examples: wound infection, UTI)
- Life-threatening, requires medication or intervention that carries risk (examples: pneumonia, arrhythmia, acute pancreatitis)
- Life-threatening, requires invasive intervention (examples: CT-guided abscess drainage, re-operation)
- Associated with residual disability or organ loss (examples: stroke, iatrogenic splenectomy)
- Death

Analysis of Complication/Death

Which factors led to the complication? (check all appropriate fields)

Personal Factors

- | | |
|---|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> time pressures |
| <input type="checkbox"/> illness of provider | <input type="checkbox"/> performance lapse |
| <input type="checkbox"/> lack of judgment | <input type="checkbox"/> poor situational awareness |
| <input type="checkbox"/> lack of experience | <input type="checkbox"/> poor task prioritization |
| <input type="checkbox"/> lack of knowledge | <input type="checkbox"/> failure to check equipment |
| <input type="checkbox"/> lack of technical skills | |

Team Factors

- no briefing
- negative attitude of the surgical team
- poor surgical team communication/coordination
- poor communication/coordination between surgical and anesthesia teams

- poor communication/coordination between physicians and nursing staff
- equipment failure
- unfamiliar equipment/monitoring
- misleading arrangement of equipment
- lack of equipment/monitoring

OR Environment

- unfamiliar surroundings
- inappropriate help/support
- patient condition
- high pressure environment
- bad working conditions
- understaffing
- unworkable policy/procedures

Disease Process

- Terminal malignancy
- Severe cardiovascular disease
- Overwhelming sepsis

In your option, this incident was:

- Preventable
- Not preventable

This complication/death belongs in the following error category (more than one category can be involved)

- Complication due to disease process
- Complication due to error in diagnosis
- Complication due to equipment failure
- Complication due to regulatory problem (government/insurance company rules)
- complication due to poor technique
- complication due to error in judgment
- complication due to systems problem

Your reasoning:

Are there any opportunities for systems improvement?

What do you suggest the hospital do to prevent similar incidents in the future?

Are there any significant ethical issues in this case?

Are there any ethnic/cultural issues in this case?

What will you do differently in your own practice as a result of this experience?

List references/evidence-based medicine reports you consulted for this case.

PATIENT SAFETY GOAL MONITORING

Name of Reviewer: _____ M.D.

Instructions: Please review 5 charts on your service each week and provide the following data on compliance with AMC policies

1) Medication related orders are free of prohibited abbreviations

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

2) Medication related Progress Notes are free of prohibited abbreviations

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

3) A complete medical history was obtained on admission with patient involvement

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

4) Comparison of pre-admission medications with those medications ordered on admission with resolution of discrepancies has been done

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

5) Time out is performed prior to all procedures performed in/out of the Operating Room Area

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

6) The entire team actively participated in the time out process

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

7) Each time out was used to verify the following:

- a) Correct patient name**
- b) Correct date of birth**
- c) Correct procedure to be performed**
- d) Correct site/side for procedure**
- e) Needed equipment is at hand (including supplies/implantable devices)**
- f) Correct patient position for procedure has been established**

MRN	Date Reviewed	Compliance
		Y/ N
		Y/ N
		Y/ N
		Y/ N
		Y/ N

RESIDENT LIBRARY

A resident library is maintained in the Resident's Room. Standard textbooks and current copies of surgical journals are provided for your on-site use. Every Senior resident and Chief resident is expected to review the basic journals in Surgery each month.

TEXTS

ACS Surgery: Volume 4-7
ACS: Ethical issues in clinical Surgery for practicing surgeons
ACS: Ethical issues in clinical Surgery for Resident
Andersen: Advances in Colorectal Carcinoma Surgery
Arrequi/ Eubanks/ Olsen/Macfadyen: Laparoscopic Surgery of the Abdomen
Artz: Complications in Surgery and Their Management
ASCRS: Textbook of Colon and Rectal Surgery
Ashcraft: Atlas of Pediatric Surgery
Badenoch: Manual of Urology
Bateman: The Shoulder and Neck
Bell: Digestive Tract Surgery
Blaisdell: Respiratory Distress Syndrome of Shock and Trauma
Blumgart: Surgery of Biliary Tract and Pancreas ('06 w/cd)
Britt: Acute Care Surgery-Principles and Practice
Cady and Rossi: Surgery of Thyroid/Parathyroid
Cameron: Current Surgical Therapy (9th Edition)
Chassin: Operative Strategy in General Surgery
Condon: Surgical Infections
Corman: Colon and Rectal Surgery
Daly: Current Opinion in General Surgery
Davis: Clinical Surgery
Delaney: Operative Techniques in Laparoscopic Colorectal Surgery
Eiseman: Prognosis of Surgical Disease
Fazio: Current Therapy in Colon and rectal Surgery
Foster: Solid Liver Tumors
Glaxo: Masters of Surgery
Gliedman: Atlas of Surgical Techniques
Greenfield: Review for Surgery
Greenfield: Surgery (1st and 3rd editions)
Grossfield: Pediatric Surgery (6th Edition)
Hanley and Belfus: Surgical Intuitions
Harken: Surgical Debates
Harris: Diseases of the Breast
Lawrence: General Surgery
Lubin: Medical Management of the Surgical Patient
Madden: Abdominal Wall Hernias
Malinin: Reversibility of Cellular Injury Due to Inadequate Perfusion
Mattox: Top Knife
Mazier: Surgery of the Colon/Rectum/Anus
McPhee: Pathophysiology of Disease
Netter: Atlas of the Human Anatomy
Nora: Operative Surgery
Norton: Basic Science and Clinical Evidence
O'Leary: Physiologic Basis of Surgery
Roberts: Clinical Procedures in Emergency Medicine
Roche: Current Modalities in Surgery
Rutherford: Vascular Surgery (5th Edition)
Sabiston: Textbook of Surgery (13th, 14th, 15th Editions)
Schwartz: Maingots Abdominal Operations (9th Edition)
Schwartz: Principles of Surgery (5th Edition)
Shackelford: Surgery of the Alimentary Tract (2nd and 3rd Edition)
Shoemaker: Textbook of Critical Care
Shields: General Thoracic Surgery
Soper/Swanstrom/Eubanks: Mastery of Endoscopy and Laparoscopic Surgery
Sterns: Surgery
Strichartz: Surgery Specialty Board Review
Tannock: Basic Science of Oncology
Valentine and Wind: Anatomic Exposure in Vascular Surgery
Vance: Controversy in Surgery
Way: Current Surgical Diagnosis and Treatment
Wilson: Vascular Access
Wolfe: Pulmonary Embolism
Zucker: Surgical Laparoscopy

JOURNALS

- The American Journal of Surgery
- Annals of Surgery
- Surgical Education
- Current Problems in Surgery
- Journal of the American College of Surgery
- Surgical Rounds
- Surgery

CME Info

- Consists of 32 two-hour DVDs – available in the residency office.

AUDIO TAPES

- Companion audio tapes to the Selected Reading series are available in the Residency office.

CD/DVD ROM'S

- The Educational Companion (for the Physiologic Basis of Surgery) – a question bank keyed to this text.
- Greenfield's Textbook of Surgery
- Selected Readings in General Surgery
- FLS program of SAGES
- Laparoscopy 101 – SAGES
- Ultrasound for Surgeons - ACS
- Bariatric Surgery Primer – ACS
- Communicating with Patients about Surgical errors and Outcomes –ACS
- Disclosing Surgical Error: Vignettes for Discussion-ACS
- Effectively Communicating to a Diverse Patient Population-Medical Society of New York
- Breast Disease Curriculum-ACS
- Blumgart: Surgery of Biliary Tract and Pancreas

COMPUTER PROGRAMS

- Web Surg – Case Simulations, Images, Text ACS Surgery – on-line Textbook
- Surgical – Tutor.org.uk – multitask program for surgical residents.
- www.surgicaleducation.com
- www.acssurgery.com
- BestResident
- SCCM Critical Care Course
- ACS Skills curriculum – on line
- Cameron – Surgical Therapy – on line text
- Primary Care Radiology – Harvard – on line
- ACS Surgery – on line
- National Library of medicine – on line surgery videos
- ACS video series – operations and procedures
- ACS Fundamentals of Surgery (demonstration module)
- WeBSurg.co,

SIMULATORS

- Upper and lower endoscopy
- Minimally Invasive Surgery
- Vascular procedures

EVALUATION OF RESIDENT PERFORMANCE AND PROGRESS

Each resident will be evaluated in all six competency dimensions. The faculty and program director will meet quarterly, discuss resident performance and issue you a written summary of the discussion. Each resident will then be required to meet with the program director to review the evaluation letter and all of the support documents considered. The program director and the resident must sign each document attesting to the review.

Each resident will be evaluated in the following competency areas:

1) **KNOWLEDGE** – The evaluation of resident knowledge of the basic science and clinical aspects of surgery is ongoing in this program. For each rotation, there are defined knowledge objectives that are contained in this manual. Faculty, senior and chief residents are solicited in regard to your mastery of this material, appropriate for level of training. In addition, your preparation for the participation in basic science and clinical science didactic sessions is assessed. Test scores on the yearly ABSITE are considered. Performance below the 35th percentile on these exams is considered cause for concern. All senior and chief residents will undergo oral examination each April to further assess discursive knowledge of clinical surgery.

2) **PATIENT CARE** – Clinical performance will be evaluated at the end of each clinical rotation by the faculty, chief residents, senior residents, nursing staff and others. Clinical performance includes such areas as the practical application of surgical knowledge, including initial patient history and physical exam, developing a diagnostic algorithm, care plan and monitoring progress and complications. This will be evaluated in an ongoing way and summarized at the end of the rotation. In the operating room your knowledge of the patient, history, physical findings, laboratory findings, indication for and ideal conduct of the operation, potential complication (appropriate for your level) will be considered. The attainment of technical skills will be assessed both formally and informally.

3) **INTERPERSONAL SKILLS AND COMMUNICATION SKILLS** – Faculty, other residents, nurses and patients will all participate in evaluating you in this regard. We will pay particular attention to your effective communication with others, your counseling and education of patients as well as your concise and complete documentation of patient progress and outcomes. The presence of medical students provides a rich opportunity to teach as well as learn. An OSCE is also provided to assess these skills.

4) **PROFESSIONALISM** – Faculty, other residents, nurses and patients will evaluate you as to ethical behavior, demonstration of knowledge of risk-benefit analysis and sensitivity to age, gender and culture of all those with whom you come in contact.

5) **PRACTICE-BASED LEARNING AND IMPROVEMENT** – Faculty will evaluate your ability to critique personal practice and outcomes as well as your demonstration of the recognition of importance of lifelong learning in surgery. A review of your resident portfolio will aid in this assessment.

6) **SYSTEMS BASED PRACTICE** – Faculty evaluation, nursing evaluation, discussions at M and M conference, review of your portfolio, journal club participation and office participation with evaluation will demonstrate that you practice high quality and cost effective care, demonstrate a knowledge of risk-benefit analysis and that you demonstrate an understanding of the role a different specialist and provider in the overall management of patients.

As part of the evaluation process, particular attention will be given to the following:

1) Scholarly activity – active participation in basic science and clinical conferences, preparation of assigned case presentation ,discussions, journal clubs and active participation in the teaching of medical students and more junior residents.

2) Research – A spirit of inquiry is a prized asset in a surgeon. Two original papers are required and others are encouraged. These may be basic science or clinical surgery (review articles are acceptable). Each PGY-3 and 4 resident must present a paper at the Annual Resident Research Day.

3) Attendance At Conferences – Arrival should be prompt. Attendance will be monitored. ALL RESIDENTS MUST ATTEND THURSDAY MORNING CONFERENCE, MORTALITY AND MORBIDITY CONFERENCE AND MONDAY CLINICAL CONFERENCE. ONLY POST CALL RESIDENTS ARE EXCUSED FROM MONDAY CASE CONFERENCE AND MORTALITY AND MORBIDITY CONFERENCE.

4) Administrative and Record Keeping Responsibilities – You should complete, in a thoughtful and timely manner the following:

- Operative notes and dictations
- Resident credentialing
- Deaths and complications lists
- Operative Case Log
- Technical skills assessments
- Office activity attestations and lists
- Medical student evaluations
- Evaluations of faculty
- Evaluations of rotations

5) Decorum – It is expected that residents will dress and behave as professionals. Operating room attire is not appropriate outside the operating room except in the MOST UNUSUAL circumstances. Clean white jackets, with hospital identification badge, dress cloths appropriate to the position and appropriate footwear are essential. Neatness is essential to a surgeon, as people will judge you by your appearance.

Mid Rotation Feedback

Faculty Feedback of Resident Performance

Constructive mid-rotation feedback is essential in the development of a surgical resident. This feedback should be formative and constructive with concrete examples and suggestions for remediation in areas of perceived deficiency. This feedback should be shared with the resident by the midpoint of the rotation or sooner. The ACGME requires that we document feedback in our program. This form provides such documentation of feedback on deficiencies in one or more areas. You may also commend a resident for his/her performance in one or more areas. Positive feedback is also important in the development of a surgical resident. Please use this form to document the positive feedback given at the midpoint of the rotation.

I have shared with the resident named above my concerns in the following areas: (indicate one or more)

Medical Knowledge	Patient Care	Professionalism	Communication and Interpersonal skills
0	0	0	0

I have shared with the resident named above the following commendation(s) on his/her performance(indicate one or more)

Medical Knowledge	Patient Care	Professionalism	Communication and Interpersonal skills
0	0	0	0

RESIDENT EVALUATION OF A ROTATION AND FACULTY

Each resident will have the opportunity to evaluate **each faculty member and rotation** at the conclusion of that experience. These evaluations will be collated at the end of each year and presented to the faculty in an autonomous way. These comments will allow us to further refine our education program.

RESIDENT COMMITTEE

A Resident Committee is elected each year consisting of chief residents and representatives from PGY-1-4 categorical residents. This Committee may bring forward, at any time, issues affecting any aspect of the resident experience. This committee will meet at least quarterly and provide written report/minutes to the Program Coordinator's office. After consideration the Program Director will respond to these issues in writing. The issues will be discussed at the quarterly faculty meeting.

RESIDENT EVALUATION OF ROTATION

ROTATION: _____

Directions: Please rate the rotation with regard to the following items using scale.

1) Outstanding 2) Above Average 3) Average 4) Marginal 5) Poor

1) The fulfillment of the goals and objectives stated for the rotation (See Resident Manual) _____

2) Service Requirements were balanced by the fulfillment of educational objectives _____

3) The number and quality of teaching conferences on the rotation _____

4) *The number and quality of clinic experiences on the rotation _____

5) This rotation provided essential information for a General Surgeon _____

6) The education of the rotating resident was a prime concern of the faculty and resident Staff _____

7) The operating room experience:
a) Was at appropriate level _____

b) Balanced service with education _____

8) Patient care by resident was appropriately supervised by attending staff _____

*Except ICU and ER

Comments:

RESIDENT EVALUATION OF FACULTY – DEPARTMENT OF SURGERY

Name of Faculty Member: _____

Directions:

1) Outstanding 2) Above Average 3) Average 4) Marginal 5) Poor

1) Serves as a suitable role model when operating, teaching (at bedside or in clinic) and in interpersonal relationships with patients, residents and colleagues _____

2) Promotes and stimulates interest and pursuits of residents and students _____

3) Provides instruction in the technical aspects of surgery _____

4) Provides insight into the decision making process governing care of surgical patients – this includes communication of the pre-operative workup, co-morbid problems, contemplated procedures and special consideration for patients admitted to the service _____

5) Provides ongoing instruction and supervision in the postoperative care of the surgical patient _____

6) Participates in the scholarly activities of the Residency Program (conference, lectures, etc.) _____

7) Is readily available for consultation and direction of patient care _____

8) Is aware of and integrates into the clinical setting the latest information available in the surgical literature (challenged you intellectually) _____

9) Communicates easily and effectively with residents when providing feedback on resident performance (receptive to resident’s ideas and viewpoint) _____

10) Exemplifies an academic surgeon _____

11) Personal Qualities:

Empathy _____ Respectfulness _____ Enthusiasm _____

Maturity _____ Initiative _____

12) Professional Qualities:

Reliability _____ Honesty _____ Motivation _____

Ethical Behavior _____ Responsibility _____ Leadership _____

Comments:

RESIDENCY OBJECTIVES

As the surgical resident program is seen primarily as an educational endeavor, certain educational objectives have been set for residents at each level of training. A brief description of the objectives follows.

Chief Resident

- 1) Provides supervision of the junior resident in carrying out patient care responsibilities for the patient chosen by the chief resident for care (patient with complex surgical problems).
- 2) Communicates the details of patient progress or complications to attending surgeon in a timely way.
- 3) Understands the sophistications of the pathophysiology of the patient's disease processes.
- 4) Perfects the elements of pre-operative preparation of the surgical patient especially in consideration of existing co-morbid factors.
- 5) Understands, in depth, the principles of the operative procedure including pertinent anatomy and technical consideration and decision making process.
- 6) Develops with the attending surgeon a post-operative plan of care considering co-morbid factors basic disease process and conduct of the procedures.
- 7) Masters the interpersonal skills in dealing with patients, staff, fellow residents and attendings.
- 8) Masters the surgical technique (under supervision of attendings) specific to those patients with complex surgical problems.
- 9) Functions as consultant to junior and senior residents as needed.
- 10) Functions as educator of surgical house staff and medical students.
- 11) Functions as administrator of the junior and senior resident staff.

Senior Resident Objectives

- 1) Provides supervision of the junior resident in carrying out patient care responsibility to include:
 - a) Confirms and reviews pertinent history and physical findings with the junior resident.
 - b) Reviews subjective and objective evidence of patient progress or complications with the junior resident.
 - c) Reviews pertinent laboratory and imaging data with the junior resident.
 - d) Modifies (as needed) patient care plan developed by the junior resident.
- 2) Communicates the details of patient progress or complications to attending surgeon in a timely way.
- 3) Masters the sophistication of the pathophysiology of the patient's disease process.
- 4) Masters the elements of preoperative preparation of the surgical patient, especially in consideration of existing com-morbid factors developed in one.
- 5) Understands the principles of the operative procedure including pertinent anatomy and technical considerations as well as decision making process.
- 6) Develops with attending surgeon a post-operative plan of care considering co-morbid factors, basic disease process and conduct of operative procedure.
- 7) Supervises the junior resident in the day to day execution of the care plan.
- 8) Educates junior and senior medical students in basic surgical diseases, surgical biology and the conduct of pre, intra and post-operative care of the surgical patient.
- 9) Refines interpersonal skills in dealing with patients, staff, fellow residents and attendings.
- 10) Learns surgical techniques (under supervision of attending surgeon) specific to the rotation.
- 11) Accomplishes course objectives stated for the rotation (see rotation goals and objectives).
- 12) Becomes conversant with the periodical surgical literature (see journal club).

Junior Resident Objectives

- 1) Performs comprehensive history and physical assessment and share information with senior resident/attending.

- 2) Uses available information, in combination with the interpretation of basic laboratory and radiographic data to develop a plan for the pre-operative preparation of the patient and discuss with the senior resident/attending.
- 3) Understands the basic pathophysiologic disease process and its surgical implications.
- 4) Understands the decision making process required of the surgeon and the principles on which the decisions are based.
- 5) Understands the basics of the surgical procedure performed, including tubes placed, drains placed, lines placed etc.
- 6) Develops, with the aid of senior resident and attending surgeon, a post-operative plan of care and surveillance. Anticipates problems particular to this patient or disease entity.
- 7) Provides for the day-to-day routine care of the patients on his or her service – writes admission orders, organizes tasks, obtains data, etc.
- 8) Serve as instructor to junior and senior medical students and supervise their assigned tasks along with the senior residents.
- 9) Develops interpersonal skills necessary for dealing with patients, nursing staff, fellow residents and attending staff.
- 10) Masters the principle of basic surgical biology as they impact on the basic care of the surgical patient (see basic science course curriculum).
- 11) Accomplishes the course objectives stated for each rotation (see goals and objectives for rotations).
- 12) Learns basic surgical skills – sterile technique, OR conduct, dressing changes, wound care, basic surgical procedures under supervision.
- 13) Complete ATLS and ACLS programs

ABS OBJECTIVES EXPECTED OF A JUNIOR RESIDENT

The American Board of Surgery as part of the Fundamentals of Surgery Project has listed the following knowledge and skill objectives for all Junior Residents in General Surgery. The resident should be able to:

- 1) Perform a competent patient assessment including a history, physical examination and document same.
- 2) Choose and order appropriate diagnostic tests and appropriately assess results.
- 3) Discuss the importance of maintaining and managing an airway.
- 4) Explain the basic concepts of fluid and electrolyte balance and acid base balance and can write patient appropriate orders.
- 5) Discuss the importance of fever in the surgical patient, appreciates the differential diagnosis and time course, microbiology and basics of surgical infections.
- 6) Explain universal precautions.
- 7) Discuss basics of nutrition in the surgical patient.
- 8) Explain the principles of pre-operative preparation of the surgical patient.
- 9) Discuss the principles of sterile technique.
- 10) Prioritize and manage complications.
- 11) Explain the basics of critical care and the management of shock.
- 12) Discuss coagulation and anticoagulation.
- 13) Explain applied cardiac physiology.
- 14) Discuss applied renal physiology.
- 15) Discuss applied pulmonary physiology.
- 16) Discuss the principles of the acute abdomen.
- 17) Explain the principles of bowel obstruction.
- 18) Appropriately manage a diabetic patient.
- 19) Explain the principles of management of the hypertensive patient.
- 20) Discuss discharge planning and the need for and arrangements for rehabilitation.

SPECIFIC LEARNER OBJECTIVES FOR CLINICAL ROTATIONS

In addition to the General Goals for General Surgery Residents at each level, we have developed specific competency based learner objectives for each rotation. Following each set of rotation specific objectives, you will find the evaluation tool (linked to the objectives) that is used by faculty to assess your performance on a given clinical service.

For junior residents, the throughst of the experience is the mastery of the pre-, peri- and post operative care of the surgery patient. The American Board of Surgery has developed knowledge and skills goals for the PGY-1 level (see above). It is expected that you will have developed competency in these areas by the completion of the junior resident experience. A copy of these competency based objectives is provided The evaluation tool is directly linked to these competency based objectives.. Be aware that there is some overlap in areas covered during each rotation in General Surgery. Please revisit these objectives when beginning any rotation. You will receive an email of the objectives prior to start of the rotation.

For senior residents the rotation specific competency based objectives. Again, the evaluation tool directly reflects the competency objectives are provided. There is certainly some overlap of clinical topics between rotations. Please review all relevant topics for a given rotation at the beginning of that rotation. You will receive by email a copy of the objectives prior to starting the rotation.

For chief residents, general objectives for the chief level are in place and the evaluation tool reflects these competency based objectives.

The SCORE Curriculum of the American Board of Surgery

In an attempt to define the minimum body of knowledge needed for the safe and effective practice of General Surgery the American Board of Surgery is developing, in concert with the Surgical Council on Resident Education(SCORE) a Patient Care Curriculum. This program will be available for resident and faculty use on or about July 1, 2009.

The curriculum uses taxonomy for body systems, disease states as well as common, uncommon and complex operative procedures.

As an adjunct to the didactic elements in place in our training program we will now add rotation specific assignments. During each clinical rotation each resident must complete enumerated elements of the SCORE curriculum . The faculty of that rotation will address various (but not all) elements of the curriculum through formal teaching rounds and other discussions. Residents are expected to complete all elements of the assigned topics, diseases and procedures during the course of the rotation. The resident will then self test this material using the SESAP question bank. Performance on this exercise will be considered a part of the evaluation process of resident performance.

Incoming PGY1 categorical and designated preliminary residents are expected to participate in this process to the extent allowed by their limited time on a given service. The educational focus for the PGY1 resident is the Fundamentals in Surgery Curriculum of the ACS. This program consists of computer case scenarios, formal didactic sessions with our faculty and faculty run skills laboratory sessions throughout the year.

PGY2 categorical residents will participate in the SCORES assignments to the extent that the length of the rotation provides. There are particular assignments linked to certain PGY2 level rotations that are to be completed in their entirety. Self testing using SESAP will apply to these areas.

PGY 3 and 4 categorical residents must complete the reading assignment, view the appropriate video material available and work through the open ended questions provided for consideration. At the conclusion of the rotation the resident must self test as described above.

Chief residents are expected to participate in the formal teaching rounds and other didactic sessions. In addition attention should be directed to the” Focused Diseases” and “Uncommon and Complex operative procedures” of the SCORE curriculum.

Following is a list topics to be completed while on a given senior level rotation.

SCORE Assignments

G1 – General
Hernia
Biliary

G2 – Liver
Pancreas
Large Intestine
Anorectal

Moores – Thoracic Surgery

ACS – Appendix
Small Intestine
Trauma
Spleen

MIS/ENDO – Endoscopy (PGY2)

SCC – Breast (PGY2)
Endocrine

SICU- Critical Care (PGY2)

MIS- Esophagus-GERD
Stomach and Morbid Obesity

Vascular – Arterial and Venous

Transplant- Access
Transplantation

Peds – Pediatric Surgery

Plastics- Plastic Surgery (PGY2)

VA- General
Hernia
Biliary

GU<GYN<Head and Neck, Neurosurgery –
independently (PGY2)

Competency Objectives for the Junior Resident Rotation on Acute Care Surgery

At the end of this rotation the resident must be able to:

Knowledge

- 1) Demonstrate a working knowledge of ATLS protocols
- 2) Discuss, in detail, the impact of trauma to the central nervous, cardiovascular, pulmonary and gastrointestinal systems as well as trauma to the extremities
- 3) Define the nutritional needs of the severely injured patient
- 4) Discuss the principles of wound management in the emergency room and other settings
- 5) Demonstrate a working knowledge of the principles of primary and secondary survey in the evaluation of the injured patient
- 6) Define and discuss the principles of critical care in the significantly injured patient.

Patient Care Skills

- 7) Effectively use ATLS protocols in the care of injured patients
- 8) Demonstrate the efficient and appropriate use of the primary and secondary survey
- 9) Apply principles of surgical critical care to the patient with significant trauma
- 10) Demonstrate surveillance skill in the monitoring of injured patients
- 11) Write appropriate orders for nutrition of the acutely injured patient.
- 12) Demonstrate appropriate wound care including splinting, casting and traction for the injured extremity

Interpersonal and Communication skills

- 13) Present in a logical, comprehensive and concise fashion the details of patient progress and complications
- 14) Maintain effective communication with all members of the health care team involved in the care of the patient.
- 15) Informs patient and family of the details of diagnosis and care using clear, simple terms and ensure that there is an appropriate level of comprehension.

Professionalism

- 16) Interact with patient and family in an empathetic and compassionate fashion offering support services that are available.

Practice Based learning

- 17) Present at trauma conference using evidence based current information to critique practices and outcomes of patient under care
- 18) Review with faculty and supervising residents the choice of antimicrobials for appropriateness, effectiveness and cost.

Systems based practice

- 19) Coordinate rehabilitative services in conjunction with discharge planners, adjunct providers and home health agencies
- 20) Discuss the economic impact of various patterns of trauma/injury to the health care system and society as a whole
- 21) Complete the computer module on substance addiction, including the pre-and post test (copy to be submitted to the residency coordinator)

Competency Objectives for the Junior Resident on rotation to the Emergency Room

At the end of this rotation the resident must be able to:

Knowledge

- 1) Demonstrate a working knowledge of the applied principles of both ACLS and ATLS
- 2) Discuss the principles and practice of the primary and secondary survey in the care of a patient with major trauma
- 3) Describe the selection, use and toxicity of local anesthetics
- 4) Discuss the differential diagnosis of patients with abdominal pain in a variety of clinical settings.

Patient Care Skills

- 5) Provide, under supervision, initial resuscitation, evaluation and stabilization of a patient with major multisystem trauma (this should include patients with multisystem problems that include ENT, Ortho GU and Neurosurgery)
- 6) Appropriately use local anesthetics
- 7) Repair, under supervision, minor laceration and care for other minor wound, burns etc.
- 8) Participate effectively, under supervision, in the primary and secondary evaluation of the seriously injured patient.
- 9) Demonstrate prioritizing skills, appropriate use of diagnostic tests and decision making as well as preparation for operation, if needed.
- 10) Demonstrate proficiency, appropriate for level, in commonly performed invasive procedures (central lines, arterial lines etc.)

Communication and interpersonal skills

- 11) Present a well organized and comprehensive discussion of patient history and physical findings to senior residents and attending
- 12) Prepare and present, at Trauma conference, a logical, focused and comprehensive discussion of patients treated.
- 13) Discuss with patients and family, under supervision, findings, diagnostic plans and proposed treatments using clear, simple language
- 14) Debrief Emergency Medical Technicians and others with pertinent information of the accident/trauma

Professionalism

- 15) Demonstrate consideration and respect to supervising residents and faculty
- 16) Interact with patient and families in an empathetic and supportive manner

Practice Based Learning

- 17) Actively participate in Trauma conference and critiques personal performance
- 18) Use the surgical literature to perform evidence based critique of patient care and outcomes, presenting this information to peers and faculty

Systems based practice

- 19) Discuss the cost effectiveness of various diagnostic tests for the patient with trauma and abdominal pain
- 20) Triage effectively patients with presenting complaints of varying severity
- 21) Use consultants effectively and efficiently with consideration of cost
- 22) Appreciate the many considerations in the delivery of emergency care to a widely diverse population in a wide geographic area

Competency Objectives for the Junior Resident in the SICU

At the end of this rotation the resident must be able to:

Knowledge

- 1) Define the criteria for respiratory support and mechanical ventilation as well as weaning parameters
- 2) Demonstrate an understanding of fluid and electrolyte balance in the critically ill patient
- 3) Discuss the four major categories of acid-base imbalance
- 4) Define the element of coagulation and aberrations thereof.
- 5) Identify aspects for consideration in the management of a hemodynamically unstable patient
- 6) Demonstrate familiarity with multisystem organ failure, its causes, implications and integrate care thereof
- 7) Define the assessment of nutritional needs of the critically ill patient

Patient Care Skills

- 8) Prioritize, analyze data and develop a comprehensive treatment plan for the critically ill patient
- 9) Write and implement basic and appropriate admission orders for admission to the SICU
- 10) Manage appropriately patients requiring ventilatory support
- 11) Demonstrate proficiency in the placement of invasive monitoring devices under supervision and be able to use data obtained to modify patient care plan
- 12) Discuss and use appropriately various drugs commonly used for the support and treatment of the critically ill patient.
- 13) Account for the nutritional needs of critically ill patient and write appropriate orders

Professionalism

- 14) Discuss basic ethical issues in critical care and end of life
- 15) Treat patient and families with concern and compassion

Communication skills

- 16) Present a concise, comprehensive and appropriately detailed account of patients to faculty and other residents
- 17) Communicate changes in patient status in an appropriate time frame to the appropriate level of supervisor
- 18) Explain the details of patient care and condition to families using simple terms while maintaining accuracy.

Practice Based learning

- 19) Discuss evidence based prophylactic measures routinely employed in the SICU
- 20) Demonstrate appropriate reading/ study on the various issues that arise in the day to day care of patients and shares insights with residents and faculty

Systems based practice

- 21) Know the appropriateness of consultation with other physicians and providers in developing a comprehensive care plan for the patient.
- 22) Discuss the risk/ benefit ration of various invasive diagnostic test routinely used in the care of the critically ill patient.
- 23) Explain the cost considerations in the use of various antimicrobials in the care of the SICU patient

Competency Objectives for the Junior Resident Rotation on Plastic Surgery

At the end of this rotation the resident must be able to:

Knowledge

- 1) Discuss the biologic process of wounding, wound healing, factors inhibiting the normal healing process and abnormal states of wound healing
- 2) Explain the pathophysiology of thermal, chemical and electric burns
- 3) Explain various types of facial trauma and their significance to the patient
- 4) Describe the surgical anatomy of the hand in regard to both sensory and motor function
- 5) Explain the various options for transfer of skin including grafts, simple and composite flaps

Patient Care Skills

- 6) Demonstrate the complete evaluation of an injured hand in regard to both sensory and motor function
- 7) Explain principles of care for both minor and major burns including initial resuscitation
- 8) Assess, using physical examination and imaging studies the extent of facial trauma
- 9) Demonstrate facility with a variety of skin closure techniques

Interpersonal and Communication skills

- 10) Discuss with patients, using simple and clear language, the plastic surgical considerations given the patient presenting problem and a diagnostic and therapeutic plan of care
- 11) Work with nursing and paraprofessional staff in creating a reassuring and supportive environment for the patient.

Professionalism

- 12) Use evidenced based medical practice in the care of patients with problems that require plastic surgical care
- 13) Provide care to patients that is informed, supportive and compassionate.

Practice Based Learning

- 14) Present and defend evolving strategies of patient care using the surgical literature in a critical and evidence based manner.
- 15) Critique one's own decision making in patient care and to consult supervising resident and faculty for guidance and feedback

Systems based practice

- 16) Demonstrate the ability to work effectively with other medical professional in a collegial fashion (Otolaryngologists, Neurosurgeons, Ophthalmologists, Orthopedist Dentists etc.)
- 17) Develop with social services and discharge planners a comprehensive discharge plan that meets all of the patients needs and provides for rehabilitative goals.

Competency Objectives for the Junior Resident on Pediatric Surgery

By the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss fluid, electrolyte, acid and base balance in health and disease in the neonate and infant.
- 2) Explain the physiologic consequences of birth
- 3) Explain the particular considerations in the pre-peri-and postoperative period for both neonate and infant.

Patient Care Skills

- 4) Develop basic care plans for the neonate undergoing surgery
- 5) Write both pre-operative and post-operative orders reflecting the special care needs of the neonate and child.
- 6) Explain appropriate diagnostic modalities for disease states in the neonate and child

Interpersonal and Communication Skills

- 7) Take a focused history from parents: perform a comprehensive physical examination of the child
- 8) Interact in a collegial fashion with all members of the health care team

Professionalism

- 9) Provide compassionate, concerned and empathetic care to patient and family
- 10) Consider the opinions of all members of the health care team

Practice Based Learning

- 11) Participate in discussions of patient care using evidence based information
- 12) Critique his/her practice patterns and outcomes to improve care

Systems Based Practice

- 13) Consider and discuss the impact of neonates and childhood surgical illnesses on the family and relevant social units
- 14) Participate actively in discharge planning for those neonates/children with special post-discharge needs

Competency Objectives for the Junior Resident Rotation on Cardiothoracic Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Explain and discuss, at a level appropriate to year of training, the following:
 - a) Cardiac anatomy and physiology
 - b) Pulmonary anatomy (including endobronchial subsegments) and physiology
 - c) Spectrum of esophageal pathology (neoplasms, dysfunctional states, reflux)
 - d) Spectrum of pulmonary diseases (neoplasms, infectious etc)
 - e) Valvular, coronary artery and congenital heart disease
 - f) Various tests of pulmonary function
 - g) Various tests of cardiac function
 - h) Technical operative approaches to common pulmonary and cardiac disease states
 - i) Different cardiac arrhythmias and their treatment

Patient Care Skills

- 2) Apply available diagnostic modalities in a reasoned and cost effective manner
- 3) Use ventilatory support under supervision
- 4) Insert thoracostomy tubes and render ongoing care thereof, under supervision
- 5) Insert, under supervision, Swan –Ganz catheters and interpret data to modify patient care plan
- 6) Choose appropriate cardiovascular monitoring modalities, interpret data and alter patient care accordingly
- 7) Appropriately use various cardioactive drugs in the ongoing care of patients
- 8) Plan and implement pre and post operative care plan individualized to the patient.

Interpersonal and Communication Skills

- 9) Communicate the details of ongoing care of the patient to supervising fellows and faculty- accurately and comprehensively
- 10) Explain to patients, using simple and clear terms, the elements of initial and ongoing care

Professionalism

- 11) Interact with all others involved in the care of the patient with a collegial attitude in a spirit of cooperation.
- 12) Render ongoing care that is empathetic, compassionate and supportive.

Practice Based Learning

- 13) Participate in Mortality and Morbidity conference, presenting evidenced based information in discussion of patient outcomes
- 14) Continually critique one's own decision making with supervising fellow and faculty

Systems based practice

- 15) Discuss with faculty and other supervisors the risk/benefit ration of diagnostic and therapeutic procedures proposed
- 16) Demonstrate the ability to work collegially with others (cardiologists, radiologist, pulmonary function and respiratory therapy technicians) in the development of a comprehensive care plan for the patient
- 17) Participate in all aspects of rehabilitation and discharge planning for patients (social services, visiting nurses, coagulation monitoring etc.)

Competency Objectives for the Junior Resident on Breast /Endocrine Rotation (SCC)

At the end of this rotation the resident must be able to:

Breast component

Knowledge

- 1) Define and discuss the anatomy of the breast including glandular architecture, vascular supply, lymphatic drainage and associated nerves
- 2) Discuss the hormonal influences on breast structure and function
- 3) Discuss the incidence, epidemiology and risk factors of breast cancer
- 4) Explain the varied pathology of benign breast lesions and their significance as risk factor for malignancy
- 5) Discuss the various modalities for evaluating the breast and a mass in the breast
- 6) Explain the significance of, and workup appropriate for, varied nipple discharges
- 7) Describe the various pathologic forms of breast cancer and their significance and implications to the patient
- 8) Discuss the various histologic and cytologic markers as they impact prognosis in breast cancer detection, treatment and outcome
- 9) Complete the ACS Breast Disease Curriculum (available from the Residency office) – CD format

Patient Care Skills

- 10) Stage, clinically and pathologically, patients diagnosed with breast cancer; present the role of sentinel lymph node biopsy in staging
- 11) Plan and perform, under supervision, a biopsy of a breast mass using fine needle aspiration technique
- 12) Plan and perform, under supervision, an open surgical biopsy of a palpable breast mass; of a non-palpable lesion.
- 13) Participate as first assistant in the operating room on partial mastectomy, segmentectomy, and total mastectomy
- 14) Participate as first assistant in the operating room on sentinel node biopsy and axillary lymph node dissection

Interpersonal and Communication Skills

- 15) Discuss with the patient the various operative treatments for a patient with a diagnosed breast cancer (OSCE)
- 16) Explain to a patient, under supervision, the use of neoadjuvant, and adjuvant chemotherapy protocols and radiation therapy in the treatment of breast cancer.(OSCE)
- 17) Discuss with a patient the strategies of hormonal manipulation in the treatment and prevention of breast disease – benign and malignant

Professionalism

- 18) Demonstrate a caring, empathetic and respectful attitude in delivering “bad news” to recently diagnosed patients with breast cancer (OSCE)

Practice Based Learning

- 19) Demonstrate awareness of community based standards of practice for the patient with breast disease
- 20) Use an evidenced based critique of these standards
- 21) Demonstrate awareness a of the evolving strategies of care for the patient with breast cancer

Systems Based Practice

- 22) Review mammograms with radiologist, understanding limitations and adjunct strategies
- 23) Review pathologic specimens (FNA, biopsy) with pathologist understanding limitations and need for additional cytologic and histologic special staining procedures
- 24) Discuss the role of medical oncologist and radiation oncologist in the treatment of patients with breast cancer
- 25) Explain to a patient the plastic surgical options for post- mastectomy reconstruction

Endocrine component

Knowledge

- 1) Explain the anatomy, embryology and physiology of the thyroid, parathyroid glands and adrenals
- 2) Discuss the incidence, epidemiology and natural history of diseases of the thyroid and parathyroid glands
- 3) Discuss the non-operative treatment of hyper and hypo functioning states of the thyroid and parathyroid glands
- 4) Explain various diagnostic test applied to masses in the thyroid

Patient Care Skills

- 5) Demonstrate proficiency in the examination of the neck in regard to thyroid and parathyroid pathology
- 6) Explain a diagnostic plan for patients with a palpable thyroid mass
- 7) Discuss the laboratory and imaging tests available for diseases of the thyroid and parathyroid and develop patient specific diagnostic plans.
- 8) Develop appropriate follow up plan for a patient with treated or untreated diseases of the thyroid and parathyroid

Professionalism

- 9) Interact with all others involved in the care of the patient with a collegial attitude in a spirit of cooperation.
- 10) Render care that is empathetic, compassionate and supportive

Practice based learning

- 11) Demonstrate appropriate reading in the therapeutic options available to patients with endocrine diseases
- 12) Review the current literature for selected issues in patient care and discuss evidenced based information with faculty and patients, under supervision.

Systems based practice

- 13) Develop, under supervision, cost effective efficient diagnostic and therapeutic plans
- 14) Discuss the role of the various treating physicians involved in the care of a patient with an endocrine disease treated by surgeons (primary physician, endocrinologist, radiologist, pathologist etc)

TO ALL PGY 2 RESIDENTS ROTATING TO THE SOUTH CLINICAL CAMPUS

- THE PURPOSE OF THIS ROTATION IS TO GAIN FACILITY IN THE DIAGNOSIS AND MANAGEMENT OF DISEASES OF THE BREAST AND ENDOCRINE SYSTEM AND TO PARTICIPATE IN OUTPATIENT AND AMBULATORY SURGERY EXPERIENCE.
- TO THIS END, EACH RESIDENT MUST ATTEND THE OFFICE ACTIVITIES OF BOTH DR. PIETROCOLA AND DR. BEYER FOR ONE FULL DAY EACH WEEK FOR A TOTAL OF TWO FULL DAYS OF OFFICE EXPOSURE EACH WEEK WHILE ON THAT ROTATION.
- THE REMAINDER OF TIME OF THE RESIDENT ASSIGNED TO THE SCC SHOULD BE SPENT PARTICIPATING IN THE OPERATING ROOM ACTIVITIES OF BOTH DR. PIETROCOLA AND DR. BEYER. IT IS ESSENTIAL THAT YOU TALK TO AND EXAMINE THE PATIENTS TO BE OPERATED ON BEFORE ENTERING THE OPERATING ROOM. YOU SHOULD DISCUSS THE DIAGNOSTICS AND DECISION MAKING THAT LED TO A DECISION FOR SURGERY WITH THE ATTENDING.
- SHOULD THERE BE 'FREE TIME' YOU MAY PARTICIPATE IN THE OPERATING ROOM WITH DR. MACDOWELL OR ANY OF THE PLASTIC SURGEONS NOT COVERED BY A PLASTIC SURGERY RESIDENT. WE CAUTION THE PGY 2 PLASTIC SURGERY RESIDENT ON THIS ROTATION NOT TO ABUSE THIS OPPORTUNITY.
- DR. TODD BEYER WILL SUPERVISE AND MONITOR THE RESIDENT EXPERIENCE WHILE AT THE SCC. ANY QUESTIONS SHOULD BE DIRECTED TO DR. BEYER.

Competency Objectives for the Junior Resident MIS/ENDOSCOPY Rotation

At the end of this rotation the resident must be able to (or has):

Knowledge

- 1) Demonstrate an understanding of the set-up process, instrumentation and general conduct of a minimally invasive procedure
- 2) Explain the indications, contra-indications and complications of various endoscopic procedures (including polypectomy)

Patient Care Skills

- 1) Completed the Laparoscopy 101 curriculum
- 2) Completed the FLS curriculum
- 3) Demonstrated an appropriate level of laparoscopic skill in both the dry lab and computer simulation lab
- 4) Demonstrated proficiency in UGI endoscopy (simulator and clinical)
- 5) Demonstrated proficiency in colonoscopy (simulator and clinical)
- 6) Demonstrated proficiency in rigid/flexible sigmoidoscopy (clinical)
- 7) Participated in a specified number of laparoscopic procedures with faculty in the operating room (as documented in Op Log)

Interpersonal and Communication Skills

- 8) Demonstrate the ability to interact with mentors and nursing staff in both the operating room and endoscopy units in a spirit of personal and professional growth.

Professionalism

- 9) Demonstrate a commitment to acquiring new skills through persistence of effort

Practice based learning

- 10) Track technical progress throughout the rotation and develop a plan for continuing development and expansion of the skills learned on this rotation.

Systems based practice

- 11) Discuss the cost of equipment used in minimally invasive surgery (reusable versus disposable)
- 12) Discuss surveillance colonoscopy in the population at large and in those with increased risk profile

Essential Information for the MIS/ENDOSCOPY Rotation

MIS component: The major goal of this rotation is to develop skill in the use of those instruments and procedural components used in the operating room for Minimally Invasive Surgery. To this end the resident is directed to complete Laparoscopy 101 course sponsored by SAGES (CD available in the Residency office). After completion of this introductory course you will complete the FLS course also sponsored by SAGES. Information on this component is available in the Residency office. You will then be able to sit for the practical (time sensitive) exam sponsored by SAGES and receive a certificate of completion. Use of the simulator under the Direction of Dr. Paul Singh in performing laparoscopic procedures will be integrated into this rotation

During this rotation you should participate in the operating room in basic laparoscopy cases. The goal of this participation is not to develop clinical technical skill (this is the role of the senior resident assigned

to that service) but rather to understand the set-up, instrumentation and general conduct of a minimally invasive procedure.

Endoscopy component: The goal of this component of the rotation is to master all aspects of Gastrointestinal endoscopy. (Endoscopy of the tracheal- bronchial tree is an integral part of the senior experience on General Thoracic Surgery). You must avail yourself of all endoscopic procedures performed both at AMC and at the VA Hospital. Please be aware that 50 colonoscopies and 35 upper endoscopies(including PEG's) are now required by the RRC and must be documented in the ACGME operative case log. Use of the endoscopy simulator will be an essential component of this experience. Drs. Lee and Valerian will supervise both the laboratory and clinical aspects of this rotation. By the end of this experience you should have developed the technical skill to carry out, under supervision, both upper and lower endoscopy. As many of the General Surgeons , both at AMC and the VA , perform upper (including PEG's) and lower endoscopy you will have ample opportunity to translate the skills learned in the laboratory to the clinic and OR.

NOTE: A SCHEDULE FOR THE MONTH'S ACTIVITIES CAN BE OBTAINED FROM DR.WARD DUNNICAN PRIOR TO STARTING THIS ROTATION.DR. BETH CADIGAN FROM THE EMERGENCY MEDICINE DEPARTMENT RUNS THE ULTRASOUND TEACHING COMPONENT OF THIS ROTATION. PLEASE CONTACT HER WELL IN ADVANCE OF YOUR START DATE TO ARRANGE TWO LEARNING SESSIONS WITH HER.

Competency Objectives for the Junior Resident on Transplantation

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss the principles of transplant immunology at a basic level
- 2) Explain the details of pre-transplantation tissue typing and evaluation
- 3) Discuss the special needs of the patient admitted for renal transplantation
- 4) Discuss the evaluation of possible infections in the immuno-suppressed patient
- 5) Define the various categories of immunosuppression, agents used, their side effects and toxicities

Patient Care Skills

- 6) Write comprehensive admission orders for the patient admitted for transplantation or a complication thereof.
- 7) Develop a post-transplantation care plan including writing post-operative and ongoing orders
- 8) Order and interpret appropriate tests for evaluation of infections in the immuno-suppressed patient.
- 9) Write, under supervision, appropriate immunosuppressive drug orders
- 10) Apply aggressive surveillance strategies to the transplant population

Interpersonal and Communication skills

- 11) Communicate the details of ongoing care to the patient in clear and simple terms answering all questions that arise, using faculty support
- 12) Communicate the details of evolving issues in patient care to resident and faculty supervisors in concise, clear and comprehensive fashion

Professionalism

- 13) Create and maintain a supportive environment for patient and family
- 14) Bring empathy and compassion to patient and family providing support resources as needed.

Practice Based Learning

- 15) Use the current literature to develop evidence based concepts for the appropriate care of the transplant patient
- 16) Present patient complications at conference and provide information that is current and evidenced based to critique particular practices and outcomes.

Systems Based Practice

- 17) Work effectively with the nursing and physician assistant support staff in the ongoing care and discharge planning for patients.
- 18) Explain the financial consideration that justifies renal transplantation for the patient and society as a whole.
- 19) View video on Organ Procurement and participate in Standardized Patient encounter

A PATIENT CARE MANUAL HAS BEEN DEVELOPED FOR THIS ROTATION AND IS AVAILABLE IN THE RESIDENCY OFFICE. Please pick up a copy **before** beginning the rotation

Competency Objectives for the Junior Resident Rotation on Vascular Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Demonstrate knowledge, appropriate for level of training, of arterial and venous anatomy
- 2) Discuss basic arterial and venous hemodynamics
- 3) Explain the clinical manifestations of both acute and chronic arterial and venous disease
- 4) Discuss the various risk factors for vascular occlusive disease
- 5) Explain the various non-invasive and invasive diagnostic tools used in the evaluation of a patient with vascular disease
- 6) Discuss non-operative care for the patient with non-life/limb threatening vascular disease

Patient Care Skills

- 7) Take and record a thorough and concise history and a thorough physical examination of the patient with both acute and chronic arterial occlusive disease
- 8) Demonstrate the bedside use of ultrasound examination of the extremities in both arterial and venous disease
- 9) Provide competent pre, peri and postoperative surveillance of the vascular patient
- 10) Write appropriate and comprehensive admission and postoperative orders for the vascular patient.
- 11) Recognize life/limb threatening signs in the pre and post operative patient.

Interpersonal and Communication skills

- 12) Obtain informed consent using clear and simple language, answering all of the patients questions and addressing all concern of patient and family
- 13) Communicate effectively with supervising residents and faculty regarding changes in status of the vascular patient
- 14) Counsels and educates patients regarding the continuing risk factors for vascular occlusive disease.

Practice based learning

- 15) Be able to critique outcomes using evidence based information from the current surgical literature
- 16) Demonstrate analytical thinking when considering a patients presentation and subsequent imaging studies

Systems based practice

- 17) Demonstrate knowledge of the risk/benefit ration for various treatments and procedures for the patient with vascular disease.
- 18) Use consultants in a reasoned and cost effective manner which enhances patient management.

Competency Objectives for the Junior Resident on General Surgery (includes G1, G2, VA)

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss the importance of maintaining and managing an airway in a variety of clinical settings
- 2) Explain the basic concepts of fluid and electrolyte balance and acid base balance
- 3) Discuss the importance of temperature elevation (fever) in the surgical patient, differential diagnosis, time course, microbiology and use of antimicrobials.
- 4) Explain nutritional needs of patients with varying diagnoses
- 5) Demonstrate an understanding of shock, varying causes, diagnostics and treatments
- 6) Explain the coagulation mechanisms and the basics of anticoagulation
- 7) Discuss considerations of change in cardiac, pulmonary and renal function in the surgical patient
- 8) Explain the phenomenon of the "acute abdomen", appropriate diagnostics and the urgency of therapy
- 9) Discuss the pathophysiology and causes of intestinal obstruction, and diagnostic and therapeutic implications

Patient Care Skills

- 10) Develop a complete history and perform a comprehensive physical examination for the surgical patient
- 11) Choose appropriate and cost effective diagnostic tests and interpret and use data to modify the care plan for the patient
- 12) Write appropriate orders for the correction of various abnormalities of fluid, electrolyte, acid and base balance in the surgical patient
- 13) Demonstrate the use of universal precautions in all patient encounters
- 14) Write complete admission, preoperative and postoperative orders for the surgical patient
- 15) Manage patients with diabetes in the preoperative and postoperative setting
- 16) Demonstrate sterile technique in the care of patients
- 17) Prioritize and manage complication in the surgical patient
- 18) Manage patients with new or continuing hypertension

Interpersonal and Communication Skills

- 19) Explain procedures and obtain consent using clear and simple language
- 20) Communicate effectively with all members of the health care team in a comprehensive and timely manner
- 21) Chart patient course and issues in an accurate, concise and legible manner

Practice Based Learning

- 22) Use the current surgical literature to apply evidence based information to the ongoing care of patients
- 23) Participate in Morbidity and Mortality reviews, presenting patient problems and provide insight into the nature of any contributing errors

Systems Based Practice

- 24) Develop discharge plans for patients working with referring physicians, consultants, social workers and other allied health professionals, ensuring patient safety and improvement.
- 25) Discuss with faculty and supervising residents the risk/benefit ratio to various operative and non-operative approaches to patient problems and the economic implications thereof.

Competency Objectives for the Junior Resident on the Night Float Rotation

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss the significance and management of postoperative chest pain
- 2) Explain differential diagnosis of post operative ventilatory problems
- 3) Discuss the causes of postoperative hypotension and the management thereof.
- 4) Explain the various causes of postoperative fever and the appropriate evaluation thereof

Patient Care Skills

- 5) Prioritize ongoing issues, acute and chronic, in patient care
- 6) Synthesize the data available, request other pertinent and essential testing to formulate a diagnostic and therapeutic plan, all under supervision
- 7) Document with accuracy and clarity the events of patient care during the responsible period

Interpersonal and Communication Skills

- 8) Present all changes in patient status to supervising residents and faculty in a timely, concise and accurate manner
- 9) Communicate effectively with nursing staff and advocate for the patient

Practice based learning

- 10) Demonstrate critical thinking in the evaluation of emerging patient problems
- 11) Critique personal practice outcomes with supervising residents and faculty

Systems based practice

- 12) Demonstrate an understanding of the role of different specialists and health care professional in the overall management of a patient with emerging problems.
- 13) Discuss the impact of patient events on length of stay and discharge planning

KNOWLEDGE AND SKILL OBJECTIVES FOR SENIOR RESIDENTS

GENERAL CONSIDERATIONS

Each senior resident is expected to continue to master the knowledge and skill objectives for each clinical area that have been outlined for junior residents.

In addition, there are specific competency objectives for each clinical rotation at the senior level.

Following are the specific competency objectives for all senior rotations. The evaluation tool used to assess competency in these areas is tied directly to these objectives.

Competency Objectives for the Senior Resident on Acute Care Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Explain the physiologic response to trauma
- 2) Discuss in detail ACLS and ATLS protocols
- 3) Explain the initial stabilization and evaluation of the patient with trauma (primary survey)
- 4) Explain the systematic evaluation of the patient with trauma (secondary survey)
- 5) Discuss nutritional needs of the acutely injured patient and methods to meet those needs
- 6) Explain the influence of age and co-morbid factors on the care of the injured patient
- 7) Discuss various monitoring techniques for the seriously injured patient

Patient Care Skills

- 8) Prioritize ongoing issues in the ER, SICU and Ward setting
- 9) Develop a plan for initial stabilization, resuscitation and evaluation of the injured patient
- 10) Use diagnostic modalities effectively to develop a therapeutic plan for the patient
- 11) Synthesize available data, request relevant additional data in formulating plans for ongoing care of the injured patient

Interpersonal and Communication Skills

- 12) Demonstrate the ability to work with other care providers in a collegial and productive manner
- 13) Inform supervising residents and faculty of significant changes in patient status in a clear and concise manner

Professionalism

- 14) Render ongoing care that is compassionate and empathetic
- 15) Demonstrate the utility of evidenced based information in the care of selected patients

Practice Based Learning

- 16) Participate at Trauma Conference providing critique of personal practice and performance
- 17) Present patients at Morbidity and Mortality Conference using current literature in the discussion

Systems Based Practice

- 18) Discuss with faculty and other team members the risk/benefit ratio for various diagnostic and therapeutic procedures proposed in the care of the injured patient.
- 19) Participate actively in the discharge planning of the patient – coordinating social services, rehabilitation services and other adjunct providers

THE FOLLOWING PROTOCOL WILL BE FOLLOWED IN THE MANAGEMENT OF CALLS AND CONSULTS FROM THE EMERGENCY ROOM

- There will be an Attending Surgeon in house 24 hours a day, every day of the week. This surgeon will also provide traditional 405 coverage of resident activity as in the past.
- There will be a Chief level General Surgery Resident (PGY5 or 4) in house 24 hours a day, every day of the week.
- There will continue to be a PGY3 ‘Night Float’ resident in house from 6PM till 6 AM.
- There will be an intern level “Night Float” in house from 6 PM till 6AM
- During the daytime hours (6AM-6PM) all calls to the Acute Care Surgery Service from the Emergency Room will go to the appropriate Chief General Surgery resident
- During the nighttime hours (6PM -6AM) all calls from the Emergency Room will go to the Senior “Night Float” resident.. Depending upon the nature of the consultation, the Chief Level General Surgery Resident will be notified immediately ,or after a brief initial survey, by the “Night Float”. The Surgery Attending will then be notified by the Chief level resident of the nature of the consultation, either immediately or after a brief assessment .

Competency Objective for the Senior Resident on General Surgery (VAMC, G1)

At the end of this rotation the resident must be able to:

Knowledge

- 1) Discuss in detail the surgical anatomy of the intra-abdominal viscera
- 2) Explain the pathophysiology of common disease states treated by general surgeons
- 3) Plan appropriate diagnostics and interventions for patients with acute and chronic diseases of the gastrointestinal tract
- 4) Select and interpret appropriate and cost effective diagnostic test to aid in diagnosis and plan treatment
- 5) Explain the influence of various co-morbid factor on the overall care of patients
- 6) Discuss nutritional support for the surgical patient with acute and chronic disease states

Patient Care Skills

- 7) Organize an effective and efficient clinical service
- 8) Provide appropriate surveillance of peri and post operative patients
- 9) Supervise junior residents and students in history taking, physical examination and the ordering of initial testing for the patient for whom surgery is indicated.
- 10) Interpret and synthesizes data obtained to create reasonable care plans for the patient
- 11) Anticipate and address postsurgical complications
- 12) Perform under supervision appropriate invasive diagnostic and therapeutic procedures

Interpersonal and Communication Skills

- 13) Mentor. Junior residents and medical students
- 14) Present in a clear concise manner the essential of patient progress and complications to the faculty supervisor
- 15) Discuss with patients in a clear, concise manner using simple terms the proposed diagnostic and therapeutic interventions proposed.

Professionalism

- 16) Strive to create a caring, compassionate and supportive environment for the care of the patient and family
- 17) Consider the risk/benefit analysis for each diagnostic and therapeutic intervention proposed.

Practice based learning

- 18) Present patient information at Morbidity and Mortality conference critiquing personal practice and outcome
- 19) Bring to the discussions of patient care evidence based information from the current surgical literature.

Systems based practice

- 20) Identify and implement various support services available to the patient on discharge
- 21) Demonstrate the ability to work with other professionals and paraprofessionals in developing a long term care plan for the patient with chronic illness.

Competency Objectives for the Senior Rotation on Transplant Surgery (G1)

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss the special needs and considerations of the patient being admitted for transplant surgery
- 2) Discuss the special considerations in the immuno-suppressed patient admitted for evaluation .
- 3) Explain in detail the principles of immuno-suppression and their clinical application
- 4) Discuss the indications for and selection of site and method to establish vascular access for the patient with renal failure
- 5) Discuss the special consideration in the post operative care of the patient undergoing renal transplantation.

Patient Care Skills

- 6) Write comprehensive orders for the admission of patient planned for renal transplantation
- 7) Write comprehensive postoperative orders for the transplant patient.
- 8) Demonstrate technical skill in establishing vascular access in the patient with renal failure, appropriate for level, under supervision of faculty
- 9) Write, under supervision, day to day immunosuppressive drug orders for the transplant patient
- 10) Evaluate immuneosupressed patient for surgical infection using cost effective diagnostic testing.

Interpersonal and Communication Skills

- 11) Discuss with patients in clear, concise and simple language proposed procedures and testing and obtain informed consent when indicated.
- 12) Readily communicate to faculty any significant change in patient status having formulated a patient care plan that addresses the situation.

Professionalism

- 13) Respect patient autonomy and provides an environment for care that is supportive and compassionate
- 14) Use vigorous surveillance in the post transplant patient in the assessment of continuing renal function, possible rejection and infections at various sites.

Practice Based Learning

- 15) Participate actively in Quality Initiative activities with faculty and staff
- 16) Critique personal practices and outcomes with faculty and develop improvement plans

Systems based practice

- 17) Discuss the impact of chronic renal failure, hemodialysis and transplantation on the individual, family and society at large.
- 18) Explain the medical economics of chronic dialysis versus successful renal transplantation.
- 19) Actively participate in discharge planning for the transplanted patient including rehabilitation, social services and chronic care initiatives.

Competency Objectives for the Senior Resident on Pediatric Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss the embryology of fetal development and post natal development
- 2) Discuss in detail the embryology, anatomy and physiologic consequences of common neonatal diseases
- 3) Explain the diagnostics of common neonatal disease states
- 4) Discuss in detail special considerations in the pre-peri and post operative management of the neonate requiring surgery
- 5) Explain the anatomic and physiologic considerations in common childhood diseases

Patient Care Skills

- 6) Develop and implement plans for pre-peri and postoperative care of the neonate undergoing surgery
- 7) Use appropriate and cost effective diagnostic modalities in the diagnosis of neonatal diseases with surgical implications
- 8) Use appropriate and cost effective diagnostic modalities in the diagnosis of surgical diseases of childhood
- 9) Develop and implement plans for the pre-peri and postoperative care of the child with a surgical illness.

Interpersonal and Communication Skills

- 10) Work effectively with nursing staff and other providers of care in the NICU , PICU and ward setting
- 11) Keep the faculty informed of changes in patient status in a clear and concise fashion

Professionalism

- 12) Treat patients and families with concern, compassion and empathy
- 13) Consider the opinions of others involved in the care of the patient and integrate this information into the overall care of the patient.

Practice Based Learning

- 14) Participate in discussions of patient care using evidence based information from the current literature
- 15) Critique his/her practice patterns and outcomes to improve patient care

Systems Based Practice

- 16) Consider and discuss the impact of neonatal and childhood surgical illnesses on the family and relevant social units.
- 17) Direct discharge planning of the neonate/child following surgery to provide for both patient and family support

Competency Objectives for the Senior Resident on the Minimally Invasive Surgery Service

At the end of the rotation the resident must be able to:

Knowledge

- 1) Explain the principles of laparoscopy including the creation and maintenance of pneumoperitoneum, choice and placement of ports and the choice and use of appropriate instruments.
- 2) Discuss the limitations of two-dimensional viewing
- 3) Discuss those complications particular to the laparoscopic approach to surgical diseases
- 4) Discuss why and when to convert to an open approach
- 5) Explain elements of pre-peri and post operative care for the patient undergoing a laparoscopic procedure
- 6) Complete the ACS “Bariatric Surgery Primer”

Patient Care Skills

- 7) Select patients appropriate for a laparoscopic approach to their surgical problem
- 8) Write appropriate pre-per and postoperative orders in the care of patient undergoing laparoscopic procedures
- 9) Safely establish and maintain pneumoperitoneum
- 10) Demonstrate technical skill appropriate for level of training and experience in performing essential parts of minimally invasive procedures

Interpersonal and Communication Skills

- 11) Discuss proposed procedures with patients and families in clear ,concise and simple terms and obtain informed consent
- 12) Work with nursing and other adjunct staff in creating and implementing a comprehensive plan for patient care

Professionalism

- 13) Demonstrate maturity in post operative surveillance of patients subjected to minimally invasive procedures
- 14) Interact with patients and families in a caring, compassionate and empathetic manner

Practice Based Learning

- 15) Discuss and critique personal performance with supervising faculty
- 16) Apply evidence based information to the care of patients

Systems Based Practice

- 17) Demonstrate an understanding of the impact of morbid obesity on the health care system and the benefit/risk ratio of procedures to address this issue
- 18) Participate in patient assessment, patient education sessions and counseling prior to selection for procedures to address morbid obesity.

Competency Objectives for the Senior Resident on Colon and Rectal Surgery G2

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss in detail the anatomy of the colon, rectum and anal canal as well as the pelvic floor
- 2) Explain the basics of the embryology of the gut and the surgical implications of anomalous development
- 3) Discuss the basic physiology of the intestinal tract – motility, absorption, secretion etc.
- 4) explain in detail the presentation, natural history and symptomatology of diseases of the colon, rectum and anal canal.
- 5) Explain and discuss the various surgical options for patients with diseases of the colon, rectum and anal canal

Patient Care Skills

- 6) Select and interpret the various appropriate diagnostic tests available for the evaluation of the colon, rectum and anal canal
- 7) Evaluate patients as candidates for various surgical procedures using risk/benefit ratio derived from evidence based medical literature
- 8) Implement appropriate nutritional support for patient undergoing surgery for diseases of the colon, rectum and anal canal.
- 9) Organize the pre-peri and postoperative care of patients undergoing surgery

Interpersonal and Communication Skills

- 10) Supervise and educate medical students and more junior residents who are part of the health care team
- 11) Discuss with patients and families in clear and simple terms the proposed procedures and obtain informed consent.

Professionalism

- 12) Interact with patients and families in a compassionate, caring and empathetic manner
- 13) Demonstrate a commitment to acquiring new information and skills during the rotation

Practice Based Learning

- 14) Reflect on his/her clinical performance using evidence based outcome criteria
- 15) Present patients to tumor board clearly and concisely exploring various adjunctive therapies and their risk/benefit ratios.

Systems based practice

- 16) Identify available social services and community resources for the patient upon discharge
- 17) Discuss screening colonoscopy and its' influence on community incidence of colon cancer and stage at presentation- including cost considerations
- 18) Work with enterostomal therapist to enhance quality of life of patients with gastrointestinal stomas

Competency Objectives for the Senior Rotation on General Thoracic Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss in detail the anatomy, physiology (including the functional and anatomic relationships) of the thoracic contents
- 2) Explain the basic embryology of the thoracic contents and implications for congenital lesions
- 3) Discuss in detail principles of ventilation, perfusion, respiration and mechanical ventilation
- 4) Discuss the common pathophysiologic conditions that affect the lung and mediastinum

Patient Care Skills

- 5) Demonstrate a facility with the various diagnostic tests available for evaluation of the lung and mediastinum and their interpretation
- 6) Evaluate the risk/benefit ratio in selecting procedures to address the patient's disease
- 7) Render appropriate and comprehensive care in the pre-peri and postoperative period
- 8) Perform various invasive diagnostic and therapeutic procedures (i.e. central lines, thoracostomy tube placement, thoracentesis)

Interpersonal and Communication Skills

- 9) Discuss with patient proposed diagnostics and procedures using clear and simple terms
- 10) Obtain informed consent from patients using clear and simple terms
- 11) Work with other providers of patient care to the overall benefit of the patient

Professionalism

- 12) Demonstrate a caring, compassionate and empathetic attitude
- 13) Demonstrates a commitment to acquiring new knowledge and skills throughout the rotation

Practice Based Learning

- 14) Participate in Tumor Board meetings presenting evidence based information in the development of a total care plan for the patient with lung neoplasms
- 15) Critique personal practice patterns and outcomes and discuss with supervising faculty

Systems based practice

- 16) Discuss the cost impact of various treatment protocols for lung and esophageal cancers
- 17) Participate with physical, occupational and speech therapist in developing a post discharge care plan for the patient
- 18) Discuss with patients and families risk profiles and possible adjustments that may influence patient outcome

Competency Objectives for the Senior Resident on Vascular Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss in detail the anatomy of the arterial and venous systems
- 2) Discuss in detail arterial and venous hemodynamics
- 3) Explain the anatomy and physiology of the arterial wall in health and disease
- 4) Explain the anatomy and physiology of the venous system in health and disease
- 5) Discuss therapeutic options for arterial reconstruction – central and peripheral

Patient Care Skills

- 6) Perform and interpret non-invasive evaluations of the arterial and venous systems
- 7) Interpret angiographic images of central and peripheral arteries and veins
- 8) Perform meaningful pre-operative risk assessment of the patient undergoing surgery
- 9) Demonstrate ability to initiate and monitor anticoagulation in the vascular patient

Interpersonal and Communication Skills

- 10) Organize and supervise an inpatient service with delegation to and supervision of junior residents and medical students
- 11) Assess and communicate clearly and concisely to supervising fellows and faculty changes in patient status
- 12) Discuss proposed treatment and procedures with patients and obtain consent

Professionalism

- 13) Demonstrate a caring, compassionate and empathetic attitude in the care of patients
- 14) Consider and integrate the opinion of other providers into the overall care of the patient

Practice Based Learning

- 15) Critique his/her practice pattern and outcome by participating in formal and informal discussion while on the service
- 16) Use evidence based reading from the current literature to improve and adjust practice patterns

Systems Based Practice

- 17) Work with discharge planners, adjunct providers etc in developing a post discharge plan for patient care
- 18) Discuss the financial and social impact of arterial vascular disease in an aging population
- 19) Discuss with patients risk factors for vascular disease and strategies to ameliorate same

Competency Objectives for Chief Resident on General Surgery

At the end of the rotation the resident must be able to:

Knowledge

- 1) Discuss in a sophisticated fashion the pathophysiology of the patient's disease process
- 2) Explain, in depth, the principles of the operative procedure proposed, the relevant anatomy, technical considerations and decision making process

Patient Care Skills

- 3) Competently prepare a patient for operative procedure considering all co-morbid factors
- 4) Develop and execute a comprehensive post operative plan for patient care
- 5) Demonstrate mastery of surgical techniques required of all surgeons

Communication and Interpersonal Skills

- 6) Communicate the details of patient progress or complications to the faculty in a concise, comprehensive and timely manner
- 7) Master the interpersonal skills needed in dealing with patient, staff, faculty and other residents

Professionalism

- 8) Provide consistent ongoing surveillance of the surgical patient
- 9) Provide care that is compassionate, caring and empathetic

Practice Based Learning

- 10) Function effectively as an educator of residents and medical students providing ongoing critique of patient care
- 11) Organize and run Mortality and Morbidity conference bringing evidence based information from the current literature to bear on the discussion

Systems Based Practice

- 12) Function effectively as an administrator of the service coordinating all aspects of inpatient care and creating a comprehensive discharge plan involving necessary adjunct providers
- 13) Participate in chart reviews to assess resident compliance with (governmental/governing body) mandates to ensure patient safety

Rules and Regulation of the Albany Medical Center

All of the rules, regulations and policies of the Albany Medical Center are included in the House Staff Manual distributed to you at new employee General Orientation. Continuing residents as well as residents new to the facility should become familiar with all of the various rules, regulations and policies of the Albany Medical Center.

These rules, regulations and policies are also readily available to all residents on the Albany Medical Center intranet (<http://intranet2.amc.edu>). Once on the intranet go to “clinical” – under policies and procedures you will find “house staff procedure and policy manual”. Click on this for the full text of the manual. It is your responsibility to understand the policies and procedures that govern your life at AMC. Ignorance of the policies and procedures is not an acceptable excuse for violation.

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