

Emergency General Surgery Service Rotation Syllabus

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Emergency General Surgery Service

I. Orientation Guide to the Service

A. Composition of the Service: Lines of Supervision

1. The Emergency General Surgery (EGS) Service includes an attending surgeon, a chief resident (R5), 2 junior residents (R3), an intern (R1) and a physician's assistant (PA) as well as a variable number of medical students and physician's assistant students.
2. Residents are responsible for 24 hour care of all EGS service patients under the supervision of an attending surgeon. The residents can identify their attending surgeon by referring to the electronic call schedule for "EGS-Emergency General Surgery" located on SmartWeb. Residents are responsible for communicating during the day with the attending surgeon assigned for rounds and after 5 pm with the EGS attending surgeon on call.

B. Roles and Responsibilities

1. **Intern (R1):** There is 1 intern assigned to EGS for day coverage of EGS patients on the ward.

Rounds: The EGS R1 reports to the ward each morning in order to be prepared for rounds. It is not necessary for the R1 to completely examine each patient before rounds, but they should be familiar with events that have unfolded during the night and the patients' current vital signs and labs. The EGS Physician's Assistant (PA) will assist the intern with gathering this information.

Ward Calls: The R1 is the *first call* physician for all EGS patients on the wards and should report any significant changes in status of the patient after rounds to a more senior resident or to the faculty member who rounded that AM. The EGS PA is an important resource for advice on when and who to call for questions and problems. *When the R1 scrubs into an operation, they must assign their pager to the PA (preferably) or the R3 so that ward calls receive proper coverage and the operation is not interrupted.*

Admits/Consults/Operations: The R1 assists the R3 with evaluating and admitting new EGS patients and is encouraged to participate in the elective and urgent operations of that day. The R1 should expect to be asked to see consults at the discretion of the R3.

Clinic: The R1 attends Trauma/EGS clinic on Mondays at 1PM and Fridays at 1 PM unless directed otherwise by the R3, R5 or the attending.

Duty Hours: The R1 is responsible for keeping track of their in-house hours in order to comply with ACGME guidelines.

Sign-out: Because the ward nurses have no way of knowing when the R1 has left the hospital for the day or has the day off, conscientious sign-out of the pager is imperative. The R1 calls the night call intern and discusses important patient care issues and then assigns their pager to the night call intern before leaving the hospital. During normal weekday duty hours if the intern has the day off or is leaving the hospital to comply with duty hour restrictions, they must assign their pager to the PA (preferably) or to the R3 (less preferably).

Resident Conference: On Monday AM's 0700 – 0930, the R1 should assign their pager to the PA.

Night call: In house night call is 1 out of every 5 or 6 evenings. The night call intern assists the R3 and R5 with the evaluations, admissions, and procedures of new Trauma and EGS patients.

2. **Junior Resident (R3):** The 2 R3s assigned to EGS will cover 12 hour shifts consisting of 3 weeks of days and 3 weeks of nights. The R3 is responsible for supervising R1 & PA care of ward patients and is the first call for EGS consults from the Emergency Department (ED) and the wards. Upon arrival in the AM, the daytime R3 receives sign-out from the evening residents to help plan for the day's scheduled activities.

Rounds: The R3 is responsible for morning EGS ward rounds with the R5, R1 and PA. The R3 should report all significant patient care issues to the R5 or the attending surgeon and be available for attending rounds later in the morning.

Admits/Consults: The R3 reports the results of their evaluations of ED & ward consults to the R5 (preferably) or directly to the attending surgeon.

Operations: The R3 participates in the operations of the EGS service as directed by the R5 or the attending surgeons. The general principle, however, is that the R5 cannot take the place of the R3 at the emergency operation without having coordinated the pre-op evaluation of the patient. R3's should expect to be in the operating room as much as possible. They should expect to be asked to participate in elective operations that have been scheduled by EGS faculty. *When preparing to scrub into an operation, the R3 should assign their pager to the R1 or PA to respond to consults.* R3's should not expect to be allowed to be "teaching" assistants to the interns except in the most basic operations.

Clinic: The R3 attends Trauma/EGS clinic Mondays at 1PM and Fridays at 1 PM unless directed otherwise by the R5 or the attending.

Duty Hours: The 2 R3s coordinate their call schedule in order to accommodate the ACGME guidelines for resident working hours. The R3 day off is Tuesday.

Sign-out: The R3's carry a generic pager (11029) that they pass to each other or to the covering resident after each shift. The R3s are responsible for communicating directly with each other regarding important patient care information and plans that have been established during their time on call. They are also responsible for keeping the R5 or the attending surgeon of the day/night apprised of any significant changes in patient status.

Resident Conference: On Monday AM's 0700 – 0930, the R3 should assign their pager to the PA.

3. **Chief Resident (R5):** The Chief Resident assigned to EGS will cover 12 hour shifts consisting of 4 weeks of days and 4 weeks of nights. The R5 is responsible for coordinating the resident coverage of elective and non-elective operations, EGS consults, ICU procedures, and clinic.

Planning for the Day: The R5 begins each day with sign-out from the night call residents. With the assistance and assent of the EGS attending of the day, the Chief develops a working plan for the day's activities including operations that need to be attended, ward and ICU rounds, and clinics.

EGS consults: The R5 discusses and evaluates EGS consults with the R3 and helps develop the operative or non-operative plan to present to the attending surgeon. The R5 may designate to the R3 on a particular day to bypass their involvement in consults for a period of time to attend to other service matters.

Operations: The R5 participates in elective and emergent EGS operations. *The R5 should not expect to be the first assistant with the attending unless they have been significantly involved in the pre-operative planning of the operation.* The R5 may function as the "teaching assistant" for basic operations with low risk for morbidity at the discretion of the attending surgeon.

Clinic: The R5 attends Trauma/EGS clinic Mondays at 1PM and Fridays at 1PM unless they are actively involved in the operating room or evaluating an urgent matter on the wards or in the ED.

Duty Hours: The R5 is expected to comply with the ACGME guidelines for resident working hours. The R5 day off is Sunday. The R5 covers the

R3 day off for 24 hours on Tuesday. The R5 post-call day is Wednesday. The R5 is available to return to the hospital if needed (i.e. back-up call) on Thursday and Friday evenings/nights and Saturday during the day after rounds and on Saturday evening/night.

Sign-out: The R5 is responsible for communicating directly with the Trauma Chief Resident who will be covering in the evening regarding important patient care information and plans that have been established during the day. They are also responsible for keeping the attending surgeon of the day/night apprised of any significant changes in patient status.

Administrative: The R5 is responsible for recording (or delegating this responsibility) the EGS team statistics daily on the EGS activity list Excel file on the J drive. These include # of admissions, # of consults, # of discharges, daily census, # and descriptions of operations/procedures, # and descriptions of complications, and # and descriptions of deaths. The R5 prepares Morbidity & Mortality forms to be presented to the faculty representative at M&M each Monday. The R5 may be asked to present complications or deaths at M&M conference.

For an outline format of the above, see appendix

C. EGS Service Weekly Schedule

1. Monday

0615 – 0700 Signout & Rounds
0700 – 0930 Grand Rounds and Resident Conference
0930 - ? Rounds
1300 – 1500 EGS Clinic
PPV Suite 330
1700 – 1800 Dept of Surgery M&M Conference
UHS-8B60

2. Tuesday

0630 - ? Sign-out & Rounds
0730 - ? EGS add-on SOR block time

3. Wednesday

0615 - 0700 Signout & Rounds
0700 – 0800 Trauma/EGS Multi-Disciplinary Conference
DCH 11th floor Auditorium
0800 - ? Rounds

4. Thursday
 - 0630 - ? Signout & Rounds
 - 0730 - ? EGS add-on SOR block time
5. Friday
 - 0630 - ? Sign-out & Rounds
 - 0930 - ? Trauma/EGS Journal Club
 - 1300 - ? EGS Clinic
PPV Suite 330
6. Saturday
 - 0700 - ? Sign-out & Rounds
7. Sunday
 - 0730 - ? Sign-out & Rounds

D. Policies

1. All new patients must have the pre-printed General Surgery H & P form filled out and signed by the admitting intern/resident/PA upon admission. Co-signing a medical student note will not suffice because the H & P must be personally completed by a licensed practitioner.
2. All patients must have daily progress notes that include a list of diagnoses and procedures, subjective complaints, pertinent physical exam, assessment, and plan of care.
3. All patients must have a hand-written operative note documented immediately following all operations and procedures. The operative dictation must be completed before the end of the day of surgery.
4. The R5 and R3 should familiarize themselves with the assessment and plan of every patient on the EGS service (ICU and ward) at least daily and more often as indicated.
5. Residents should maintain professional demeanor at all times. All patients' diagnoses and conditions are confidential and protected information. Families of patients should be kept informed of the patient's condition and plan for treatment if the patient or next-of-kin desires.

6. Residents are expected to attend required department and service conferences.
7. Residents are required to comply with ACGME mandated duty hour limitations.
8. Residents are expected to report to a resident senior to them or to an attending if they are sufficiently stressed or fatigued that they feel their duties to safe patient care may be compromised.

II. Curriculum

Intern (R-1)

A. Goals

1. Medical Knowledge

- a. Understand the pathophysiology and clinical presentation of the following emergency/urgent surgical problems:
 1. appendicitis
 2. bowel obstruction
 3. cholecystitis
 4. colonic diverticulitis
 5. soft tissue infection (uncomplicated, non-necrotizing)
- b. Understand the appropriate use of antibiotics in the following emergency/urgent surgical problems:
 1. appendicitis
 2. cholecystitis
 3. colonic diverticulitis
 4. soft tissue infection (uncomplicated, non-necrotizing)
- c. Understand the general principles of wound care.
- d. Understand the principles of postoperative feeding/nutrition.

2. Patient Care

- a. Learn to synthesize all available information in order to make appropriate clinical decisions.
- b. Understand the importance of generating accurate, thorough medical records.
- b. Understand appropriate initial nonoperative management of:

1. partial small bowel obstruction
2. uncomplicated diverticulitis
3. cellulitis

f. Develop technical skills for common procedures and operations encountered on the service appropriate for the intern level of training.

3. Practice-based Learning

- a. Develop an attitude of responsibility for the patients on the ward, and in so doing develop the skill of self-assessment with the goal of continuous improvement in practice management style.
- b. Understand the importance of critically reading and discussing medical literature pertinent to patients on the service.

4. Systems-based Practice

- a. Understand the importance of supporting medical and ancillary services in the complete and efficient care of the patient.
- b. Develop a cost-effective attitude toward patient management.
- c. Develop an appreciation for the patients' interests and convenience in care management plans.

5. Interpersonal and Communication Skills

- a. Develop the ability to respectfully and clearly communicate with other healthcare professionals.
- b. Learn to present patients to senior residents and attendings in an organized and precise manner.
- c. Learn how to function effectively as a member of a team.
- d. Learn to communicate effectively with patients and their families.

6. Professionalism

- a. Demonstrate respect and compassion for patients and professional staff on the wards, in the clinics, and in the operating room.
- b. Develop open-mindedness regarding alternative treatments.
- c. Understand need for continual self-assessment and improvement.

d. Develop an attitude of responsibility for patient care requests by senior residents and attendings.

B. OBJECTIVES

1. Medical Knowledge

- a. > Describe symptoms and physical exam findings consistent with acute appendicitis.
 - > Name laboratory tests useful in the evaluation of acute appendicitis, and describe expected results in patients who have the disease.
 - > Name radiographic studies useful in the evaluation of acute appendicitis, and describe expected findings in patients who have the disease.

- b. > List the etiologies of both small & large bowel obstruction.
 - > Describe symptoms and physical exam findings consistent with small bowel obstruction.
 - > Describe symptoms and physical exam findings consistent with large bowel obstruction; explain the differing presentations as related to the specific etiology.
 - > Name the radiographic studies used to evaluate small bowel obstruction, and describe the expected findings in patients who have this problem.
 - > Name the radiographic studies used to evaluate large bowel obstruction, and describe the expected findings in patients who have this problem; explain the differing findings as related to the specific etiology.

- c. > Define biliary colic, acute cholecystitis, and chronic cholecystitis.
 - > Describe the pathogenesis of cholelithiasis (i.e., etiology and biochemical composition of gallstones) as it relates to biliary colic and cholecystitis.
 - > Describe the symptoms and physical exam findings typical of biliary colic, acute cholecystitis, and chronic cholecystitis.
 - > Name the radiographic studies useful in the evaluation of gallbladder and biliary tract disease, and describe the expected findings in uncomplicated cholelithiasis versus cholecystitis.
 - > Name the laboratory tests useful in the evaluation of gallbladder and biliary tract disease, and explain the expected results in patients with cholecystitis.

- d. > Describe the etiology and usual anatomic distribution of typical colonic diverticulitis
 - > Define “uncomplicated” diverticulitis.
 - > Describe the symptoms and physical exam findings in a patient who presents with uncomplicated diverticulitis.
 - > Name the radiographic studies useful in the evaluation diverticulitis, and describe the expected findings in patients who have uncomplicated disease.

- > Name the laboratory tests useful in the evaluation of diverticulitis, and explain the expected results in a patient who presents with this problem.
- e. > Define cellulitis and list the most common pathogens in “uncomplicated” cases.
- > Define abscess and list the most common pathogens in cases involving the torso/head/neck/extremities versus the perirectal area.
 - > Describe the symptoms and physical exam findings in a patient who presents with an abscess of the torso, head/neck, and extremities.
 - > Describe the symptoms and physical exam findings in a patient who presents with a perirectal abscess.
 - > Name radiographic studies that may help differentiate between equivocal cases of abscess versus cellulitis, and describe the expected findings of abscess versus cellulitis.
 - > Name the laboratory tests useful in the workup of cellulitis and abscess.
- h. > Describe appropriate perioperative antibiotic coverage for acute/uncomplicated versus perforated/ruptured appendicitis.
- > Describe appropriate antibiotic prophylaxis for patients undergoing operation for bowel obstruction.
 - > Describe appropriate perioperative antibiotic coverage for acute cholecystitis.
 - > Describe appropriate antibiotic coverage for uncomplicated acute diverticulitis.
 - > Describe appropriate antibiotic coverage for patients with “uncomplicated” cellulitis; appropriate alternatives for patients who have penicillin allergies or MRSA.
 - > Describe appropriate perioperative antibiotic coverage for abscess of the torso, head/neck, or extremities.
 - > Describe appropriate perioperative antibiotic coverage for perirectal abscess.
- i. > With respect to wound closures, define and explain the indications for:
1. primary closure
 2. delayed primary closure
 3. healing by secondary intention
- > List (and explain the rationale for) the indications for nonclosure of surgical incisions (“leaving the wound open”).
 - > Describe 3 forms of open wound dressing changes, including the Wound Vac system, and explain the rationale for effectiveness of each.
 - > Describe the signs and physical exam findings of postoperative wound infection.
- j. > List the indications for placement of enteric feeding tubes (gastrostomy, jejunostomy, nasoduodenal).
- > Name at least 3 serious or life-threatening complications related to enteric feeding tubes.

- > Describe principles of postoperative feeding/nutrition in patients status post:
 1. appendectomy
 2. relief of bowel obstruction
 3. cholecystectomy
 4. small bowel or colon resection

2. Patient Care

- a. > Demonstrate the ability to produce a legible and thorough history and physical, which incorporates laboratory and diagnostic data, as well as an assessment and plan.
 - > Demonstrate the ability to dictate a thorough yet concise discharge summary, which incorporates all of the following:
 - name of attending physician
 - primary final diagnosis
 - additional pertinent diagnoses
 - principal procedure
 - additional procedures
 - BRIEF summary of hospitalization
 - discharge medications
 - recommendations for post-hospital activity, diet, dressing changes
 - follow-up appointment
 - cc: to primary care physician and referring physician (if different)
 - > Gain experience in the ability to dictate operative reports.
 - > Assist the attending in producing a daily progress note for each patient, which is suitable for DRG identification and E/M coding.
- b. Justify daily selection of laboratory and diagnostic testing for each patient on the service.
- c. > Describe the indications for nonsurgical management of partial small bowel obstruction.
 - > Describe the components of the nonsurgical management of partial small bowel resection.
- d. > Describe the indications for nonsurgical management of uncomplicated diverticulitis.
 - > Describe the components of the nonsurgical management of uncomplicated diverticulitis.
- e. Describe appropriate management of uncomplicated cellulitis.
- f. Develop technical skills for:
 1. open appendectomy
 2. open gastrostomy
 3. open feeding jejunostomy

4. abscess drainage (including perirectal)
5. central line placement
6. opening of an infected postoperative wound

3. Practice-Based Learning

- a. Critically discuss performance with respect to care of patients and progress made during rotation with Chief of Service or designee at mid-rotation meeting.
- b. At least three times during the rotation, choose a pertinent issue pertaining to a patient on the service, and critically evaluate an article from the literature which addresses the problem, and present conclusions to the entire team on rounds.

4. Systems-based practice

- a. Facilitate discharge planning by daily communication with inpatient care manager.
- b. Describe indications for medical consultation in the pre- and post-operative periods, particularly with respect to these specialties:
 - cardiology
 - gastroenterology
 - pain management service
 - interventional radiology
 - hematology> Facilitate daily communication with consulting physicians.
- c. As pertinent for each individual patient, facilitate daily communication with ancillary services, such as:
 - physical therapy
 - occupational therapy
 - speech
 - enterostomal therapy
 - nutrition
 - mental health
 - social services

5. Interpersonal and Communication Skills

- a. Consistently answer nursing questions/pages clearly and effectively.
- b. Present patients on inpatient rounds in an organized and concise manner.
- c. Present clinic patients to the attending efficiently to facilitate clinic flow.

d. Gain experience in explaining results of evaluations and recommendations for treatment to patients and their families (practice patient education).

6. Professionalism

a. Use appropriate speech and tone of voice when speaking to patients, families, and all other healthcare professionals.

> Allow others the chance to speak, and listen attentively when being spoken to.

b. Demonstrate a conscientious approach to patient care by minimizing delay of care and minimizing passage of incomplete tasks to fellow residents.

JUNIOR RESIDENT (R3)

A. GOALS

1. Medical Knowledge

a. Understand the pathophysiology and clinical presentation of the following emergency/urgent surgical problems:

appendicitis (non-ruptured versus ruptured)

bowel obstruction (partial versus complete)

cholecystitis with or without choledocholithiasis

ascending cholangitis

colonic diverticulitis (uncomplicated versus ruptured)

soft tissue infection (uncomplicated versus necrotizing)

gastrointestinal hemorrhage

pancreatitis (uncomplicated versus complicated)

intra-abdominal abscess

b. Understand the appropriate use of antibiotics in the following emergency/urgent surgical problems:

appendicitis

cholecystitis with or without choledocholithiasis

ascending cholangitis

colonic diverticulitis (uncomplicated versus ruptured)

soft tissue infection (uncomplicated versus necrotizing)

pancreatitis (uncomplicated versus complicated)

intra-abdominal abscess

c. Understand the indications for operative intervention of:

appendicitis (non-ruptured versus ruptured)

bowel obstruction (partial versus complete)

cholecystitis with or without choledocholithiasis

colonic diverticulitis (uncomplicated versus ruptured)

soft tissue infection (uncomplicated versus necrotizing)
gastrointestinal hemorrhage
pancreatitis (uncomplicated versus complicated)
intra-abdominal abscess

- c. Understand the general principles of wound care.
- d. Understand the principles of postoperative feeding/nutrition.

2. Patient Care

- a. Learn to synthesize all available information in order to make appropriate clinical decisions.
- b. Understand the importance of generating accurate, thorough medical records.
- c. Understand appropriate nonoperative management of or alternative therapies for:
 - partial small bowel obstruction
 - uncomplicated diverticulitis
 - soft tissue cellulitis
 - intra-abdominal abscess
 - gastrointestinal bleeding
- d. Develop technical skills for common procedures and operations encountered on the service appropriate for the R3 level.

3. Practice-based Learning

- a. Develop an attitude of responsibility for the patients on the ward, and in so doing develop the skill of self-assessment with the goal of continuous improvement in practice management style.
- b. Understand the importance of critically reading and discussing medical literature pertinent to patients on the service.

4. Systems-based Practice

- a. Understand the importance of supporting medical and ancillary services in the complete and efficient care of the patient.
- b. Develop a cost-effective attitude toward patient management.

c. Develop an appreciation for the patients' interests and convenience in care management plans.

d. Develop team leader management skills in the supervision of the R1, PA, and medical students.

5. Interpersonal and Communication Skills

a. Perfect the ability to respectfully and clearly communicate with other healthcare professionals.

b. Improve ability to present patients to senior residents and attendings in an organized and precise manner.

c. Learn how to function effectively not only as a member of a team, but also as a team leader.

d. Improve ability to communicate effectively with patients and their families.

6. Professionalism

a. Demonstrate respect and compassion for patients and professional staff on the wards, in the clinics, and in the operating room.

b. Develop open-mindedness regarding alternative treatments.

c. Understand need for continual self-assessment and improvement.

d. Develop an attitude of responsibility for patient care requests by senior residents and attendings.

B. OBJECTIVES

1. Medical Knowledge

a.> Describe symptoms and physical exam findings consistent with acute appendicitis.

> Name laboratory tests useful in the evaluation of acute appendicitis, and describe expected results in patients who have the disease.

> Name radiographic studies useful in the evaluation of acute appendicitis, and describe expected findings in patients who have the disease.

> List complete differential diagnosis of acute appendicitis

b. > List the etiologies of small & large bowel obstruction.

> Describe symptoms and physical exam findings consistent with small bowel obstruction.

- > Describe symptoms and physical exam findings consistent with large bowel obstruction; explain the differing presentations as related to the specific etiology.
 - > Name the radiographic studies used to evaluate small bowel obstruction, and describe the expected findings in patients who have this problem.
 - > Name the radiographic studies used to evaluate large bowel obstruction, and describe the expected findings in patients who have this problem; explain the differing findings as related to the specific etiology.
 - > Name laboratory tests useful in the evaluation and management of the fluid shifts associated with bowel obstruction; explain the expected results in patients presenting with early/partial versus complete obstruction.
- c. > Define biliary colic, acute cholecystitis, chronic cholecystitis, and ascending cholangitis.
- > Describe the pathogenesis of cholelithiasis (i.e., etiology and biochemical composition of gallstones) as it relates to biliary colic and cholecystitis.
 - > Describe the symptoms and physical exam findings typical of biliary colic, acute cholecystitis, chronic cholecystitis, and ascending cholangitis.
 - > Name the radiographic studies useful in the evaluation of gallbladder and biliary tract disease, and describe the expected findings in uncomplicated cholelithiasis versus cholecystitis.
 - > Name the laboratory tests useful in the evaluation of gallbladder and biliary tract disease, and explain the expected results in patients with cholecystitis and ascending cholangitis.
- d. > Describe the etiology and usual anatomic distribution of typical colonic diverticulitis
- > Define “uncomplicated” and “complicated” diverticulitis.
 - > Describe the symptoms and physical exam findings in a patient who presents with uncomplicated versus complicated diverticulitis.
 - > Name the radiographic studies useful in the evaluation of diverticulitis, and describe the expected findings in patients who have uncomplicated versus complicated disease.
 - > Name the laboratory tests useful in the evaluation of diverticulitis, and explain the expected results in a patient who presents with this problem.
- e. > Define cellulitis and list the most common pathogens in “uncomplicated” and “complicated” cases.
- > Describe the symptoms and physical exam findings in a patient who presents with an uncomplicated case of cellulites versus the findings that indicate the likelihood of complicated i.e. necrotizing infection.
 - > Define abscess and list the most common pathogens in cases involving the torso/head/neck/extremities versus the perirectal area.
 - > Describe the symptoms and physical exam findings in a patient who presents with an abscess of the torso, head/neck, and extremities.

- > Describe the symptoms and physical exam findings in a patient who presents with a perirectal abscess.
 - > Describe the possible complications of a complicated or untreated perirectal abscess
 - > Name radiographic studies that may help differentiate between equivocal cases of abscess versus cellulitis, and describe the expected findings of abscess versus cellulitis.
 - > Name the laboratory tests useful in the workup of cellulitis and abscess.
- f. > List the most common etiologies of upper gastrointestinal hemorrhage versus lower gastrointestinal hemorrhage.
- > Describe the history and physical exam findings consistent with upper gastrointestinal hemorrhage versus lower gastrointestinal hemorrhage.
 - > Name the radiographic and endoscopic tests useful in the workup of upper gastrointestinal hemorrhage versus lower gastrointestinal hemorrhage.
 - > Name the laboratory tests useful in the evaluation of gastrointestinal hemorrhage.
 - > Describe the *specific* indications for and appropriate peptic ulcer prophylaxis in routine postop patients.
- g. > List the most common etiologies of pancreatitis.
- > Explain the difference between acute and chronic pancreatitis.
 - > Define and list Ranson's criteria.
 - > List the potential long-term sequelae of pancreatitis.
 - > Describe the history and physical exam findings consistent with acute versus chronic pancreatitis.
 - > Name the radiographic studies helpful in the diagnosis and characterization of pancreatitis, and describe the expected findings in acute versus chronic disease.
 - > Name the laboratory tests helpful in the diagnosis and management of pancreatitis
- h. > Describe appropriate perioperative antibiotic coverage for acute/uncomplicated versus perforated/ruptured appendicitis.
- > Describe appropriate antibiotic prophylaxis for patients undergoing operation for bowel obstruction.
 - > Describe appropriate perioperative antibiotic coverage for acute cholecystitis.
 - > Describe appropriate antibiotic coverage for uncomplicated acute diverticulitis.
 - > Describe appropriate antibiotic coverage for patients with "uncomplicated" cellulitis; describe appropriate alternatives for patients who have penicillin allergies or MRSA.
 - > Describe appropriate perioperative antibiotic coverage for abscess of the torso, head/neck, or extremities.
 - > Describe appropriate perioperative antibiotic coverage for perirectal abscess.

- i. > With respect to wound closures, define and explain the indications for:
 - primary closure
 - delayed primary closure
 - healing by secondary intention
 - > List (and explain the rationale for) the indications for nonclosure of surgical incisions (“leaving the wound open”).
 - > Describe 3 forms of open wound dressing changes, including the Wound Vac system, and explain the rationale for effectiveness of each.
 - > Describe the signs and physical exam findings of postoperative wound infection.

- j. > List the indications for placement of enteric feeding tubes (gastrostomy, jejunostomy, nasoduodenal).
 - > Name at least 3 serious or life-threatening complications related to enteric feeding tubes.
 - > Describe principles of postoperative feeding/nutrition in patients status post:
 - appendectomy
 - relief of bowel obstruction
 - cholecystectomy
 - small bowel or colon resection

2. Patient Care

- a. > Demonstrate the ability to produce a complete emergency department consultation which includes a legible and thorough history and physical, laboratory and diagnostic data, and an analytical and appropriate assessment and plan.
 - > Demonstrate the ability to dictate a thorough yet concise operative report, which incorporates all of the following:
 - Attending and resident surgeons
 - Pre and post-operative diagnoses
 - Operation performed
 - Brief narrative of operative indication
 - Brief summary of findings
 - Pertinent description of operation
 - Disposition of patient postoperatively
 - > Assist the attending in producing a daily progress note for each patient, which is suitable for DRG identification and E/M coding.

- b. Justify daily selection of laboratory and diagnostic testing for each patient on the service.

- c. Describe the indications for and components of nonsurgical management of partial small bowel obstruction.

- d. > Describe the indications for nonsurgical management of uncomplicated diverticulitis.

> Describe the components of the nonsurgical management of uncomplicated diverticulitis.

e. Describe appropriate management of uncomplicated cellulitis.

f. Improve technical skills for:

- open appendectomy
- open gastrostomy
- open feeding jejunostomy
- abscess drainage (including perirectal)
- central line placement
- opening of an infected postoperative wound

g. Develop technical skills for:

- Laparoscopic appendectomy
- Laparoscopic and open cholecystectomy
- Lysis of adhesions
- Colostomy
- Debridement of necrotic soft tissue

3. Practice-Based Learning

a. Critically discuss performance with respect to care of patients and progress made during rotation with Chief of Service or designee at mid-rotation meeting.

b. Three times during the 6 week rotation, choose a pertinent issue pertaining to a patient on the service, critically evaluate an article from the literature which addresses the problem, and present summary to weekly multi-disciplinary Trauma/EGS Conference.

c. When requested by the Quality Assurance Program, prepare patient and literature presentation relating to a complication or death on the service and present to weekly M&M conference.

4. Systems-based practice

a. Facilitate discharge planning by supervising daily communication between team and the inpatient care manager.

b. > Describe indications for medical consultation in the pre- and post-operative periods, particularly with respect to these specialties:

- cardiology
- gastroenterology
- pain management service
- interventional radiology
- hematology

> Facilitate daily communication with consulting physicians.

c. As pertinent for each individual patient, facilitate daily communication with ancillary services, such as:

- physical therapy
- occupational therapy
- speech
- enterostomal therapy
- nutrition
- mental health
- social services

d. Develop a new or improve an existing patient care management pathway/protocol.

5. Interpersonal and Communication Skills

a. Consistently answer nursing questions/pages clearly and effectively.

b. Consistently communicate patient assessments and plans to senior resident or attending surgeon.

c. Present clinic patients to the attending surgeon efficiently to facilitate clinic flow.

d. Consistently respond to consultation requests by the ER and inpatient ward teams in a timely fashion.

e. Gain experience in explaining results of evaluations and recommendations for treatment to patients and their families (practice patient education).

6. Professionalism

a. Use appropriate speech and tone of voice when speaking to patients, families, and all other healthcare professionals.

b. Allow others the chance to speak, and listen attentively when being spoken to.

c. Demonstrate a conscientious approach to patient care by minimizing delay of care and minimizing passage of incomplete tasks to fellow residents.

CHIEF RESIDENT (R5)

A. GOALS

1. Medical Knowledge

- a. Understand the pathophysiology and clinical presentation of the following emergency/urgent surgical problems:
 - appendicitis (non-ruptured versus ruptured)
 - bowel obstruction (partial versus complete)
 - cholecystitis with or without choledocholithiasis
 - ascending cholangitis
 - colonic diverticulitis (uncomplicated versus ruptured)
 - soft tissue infection (uncomplicated versus necrotizing)
 - gastrointestinal hemorrhage
 - pancreatitis (uncomplicated versus complicated)
 - intra-abdominal abscess
 - ischemic bowel disease
 - colonic volvulus
 - other abdominal catastrophe
- b. Understand the appropriate use of antibiotics in the following emergency/urgent surgical problems:
 - appendicitis
 - cholecystitis with or without choledocholithiasis
 - ascending cholangitis
 - colonic diverticulitis (uncomplicated versus ruptured)
 - soft tissue infection (uncomplicated versus necrotizing)
 - pancreatitis (uncomplicated versus complicated)
 - abdominal catastrophe
- c. Understand the indications for operative intervention of:
 - appendicitis (non-ruptured versus ruptured)
 - bowel obstruction (partial versus complete)
 - cholecystitis with or without choledocholithiasis
 - colonic diverticulitis (uncomplicated versus ruptured)
 - soft tissue infection (uncomplicated versus necrotizing)
 - gastrointestinal hemorrhage
 - pancreatitis (uncomplicated versus complicated)
 - intra-abdominal abscess
 - ischemic bowel disease
 - sigmoid volvulus
 - abdominal catastrophe
- c. Understand the general and advanced principles of wound care.
- d. Understand the principles of pre and postoperative feeding/nutrition.

2. Patient Care

- a. Learn to synthesize all available information in order to make appropriate clinical decisions.
- b. Understand the importance of generating accurate, thorough medical records.
- c. Understand appropriate nonoperative management of or alternative therapies for:
 - partial small bowel obstruction
 - uncomplicated diverticulitis
 - soft tissue cellulitis
 - intra-abdominal abscess
 - gastrointestinal bleeding
 - ischemic bowel disease
 - colonic volvulus
- d. Develop technical skills for common procedures and operations encountered on the service appropriate for the R5 level.

3. Practice-based Learning

- a. Develop an attitude of responsibility for the patients on the ward and in the ICU, and in so doing develop the skill of self-assessment with the goal of continuous improvement in practice management style.
- b. Understand the importance of critically reading and discussing medical literature pertinent to patients on the service.

4. Systems-based Practice

- a. Understand the importance of supporting medical and ancillary services in the complete and efficient care of the patient.
- b. Develop a cost-effective attitude toward patient management.
- c. Develop an appreciation for the patients' interests and convenience in care management plans.
- d. Develop team leader management skills in the supervision of the R1, R3, PA, and medical students.

5. Interpersonal and Communication Skills

- a. Perfect the ability to respectfully and clearly communicate with other healthcare professionals.
- b. Perfect ability to present patients to attendings in an organized and precise manner.
- c. Perfect ability to function not only as a member of a team, but also as a team leader.
- d. Perfect ability to communicate effectively with patients and their families.

6. Professionalism

- a. Demonstrate respect and compassion for patients and professional staff on the wards, in the clinics, and in the operating room.
- b. Develop open-mindedness regarding alternative treatments.
- c. Understand need for continual self-assessment and improvement.
- d. Develop an attitude of responsibility for patient care requests by other residents and attendings.

B. OBJECTIVES

1. Medical Knowledge

- a. > Describe symptoms and physical exam findings consistent with acute appendicitis.
 - > Name laboratory tests useful in the evaluation of acute appendicitis, and describe expected results in patients who have the disease.
 - > Name radiographic studies useful in the evaluation of acute appendicitis, and describe expected findings in patients who have the disease.
 - > List complete differential diagnosis of acute appendicitis
- b. > List the etiologies of small & large bowel obstruction.
 - > Describe symptoms and physical exam findings consistent with small bowel obstruction.
 - > Describe symptoms and physical exam findings consistent with large bowel obstruction; explain the differing presentations as related to the specific etiology.
 - > Name the radiographic studies used to evaluate small bowel obstruction, and describe the expected findings in patients who have this problem.
 - > Name the radiographic studies used to evaluate large bowel obstruction, and describe the expected findings in patients who have this problem; explain the differing findings as related to the specific etiology.

- > Name laboratory tests useful in the evaluation and management of the fluid shifts associated with bowel obstruction; explain the expected results in patients presenting with early/partial versus complete obstruction.
- c. > Define biliary colic, acute cholecystitis, chronic cholecystitis, and ascending cholangitis.
- > Describe the pathogenesis of cholelithiasis (i.e., etiology and biochemical composition of gallstones) as it relates to biliary colic and cholecystitis.
 - > Describe the symptoms and physical exam findings typical of biliary colic, acute cholecystitis, chronic cholecystitis, and ascending cholangitis.
 - > Name the radiographic studies useful in the evaluation of gallbladder and biliary tract disease, and describe the expected findings in uncomplicated cholelithiasis versus cholecystitis.
 - > Name the laboratory tests useful in the evaluation of gallbladder and biliary tract disease, and explain the expected results in patients with cholecystitis and ascending cholangitis.
- d. > Describe the etiology and usual anatomic distribution of typical colonic diverticulitis
- > Define “uncomplicated” and “complicated” diverticulitis.
 - > Describe the symptoms and physical exam findings in a patient who presents with uncomplicated versus complicated diverticulitis.
 - > Name the radiographic studies useful in the evaluation of diverticulitis, and describe the expected findings in patients who have uncomplicated versus complicated disease.
 - > Name the laboratory tests useful in the evaluation of diverticulitis, and explain the expected results in a patient who presents with this problem.
- e. > Define cellulitis and list the most common pathogens in “uncomplicated” and “complicated” cases.
- > Describe the symptoms and physical exam findings in a patient who presents with an uncomplicated case of cellulites versus the findings that indicate the likelihood of complicated i.e. necrotizing infection.
 - > Define abscess and list the most common pathogens in cases involving the torso/head/neck/extremities versus the perirectal area.
 - > Describe the symptoms and physical exam findings in a patient who presents with an abscess of the torso, head/neck, and extremities.
 - > Describe the symptoms and physical exam findings in a patient who presents with a perirectal abscess.
 - > Describe the possible complications of a complicated or untreated perirectal abscess.
 - > Name radiographic studies that may help differentiate between equivocal cases of abscess versus cellulitis, and describe the expected findings of abscess versus cellulitis.
 - > Name the laboratory tests useful in the workup of cellulitis and abscess.

- > Describe the indications for aggressive, life-saving exploration and debridement of spreading necrotizing soft tissue infection and the criteria for adequate debridement.

f. > List the most common etiologies of upper gastrointestinal hemorrhage versus lower gastrointestinal hemorrhage.

- > Describe the history and physical exam findings consistent with upper gastrointestinal hemorrhage versus lower gastrointestinal hemorrhage.

- > Name the radiographic and endoscopic tests useful in the workup of upper gastrointestinal hemorrhage versus lower gastrointestinal hemorrhage.

- > Name the laboratory and radiologic tests useful in the evaluation of gastrointestinal hemorrhage.

- > Describe the *specific* indications for and appropriate peptic ulcer prophylaxis in routine postop patients.

- > Describe the surgical and nonsurgical management of acute variceal hemorrhage.

- > Describe the specific indications for operative intervention of upper and lower gastrointestinal hemorrhage.

g. > List the most common etiologies of pancreatitis.

- > Explain the difference between acute, chronic, and necrotizing pancreatitis.

- > Define and list Ranson's criteria.

- > List the potential acute, severe and long-term, chronic sequelae of pancreatitis.

- > Describe the history and physical exam findings consistent with acute versus chronic pancreatitis versus necrotizing pancreatitis.

- > Name the radiographic studies helpful in the diagnosis and characterization of pancreatitis, and describe the expected findings in acute versus chronic versus necrotic disease.

- > Name the laboratory tests helpful in the diagnosis and management of pancreatitis

- > Describe the specific indications for surgical debridement of necrotizing pancreatitis.

h. > Describe appropriate perioperative antibiotic coverage for acute/uncomplicated versus perforated/ruptured appendicitis.

- > Describe appropriate antibiotic prophylaxis for patients undergoing operation for bowel obstruction.
- > Describe appropriate perioperative antibiotic coverage for acute cholecystitis.
- > Describe appropriate antibiotic coverage for uncomplicated acute diverticulitis.
- > Describe appropriate antibiotic coverage for patients with “uncomplicated” cellulitis; describe appropriate alternatives for patients who have penicillin allergies or MRSA.
- > Describe appropriate perioperative antibiotic coverage for abscess of the torso, head/neck, or extremities.
- > Describe appropriate perioperative antibiotic coverage for perirectal abscess.

- i. > With respect to wound closures, define and explain the indications for:
 - primary closure
 - delayed primary closure
 - healing by secondary intention
 - > List (and explain the rationale for) the indications for nonclosure of surgical incisions (“leaving the wound open”).
 - > Describe 3 forms of open wound dressing changes, including the Wound Vac system, and explain the rationale for effectiveness of each.
 - > Describe the signs and physical exam findings of postoperative wound infection.
- j. > List the indications for placement of enteric feeding tubes (gastrostomy, jejunostomy, nasoduodenal).
 - > Name at least 3 serious or life-threatening complications related to enteric feeding tubes.
 - > Describe principles of postoperative feeding/nutrition in patients

status post:

- appendectomy
- relief of bowel obstruction
- cholecystectomy
- small bowel or colon resection
- abdominal catastrophe

- k. Describe the indications for the use of the “open abdomen technique” in the management of the abdominal catastrophe, including peritonitis, necrotizing pancreatitis, and abdominal compartment syndrome.

2. Patient Care

- a. > Demonstrate the ability to evaluate in concert with the junior resident, an emergency department consultation of a complicated patient that requires an advanced analysis of the history and physical exam, laboratory

and diagnostic data, and to present the findings and a thoughtful plan to the attending surgeon.

> Perfect the ability to dictate a thorough yet concise operative report, which incorporates all of the following:

- Attending and resident surgeons
- Pre and post-operative diagnoses
- Operation performed
- Brief narrative of operative indication
- Brief summary of findings
- Pertinent description of operation
- Disposition of patient postoperatively

b. Describe the indications for and components of nonsurgical management of partial small bowel obstruction.

c. Describe the indications for nonsurgical management of uncomplicated diverticulitis.

d. Describe appropriate management of uncomplicated cellulitis.

e. Master technical skills for:

- Open and laparoscopic appendectomy, including ruptured appendectomy
- Open and laparoscopic cholecystectomy with cholangiogram
- Lysis of adhesions
- Colostomy
- Exploratory laparotomy for abdominal catastrophe
- Debridement of necrotic pancreas
- Debridement of necrotic soft tissue
- Open abdominal techniques/temporary abdominal closure

3. Practice-Based Learning

a. Critically discuss performance with respect to care of patients and progress made during rotation with Chief of Service or designee at mid-rotation meeting.

b. Three times during the 6 week rotation, choose a pertinent issue pertaining to a patient on the service, critically evaluate an article from the literature which addresses the problem, and present summary to weekly multi-disciplinary Trauma/EGS Conference.

c. When requested by the Quality Assurance Program, prepare patient and literature presentation relating to a complication or death on the service and present to weekly M&M conference.

4. Systems-based practice

- a. Facilitate discharge planning by supervising daily communication between resident team and the inpatient care manager.
- b. > Describe indications for medical consultation in the pre- and post-operative periods, particularly with respect to these specialties:
 - cardiology
 - gastroenterology
 - pain management service
 - interventional radiology
 - hematology> Facilitate daily communication with consulting physicians.
- c. As pertinent for each individual patient, facilitate daily communication with ancillary services, such as:
 - physical therapy
 - occupational therapy
 - speech
 - enterostomal therapy
 - nutrition
 - mental health
 - social services
- d. Develop a new or improve an existing patient care management pathway/protocol.

5. Interpersonal and Communication Skills

- a. Consistently answer nursing and junior resident questions/pages clearly and effectively.
- b. Consistently communicate patient assessments and plans to other residents or attending surgeon.
- c. Present clinic patients to the attending surgeon efficiently to facilitate clinic flow.
- d. Consistently respond to consultation requests by the ER and inpatient ward teams in a timely fashion.
- e. Perfect skill of explaining results of evaluations and recommendations for treatment to patients and their families (patient education).

6. Professionalism

- a. Use appropriate speech and tone of voice when speaking to patients, families, and all other healthcare professionals.
- b. Allow others the chance to speak, and listen attentively when being spoken to.
- c. Demonstrate a conscientious approach to patient care by minimizing delay of care and minimizing passage of incomplete tasks to fellow residents.

C. Instructional Methods

The residents assigned to EGS have a variety of rich educational conferences available through integration with the Trauma/Critical Care Services (see schedule). In addition, the R3 or the R5 will be expected to prepare and present a patient-based topic weekly at Trauma/EGS conference. Attendings assigned to daily rounds will be expected to use rounds for selected topic discussion. Finally, each resident will be instructed operative technique by the attending during operations.

D. Assessment and Evaluation

Each resident will be observed during daily interactions with faculty surgeons. Each resident will be scheduled for a 30 minute meeting with Chief of Service or faculty designee halfway through the rotation for a discussion of performance and goals. The R1 will complete a online written examination specifically addressing R1 medical knowledge objectives. The R3 and R5 will be evaluated by a faculty surgeon with an oral exam in a Patient Case Scenario format. Finally, attendings will complete a multifaceted evaluation of all residents (Veriform) according to the ACGME outcomes parameters.

E. Feedback Mechanisms

Daily opportunities for practice feedback exist between residents and attendings. As noted above, the R1 and R3 will meet for 30 minutes halfway through the rotation for professional guidance and feedback. Finally, all residents will have an opportunity to evaluate attendings through the Veriform online system and will have access to their attending evaluations

F. References

1. The Surgical Intern Pocket Survival Guide, International Medical Publishing, 1996. (recommended)
2. Cope's Early Diagnosis of the Acute Abdomen, 21st Edition, Silen, W. Oxford University Press, 2005. (provided)
3. Wall DB, Klein SR, Black S, de Virgilio C. A simple model to help distinguish necrotizing fasciitis from nonnecrotizing soft tissue infection. JACS 2000;191:227-31. (provided)
4. Savino JA, LaPunzina C, Agarwal N, Cerabona TD, Policastro AJ. Open versus closed treatment of necrotizing pancreatitis. Shock 1996;6:S65-S70. (provided)

Appendix

I. Specific Responsibilities

A. Chief Resident

1. Signout each AM & PM.
2. Assigns daily responsibilities to junior residents, intern, and students
3. Rounds beginning at least by 8AM each day. Faculty rounds by noon each day.
4. Supervises junior resident in the evaluation of EGS consults.
5. Communicates with the attending surgeon on call regarding the plan for diagnostic studies and further care.
6. Participates in elective and urgent/emergent operations of EGS patients. These operations will be performed directly with the attending surgeons or in some cases in a teaching capacity with the junior resident or intern under faculty supervision.
7. Attends EGS clinic at 1PM Monday and Friday.
8. Teaches junior residents, interns and students
9. Chooses patients and prepares scholarly information to be presented on 1 EGS patient each week at Trauma/EGS Conference (this responsibility is divided with the Junior Resident).
9. Records (or delegates this responsibility) the EGS team statistics daily on the Excel data form. These include # of admissions, # of discharges, daily census, # and descriptions of operations/procedures, # and descriptions of complications, and # and descriptions of deaths. Fills out M&M forms and give to faculty representative each Monday at M&M. Prepares Morbidity & Mortality Conference presentations when assigned.

B. Junior Resident

1. Signout each AM & PM.
2. Rounds beginning at least by 8AM each day. Faculty rounds by noon each day.
3. Responds to ED and ward EGS consults and reports evaluation to the Chief resident or the attending.
4. Participates in elective and urgent/emergent operations of the EGS patients.

5. Teaches the intern and students non-operative and post-operative care of EGS patients.
6. Attends EGS Clinic Monday and Friday at 1PM.
7. Presentation of 1 EGS patient and scholarly review each week at Trauma/EGS Conference (this responsibility is divided with the Chief Resident).

C. Intern

1. Pre-rounds and rounds on ward with the team.
2. Keeps a running record of labs in order to answer attending questions on rounds regarding patient's progress over several days.
3. Obtains verbal and dictated reports of all radiographic studies
4. Dictates summaries of ward discharges and deaths. The PA will assist with dictations
5. Updates daily patient list
6. Prepares daily note on non-operative patients on carbon copy pre-printed form and provides to faculty to attest and sign.
4. Attends EGS Clinic Mondays and Fridays at 1PM unless directed by the chief or junior resident or attending.

D. Physician's Assistant

1. Assists intern with pre-rounds, rounds, daily notes, and discharge summaries.
2. Assists intern during the day after rounds with ward decisions and procedures. The PA is a resource person for the intern and residents on the policies and protocols of the EGS service.
3. Covers the pager of the intern and junior resident when in Monday conference or scrubbed in the OR.
4. Assists the faculty surgeons with operations in the absence of available residents/intern.
5. Assists with discharge planning.
6. Attends EGS clinic Mondays and Fridays at 1PM.

E. Medical and PA Students

1. Rounds each morning starting on the ward. Presents assigned patients to the attending during attending rounds later in the AM. Participates in the discussion and development of plan of care.
2. Perform literature search on unusual problems and educate the team regarding pertinent information.
3. (Senior students only) Present assigned EGS topic (10 minutes) at Trauma/EGS Conference
4. Attends all conferences/clinics/operations as directed by the residents or attending.

II. Evaluation Tools

(See attached operative skills tool and Veriform resident evaluation tool)

Emergency General Surgery Procedural Skills Performance Ratings

Faculty _____ Date _____

Resident _____

Training Level: PGY-1
 PGY-3
 PGY-5

Procedure

- Appendectomy
- Laparoscopic appendectomy
- Laparoscopic cholecystectomy
- Incision & drainage of soft tissue infection
- Exploratory laparotomy for bowel obstruction or abdominal catastrophe

Evaluation

On a 5 point scale in which 1=deficient and 5=outstanding, assess the resident on the following characteristics:

	1	2	3	4	5
1. Knowledge of the Procedure	Shows little evidence of preparation		Adequate job		Confident & well prepared
2. Technical Operative Skills	Fumbles; Does not know Anatomy		Average procedural skills		Technically gifted. Knows anatomy well
3. Adaptability to Unexpected Events	Is unable to react when the unexpected occurs		Can react appropriately to unexpected events		Able to work through complex and difficult procedures
4. Mastery of the Procedure	Shows little evidence of ability to take the initiative to perform the procedure		Knows the basics of the procedure, but would need some guidance to accomplish it		Could likely perform the procedure without guidance

DEPARTMENT OF SURGERY RESIDENT EVALUATION

Resident: _____ Dates: _____
 Evaluated by: _____ Rotation Site: _____

Use the scale of 1-5 (1=poor, 5=excellent) to rate the following areas regarding the resident's performance. If not applicable or unobserved, please indicate by using "N."

Unsatisfactory	Marginal	Meets Satisfactory Level (Average OHSU Resident)	Above Average Level	Exceptional Performance	Not Observed
1	2	3	4	5	N
MEDICAL KNOWLEDGE					
•Anecdotal approach			1 2 3 4 5	N	•Evidence-based approach to care
•Limited knowledge base			1 2 3 4 5	N	•Extensive knowledge base
•Fragmented facts			1 2 3 4 5	N	•Well integrated knowledge base
•Unable to apply basic science knowledge to clinical care			1 2 3 4 5	N	•Easily and consistently applies basic principles to clinical care
•No evidence of reading the syllabus			1 2 3 4 5	N	•Firm grasp of syllabus material
PATIENT CARE					
•Gathers incomplete, inaccurate patient history and examinations			1 2 3 4 5	N	•Gathers accurate and complete patient history and examinations
•Gathers incomplete, inaccurate clinical data			1 2 3 4 5	N	•Gathers accurate and complete clinical data
•Fails to synthesize clinical data to make decisions in clinical decisions			1 2 3 4 5	N	•Synthesizes all available information in clinical decisions
•Takes no responsibility for accomplishing goals in patient care			1 2 3 4 5	N	•Innovative and resourceful in accomplishing goals in patient care
•Care plans unfocused, poorly managed			1 2 3 4 5	N	•Focused, concise, and complete patient care plans
•Shotgun approach to test ordering			1 2 3 4 5	N	•Well justified selection of clinical tests
•Rarely counsels or teaches patients			1 2 3 4 5	N	•Effectively counsels and educates patients
•Requires step-by-step direction for procedures			1 2 3 4 5	N	•Requires minimal supervision for procedures
•Unprepared for procedures			1 2 3 4 5	N	•Well prepared for procedures
•Deficient procedural skills			1 2 3 4 5	N	•Excellent procedural skills
PRACTICE-BASED LEARNING					
•Fails to perform self-evaluation			1 2 3 4 5	N	•Consistently evaluates own performance for improvement
•Resists or ignores feedback			1 2 3 4 5	N	•Invites and embraces feedback
•Lacks critical analysis skills			1 2 3 4 5	N	•Critically reads and discusses literature
•Fails to use IT to enhance learning			1 2 3 4 5	N	•Effectively uses IT to enhance learning
•Rarely teaches or shares knowledge			1 2 3 4 5	N	•Facilitates learning of entire team
•Lacks clinical competence appropriate for level of training			1 2 3 4 5	N	•Has achieved clinical competence appropriate for level of training

INTERPERSONAL & COMMUNICATION SKILLS

•Poor listening and nonverbal skills	1	2	3	4	5	N	•Behavior sets standard for communication
•Writing is unfocused, illegible	1	2	3	4	5	N	•Writing is clear, concise
•Frequently unavailable to patients, nurses, peers	1	2	3	4	5	N	•Always available and cordial to all
•Does not earn respect of patients, peers	1	2	3	4	5	N	•Highly respected by all
•Frequently short, impatient	1	2	3	4	5	N	•Always listens, explains, values opinion of others
•Disorganized presentations	1	2	3	4	5	N	•Presentations lucid and well organized

PROFESSIONALISM

•Does not display respect for others	1	2	3	4	5	N	•Always demonstrates respect for others
•Lacks integrity, honesty	1	2	3	4	5	N	•Demonstrates integrity, honesty, consistency
•Insensitive to diversity	1	2	3	4	5	N	•Teaches/models responsible behavior
•Shirks responsibility	1	2	3	4	5	N	•Willingly accepts responsibility for others
•Disregards need for self-assessment	1	2	3	4	5	N	•Total commitment to self-assessment
•Places self-interest above patients and society	1	2	3	4	5	N	•Readily places needs of others above self-interest
•Rigid, stubborn	1	2	3	4	5	N	•Open minded

SYSTEMS-BASED PRACTICE

•Unable to access ancillary resources	1	2	3	4	5	N	•Highly effective with ancillary resources
•Provincial in approach, interactions services	1	2	3	4	5	N	•Always involves other appropriate and resources
•Fails to use pathways, protocols	1	2	3	4	5	N	•Consistently invokes pathways, protocols
•Causes excessive cost in patient care	1	2	3	4	5	N	•Cost effective in care delivery
•Rarely concerned with patient interests	1	2	3	4	5	N	•Considers, advocates for patient interests
•Unsupportive of staff, peers, team	1	2	3	4	5	N	•Supports/involves entire team in patient care

GLOBAL EVALUATION

Please provide a brief narrative description of critical incidents (both positive and negative) that support the above evaluation: