

# **Portland VA Medical Center**

## **General Surgery Rotation Syllabus 3/08**

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## **I. Orientation to Service**

The VAMC service is composed pre-operative, intra-operative and post-operative care of the Veteran surgery patient. This service has a wide range of cases, from basic general surgery—hernias, gallbladder disease, esophageal reflux, small bowel obstruction, appendicitis and removal of subcutaneous lesions or abscesses, to often advanced staged oncologic cases, particularly in colorectal, but also including melanoma, esophageal and pancreatic cancers. With increasing numbers of women involved in the military service, we are also beginning to see more breast disease and cancers, along with the approximately annual male breast cancer case. Veterans may come from throughout the state of Oregon, as well as Southern Washington, Northern California, and occasionally from Idaho. Plans for these patients' care must often involve consideration of this aspect. The veteran population also requires careful pre-op scrutiny, given the high incidences of co-morbidities these patients have.

### **A. COMPOSITION OF THE SERVICE:**

The VAMC general surgery service is comprised of two “chief” residents (PGY5 x 2, or PGY5 and PGY4), a junior resident (PGY2/3), and two interns (PGY1). The service will also have various medical students assigned to them. We have 2 PA's, whose duties are to run their own post-operative clinic without residents (Wednesdays/Fridays), run a minor procedures clinic on Mondays, present cases at tumor board, and to help with the esophageal/GERD patients and the other on wards. They assist only in the Monday surgeries when residents are in mandatory conference. Our surgery facilitator helps in the scheduling of cases and a surgery coordinator also aids in the care of our patients. We are assigned a social worker who is very necessary in helping with discharge planning with the interns. Residents are supervised by the faculty members on the general surgery service.

Residents are responsible for the day-to-day care of all general surgery patients and general surgery consults under supervision of the faculty. Residents communicate directly with the individual senior to them on all admissions, consultations, and significant changes in the condition of all inpatients and outpatients. Monday through Fridays residents should communicate with the attending responsible for each patient. On call in the evenings or weekends, problems are addressed with the on-call faculty member.

### **B. ROLES AND RESPONSIBILITIES OF EACH TEAM MEMBER**

Interns are responsible for the care of the ward patients. They are to apprise the chief residents of changes in the condition of the patients. They are also responsible for admissions to the ward, work up of patients in surgical pre-op, and patient discharge. They are expected to participate, seeing particularly new patients in the general surgery Tuesday clinics and staffing the patients with faculty, if they are not post call. They are also expected to participate in appropriate intern level cases in the OR and procedures (listed under Policies). They attend colorectal clinic (4D) on Wednesdays and Thursdays if the junior is post call. While on call in house, they are responsible for first call of the ward care and calls of the general, vascular, urology, and orthopedic services. They may also assist in ECU and consults on call. They assist with care of inhouse plastic surgery patients and during the day staff these directly with the Plastic Surgery Staff.

Junior residents are responsible for supervising general surgery ICU patients along with the SICU resident (See separate VA SICU Goals and Objectives). They are also often the first resident assigned to see consults to the general surgery service and staff them first with the Chief Residents. Juniors are also responsible for attending Colorectal Clinics on Wednesdays and Thursdays, where they participate one-on-one in a mentorship fashion with a faculty, doing endoscopies, anoscopies, and seeing these clinic patients. If necessary, they may be asked to assist in supervising interns with ward service. On call, these residents are in house and responsible for Surgery and subspecialty surgery ICU patients and consults for general surgery and vascular. While on call they staff any plastic surgery ECU or consults if plastics PA or attendings had not been immediately available for emergencies, directly with the Plastic Surgery attending.

Chief residents are responsible for the overall smooth running of the service and must serve as a role model for appropriate professional behavior, leadership, surgical knowledge and patient care. They make the service call schedules. They help oversee and enforce the duty hours of the team. They oversee the general surgery patient wards, ICU and consult service. They delegate responsibilities to their team and keep staff informed. Coverage of operations is delegated by them. They may have home call shared amongst the Vascular and two General surgery Chiefs if there is a shortage. The general surgery chiefs are responsible for directing weekly Thursday educational conferences. The chiefs of vascular and general surgery at the VA all share in giving the Thursday morning talks for resident conference at 0730. Both services attend the talks. Faculty give one talk a month and arrange for some talks regarding ethics, wound care nurses, pharmacists, and social workers. Chief residents are given the schedule for dates if there are attending talks. The last Thursday of the month is reserved for all VA M&M preparation and presentation; (please turn in the same forms used for OHSU M&Ms and turn into Dr. Edwards on the M&M Thursday). M&Ms that have been chosen for the Monday OHSU M&M do not need to be repeated at our monthly VA presentations.

On the remaining Thursdays, the chiefs arrange amongst themselves, their own teaching talks and schedule attended by the surgery and vascular teams and faculty. In the past, these talks, ranging from journal article discussions, to presentations, to surgical jeopardy have been really well received by the juniors and staff. Plan on about 40-50 minutes max, since we must be done by 0830. (Also means teams should be on time attending these conferences). Bagels, donuts, coffee and OJ are usually provided.

Chiefs are also responsible for presenting all operative cases for the week at our Tuesday indications conferences, (list of cases are provided by our facilitator). They should be versed in particular risk factors and work ups of patient cases, with careful note on cardiac status, or pertinent studies, such as BE on ostomy takedown patients, etc. As aforementioned, the chiefs also present all VA monthly M&Ms of general surgical patients.

### C. POLICIES

Below are requirements of the VA. Please help us in accomplishing these requirements.

-Procedures: All procedures done in ECU should have documentation in the progress note of discussion with staff (list the surgery staff), and PARQ **prior** to procedure. A procedure note must be entered after the procedure (basically a brief Op note).

-Unscheduled admits (ECU) or consults: These patients must be staffed with a faculty within 24 hours. Initial note must document with which senior resident/attending the assessment and plan were discussed. All unscheduled admissions must have a full H&P documented within 24h..

-Please notify ICU attending and resident for admissions or transfers to the ICU.

-Clinics: Please include name of surgery faculty who helped staff and make plans in the progress note. Encounter needs to be filled out (tab in notes section), as well as clinic check out (in orders section).

-OR: Patients who have not had a note by a surgery MD (staff or resident) within 24 hours of their surgery need a short note stating what surgery they are having, and that it is still indicated. This is a JCAHO requirement. Consents may no longer be revised with patient initials, but must be re-written on a new consent.

-OR: Prior to surgery (in pre-op area), a member of the surgical team must mark the site and side of surgery on the patient. Please check at this time if desired antibiotics have been ordered and are being administered.

-OR: In OR, a nurse will ask for a pause to confirm correct site, side and surgery. If X-rays are available to confirm the side or level they should be viewed at this time. Please also write names of participating residents and students on the board and indicate who is dictating.

-Staff must be present for all OR cases. They cannot be “en route” from other hospitals. Patients will not be brought into the OR until staff is present. It is the staff’s responsibility to find a replacement or make the cancellation if they are not available and to notify the OR in a timely fashion. Staff must be in OR suite for the “key element” as defined by surgeons.

-All operations must have a dictation, but also a brief op note in CPRS after procedure. Please use the Template for Brief Op Note, and be sure it is titled “Brief Op Note.”

-Contact Robin Montgomery for any patients to be added for VA Tumor board. If she is unavailable, you may post patients directly with the Cancer Data Center: Hazel Hagen 55844 or Jennifer Wesner 55941. These are due Thursday mornings by 10am for Monday presentations. If you do not plan to present patient yourself, please leave a message with, or let Robin know the patient name, dx, and last four of SSN.

For all Surgery Residents:

#### Telephone Consents:

Process is now easier at the VA. To obtain a telephone consent: call family member who is consenting, explain PARQ. After this is done, hand phone to a witness who will ask if they understood and have any questions and if they gave consent. And that is all. No calls to AOD or dictations, etc. Also, remember if you are obtaining consent for surgery, to have them wait for anesthesia call so they can consent person as well. Otherwise family will often be on the way to the hospital and anesthesia cannot reach to consent, so patient has to wait to go to OR.

To acquire a VA Primary Care Provider for a veteran patient, please alert the social worker either via the consult tab process or by personal request. Without a PCP the patient is reduced to using the emergency dept or telephone care so I really appreciate PCP referrals.

#### In Person Consents:

We are now using the IMed computer consents. These are accessed through the CPRS chart, then clicking on tools and IMed Consent.

## **Procedures:**

The following are a list of non-operating room procedures that may be done by residents with staff supervision but not presence:

### **General Surgery and Vascular**

Central lines: including CVP, Pulmonary Artery Catheter, and “site rite” assisted line insertion—

**Interns must be supervised; (chief should assist with data interpretation); 2<sup>nd</sup> year residents that have done fewer than 10 central lines or PAC insertion should be supervised by chief resident or very experienced R3. Chief resident must be aware of procedure**

Arterial lines— **chief resident must be aware of procedure or supervise inexperienced residents.**

Chest tubes—**same as central line**

Thoracentesis—**same as central line**

Incision and drainage of abscess (non-OR)—**chief resident to supervise, attending to be aware**

Skin biopsies (non-OR)—**chief resident to supervise, attending to be aware**

Aspirations of cysts—**chief resident to supervise, attending to be aware**

Opening surgical wounds (non-OR)—**chief resident to be aware; if mesh in place, attending must also be aware**

Removing stitch or stitch abscess (non-OR)—**chief resident or attending aware**

### **Surgical ICU**

Emergency intubation—**ACLS certified house officer, chief resident to be aware at reasonable time following intubation, attending to be aware within 12 hours**

Bronchoscopy—**SICU fellow, chief resident or attending to supervise**

## II. WEEKLY VA GENERAL SURGERY SCHEDULE

- MONDAY: OHSU Grand Rounds 0700-0815 (Old library)  
OHSU Resident Conference 0830-0930  
Dr. Rehm Clinic 0830-1100  
OR- Dr. Goldman  
Tumor Board 1130-1230 Bldg 103 Rm 201  
Minor Procedure Clinic 1300  
OHSU M&M conference 1700
- TUESDAY: McConnell/Attending rounds 0800-0900 (starts in SICU)  
Indications Conference 0900-1000 Bldg 101  
General Surgery Clinic 1000- until done approximately 4pm (with  
Lunch break)
- WEDNESDAY: OR- Drs. Rehm & Kwong  
Colorectal clinic Dr. Lu- 0900 until done (junior or R1 if no junior)
- THURSDAY: Resident Teaching Conference 0730-0830 Rm 314 OCD or as assigned  
Dr. Kwong Sigmoid clinic 0900 until done (junior or R1 if no junior)  
OR- Dr. McConnell and Dr. Spight
- FRIDAY: OR- Dr. Lu

Note: Staff operate on days other than listed OR days, but these are the general guidelines.

### **III. Curriculum/Educational Goals and Objectives**

#### **A. Educational Goals and Objectives**

##### **Intern (PGY-1)**

##### **Goals:**

##### Medical Knowledge

- Understand the overall evaluation and management of the surgical patient.
- Understand the physiology of common postoperative problems in patients on the ward, including surgical infections, hemorrhage, thrombotic events, and the management of fluids and electrolytes.
- Understand the perioperative risk stratification of patients.
- Understand the initial work up and physiology of patients with hernias, abscesses, biliary disease, abscesses, bowel obstructions, diverticulitis, and cancer patients.
- Understand the anatomy of the above patients.
- Understand the physiologic changes following surgeries.
- Understand the nutritional assessment and needs of the surgical patient.
- Understand the management of patients with coronary artery disease, diabetes, hypertension, pulmonary dysfunction, and anticoagulation needs.
- Understand the principles and recognition of necrotizing fasciitis.

##### Patient Care:

- Develop an understanding of the management of common postoperative patients on surgery and how these principles prevent complications.
- Understand the common methods of treating common postoperative complications including: chest pain, shortness of breath, hypotension, low urine output, fever, abdominal pain, wound infections and dehiscences, and anastomotic leaks.
- Understand the concepts surrounding drain and catheter care including: central lines, bladder catheters, chest tubes, feeding tubes, nasogastric tubes, and surgically placed drains.
- Counsel and educate patients and their families
- Learn to make informed decisions about diagnostic tests and therapeutic interventions.
- Understand the management of small bowel obstruction
- Understand the management of enterocutaneous fistula.
- Understand the management of fileus.
- Understand the interpretation of laboratory and radiographic tests.
- Understand the initial workup for patients with cancers, such as rectal, melanoma, colon, and breast.
- Understand the perioperative issues of the patient undergoing splenectomy.
- Understand the potential complications of abdominal wall hernia repairs and their preventative strategies.
- Understand the management of complicated wounds.
- Understand the effects of aging on perioperative management of the surgical patient.

## Professionalism:

- Learn to communicate effectively and compassionately with patients, patient's family, team members, and staff.
- Learn to efficiently sign out patients to other teams.
- Be sensitive to patients and in their social and cultural context as well as with mental health diseases, such as PTSD, anger issues, schizophrenia, depression or limited resources.
- Be sensitive to patients who have come back from wars, as well as for the service the patients have provided in previous military service.
- Understand the importance of completing documentation of patient charts, discharges, your operative logs and duty hours.
- Learn and practice the ethical principles involved with caring for the surgical population, including consent-ability, confidentiality, and informed consent.

## Interpersonal and Communication Skills

- Respectfully interact with patients, staff and families in a way that they can understand.
- Learn to listen and assess non-verbal cues from patients and staff.
- Work effectively with the team, communicating issues appropriately and succinctly.
- Work effectively with ancillary care such as social workers, pharmacists, and other medical fields.

## Practice-Based Learning

- Accept responsibility for the care of patients on the ward, learning and modifying practice management style.
- Apply knowledge of scientific data to the care of the surgical patient.
- Facilitate the learning of medical students on the team.
- Use the OHSU library, internet, VA library, and other IT to access medical information and review recent advances of the surgical patient.

## System-Based Practice

- Develop systems to help maintain consistent quality of patient care.
- Understand, utilize and review clinical pathways for patients.
- Learn to practice cost-effective health care without sacrificing quality of care.
- Assist patients to negotiate the medical system in a consistent and fair manner.
- Partner with surgical facilitators, coordinators and social workers to provide seamless care across the system.

## **Educational Objectives for Interns:**

### Medical Knowledge:

- Describe the potential complications arising from disorders in electrolytes and in under or over resuscitation.
- Describe the management of glucose in the diabetic patient.

- List etiologies for persistent high NGT output in the postoperative patient, or patient with small bowel obstruction.
- Describe the clinical presentation of a patient with hernias, abscesses, biliary disease, abscesses, bowel obstructions, diverticulitis, hemorrhoids, fissures, and cancer patients.
- Draw the anatomy of the gallbladder, triangle of Calot, and hepatic artery.
- Describe the blood supply of the colon and rectum.
- Describe epidural and PCA complications
- List at least seven etiologies for small bowel obstructions and ileuses.
- List three of four causes of mesenteric ischemia
- Describe the Childs classification and its impact on cholecystectomy or any abdominal surgery.
- Describe the risks associated with hernia repair, cholecystectomy, I&D of abscesses.
- List the differential diagnosis of the patient with chest pain, low urine output, hypotension, hypertension, and hypoxia.
- Describe the important history and data to be taken prior to central line placement.
- List the important factors in prognosis for melanoma.

## Patient Care:

- List the nutritional options for the pre and post-operative patients, the risks and benefits of each depending on the different operations, such as colon surgery, small bowel, cholecystectomies, cancer surgeries.
- Calculate the estimated energy requirements for the postoperative patient.
- Describe appropriate pre-operative strategies to decrease post operative MI in patients.
- Describe the treatment of a patient with mild or severe hypo or hyper natremia.
- List intravenous and enteral options for hyper or hypokalemia, phosphatemia and magnesium.
- Describe the calculation of IV solution rate and choice of IV solution.
- Describe the symptoms, evaluation, and management of intraabdominal abscess.
- List the appropriate studies and interpretations for evaluation of a patient with chest pain, hypoxemia, low urine output, hypotension and hypertension.
- List the appropriate studies and management of patients requiring anticoagulation based on history of DVT, PE, mitral valve, other valves, low EF, atrial fibrillation, and cardiac stents.
- List the appropriate DVT prophylaxis in mild, moderate and high risk surgical patients.
- List appropriate immunizations for proposed splenectomy.
- Describe the signs and symptoms, diagnostic tests and management of small bowel obstruction.
- Differentiate between ileus and small bowel obstruction.
- Identify the common clinical presentation of the patient with mesenteric ischemia.
- Describe the work up of a patient with a breast mass and cancer and interpret a mammogram if patient encountered on service in regards to orientation and suspicious findings.
- Describe the appropriate evaluation of suspected leak in a patient.
- Describe the work up of a patient with diverticulitis and management as well as complications and management of these complications from diverticulitis and surgery. Describe the post operative dietary instructions for the patient during the treatment for diverticulitis and for diverticulosis.
- Describe the management, operative and medical for patients with fissures, fistulas in and, and hemorrhoids. Describe the corresponding surgeries for these. Describe the banding procedure.
- List the indications for cholecystectomy, herniorrhaphy
- Scrub in the OR as assisting surgeon to at least 4 hernia (inguinal or umbilical) repairs while on the service and practice technical expertise and list steps in the procedure.
- Scrub in the OR as assisting surgeon for at least 1 I&D of abscess if occurs during service and delineate important steps in the procedure.

- Scrub in the OR for at least 1 subcutaneous procedure or breast biopsy if occurs during service and practice wound closure techniques, tissue dissection.
- Scrub in the OR if on service during patient with appendicitis and describe workup, and anatomy and steps in the procedure.
- Demonstrate one and two-handed ties in the operating room.
- Perform history and physicals on patients in Surgery Prep Clinic, general surgery clinic and on wards and present patients to resident team of faculty, listing important elements of patient's H&P and developing an assessment and plan. Present in an orderly and organized manner of a formal H&P.
- Round on ward patients and present pertinent SOAP info to surgery team and pertinent I/O's.
- Attend indications conference and present pertinent information on patients seen in Surgery Prep Clinic as an adjunct to Chief resident presentation.
- Present case at attending rounds and list main medical knowledge aspects of that patient's disease, and your plans for the patient care.

### Professionalism:

- Attend Grand Rounds, Resident Conference, Mortality and Morbidity, Thursday VA Resident education conference, Indications conference and Tuesday attending conference.
- Be on time to all conferences.
- Complete documentation, such as discharge summaries (within 24 hours or at discharge for transfers to other facilities), operative dictations (same day), operative logs, duty hours on time.

### Interpersonal and Communication Skills

- Complete discharges and orders, and speak with social worker and wound care nurses by phone or in person (M-F) on complicated discharges. For complicated weekend discharges, anticipate their needs (transportation, visiting nurse needs, wound care) and discuss with social worker and nurse coordinators during weekdays. Communicate with wound care nurse regarding ostomy marking and post operative care. Remember to involve the American Cancer Society's Reach for Recovery Program for all breast cancer patients via our coordinator.

### Practice-Based learning:

- Evaluate an article relating to pertinent patient care issues. (Articles collected in binder in SICU resident room can be particularly helpful).

### Systems-Based Practice:

- Review and recommend updates and improvements to current practice guidelines and problems particular to the VA.

## **Junior (PGY-2)**

All intern goals and objectives as well as these Junior Resident specific goals

### **Goals:**

#### Medical Knowledge:

- Understand the physiology of the acutely-ill postoperative patient in the SICU, including SIRS, hemostasis, ventilator management.
- Understand the physiology of shock: including hemorrhagic/hypovolemic shock, cardiogenic shock, septic shock and obstructive shock.
- Understand the monitoring of arterial blood pressure, pulmonary artery catheters and hemodynamic monitoring, respiratory monitoring and renal monitoring.
- Understand cancer biology, screening, and tumor markers and receptors for cancers such as colon and breast.
- Understand the physiology of the patient with portal hypertension and liver failure
- Understand the physiology of digestion in the small intestine.
- Understand the physiology of gastric acid secretion, motility and hormones.
- Understand the physiology of acute and chronic pancreatitis.
- Understand the physiology and anatomy of the rectum and diseases.
- Understand the principles of anal cancers.
- Understand the principles and presentations of Crohns and Ulcerative Colitis
- Understand the physiology of the obese patient.

#### Patient Care:

- Develop and practice management procedures for the care of the acutely ill postoperative patient.
- Understand the diagnosis and management of abdominal compartment syndrome, shock and SIRS.
- Understand the appropriate work up of the patient with pancreatic, colorectal, breast cancer.
- Understand the management of acute hemorrhage.
- Understand the management of patient with complications of diverticulitis.
- Develop the ability to appropriately ready a patient for the OR.
- Develop a system of evaluation and treatment of the ICU patient.
- Efficiently communicate with the SICU team.
- Counsel patients and families regarding end of life decisions in ethically appropriate manner.
- Understand the principles of performing a safe cholecystectomy
- Understand the principles of performing a safe herniorrhaphy.
- Understand the appropriate work up to minimize post operative MI, CVA, DVT, PE's in patients.
- Understand the management of GI bleeding.
- Develop a more advanced assessment of small bowel obstruction.
- Understand the classifications of cirrhosis and the prediction of surgical outcome.
- Understand the management of the patient with acute pancreatitis and late complications such as pancreatic pseudocyst.
- Understand the risks of colonoscopy and safe procedure.
- Develop a history and exam for anal diseases.
- List the treatment of necrotizing fasciitis.

## Professionalism:

- Learn to effectively collaborate with the SICU team
- Learn to effectively use and respond to consultation of other physician specialties
- Learn to assume a leadership position with the team when necessary.
- Demonstrate responsiveness to patient needs, balancing ethical issues regarding withholding of care.

## Interpersonal and Communication Skills:

- Effectively communicate with other team members in a leadership role.
- Assist the chief residents by taking responsibility when the chief is unavailable.
- Effectively consult other services.

## Practice-Based Learning:

## Systems-Based Practice:

Same as intern

## **Educational Objectives for Junior:**

### Medical Knowledge:

- Describe the therapeutic options for the patient with Barretts disease with dysplasia
- Describe the risks of central line placement and steps towards placement.
- Describe the various areas for complications in doing a lap cholecystectomy.
- Describe the utilization, circumstances and rationale of subtotal cholecystectomy in open cases.
- List the etiologies of pancreatitis, and the risk factors associated with prognosis.
- List four operations for peptic ulcer disease.
- Describe different strategies in management of diverticulitis.
- Describe management of breast cancer both of breast and lymph nodes.
- List the operative strategies for melanomas based on depth
- List the steps for sentinel lymph node biopsies.
- Describe techniques for bowel anastomoses both stapled and hand sewn.
- List the risks of colonoscopy or endoscopy and counsel patient on these risks prior to procedure. Know techniques that can help avoid complications.
- Do a Mallampati evaluation and list the rationale on a patient receiving moderate conscious sedation and document on the paperwork.
- See surgical consult patients and present your consult to the chief resident. Include appropriate H&P, laboratory and radiologic studies. Make an assessment and plan prior to hearing one from above levels.
- See patients in clinic and present same as above to faculty.
- Present ICU cases at attending rounds in a formal organized manner for the ICU by systems and list appropriate laboratory and radiologic studies.

## Patient Care:

- List the indications for surgical treatment of a bleeding duodenal ulcer.
- Describe the evaluation of the patient with occult or obscure GI bleed.
- Demonstrate safe placement of central line and assist interns when proficient (see procedure section).
- Describe the management of a post operative MI, CVA, PE ICU patient.
- Describe the steps to an open cholecystectomy.
- Describe indications for open lymph node biopsy vs. FNA
- Describe the evaluation of Swan use.
- Describe the signs, symptoms and management of bile leak, with or without drain.
- Describe the strategy using mammograms of a needle localization breast biopsy and subsequent techniques for identifying the lesion in the specimen.
- Scrub into the OR and demonstrate appropriate knowledge of sequence of operations for cholecystectomy, hernias, bowel surgery.
- Demonstrate two-handed ties, one-handed ties, and appropriate tissue handling and use of the needles and suturing in the OR.
- Describe circumstances for verress technique vs Hassan in laparoscopic procedures and how to do them.
- Describe trouble shooting of equipment for laparoscopic surgery, to include alarms for high pressures, camera problems.
- List separate concerns of the obese patient that differ from non-obese in post operative care.

## Professionalism:

- Same as interns
- Complete documentation of consults.
- Complete OR logs, dictations, duty hour duties on time (same as listed in intern section but repeated here for added emphasis).

## Interpersonal and Communication Skills

- Demonstrate appropriate hand off of patients to on call SICU or Junior resident.
- Demonstrate method of consulting another service.

## Practice-Based Learning Systems-Based Practice

- Same as intern but articles on higher level, particularly ICU

## **Chief (PGY-5)**

Responsible for all intern and junior goals and specific ones listed.

### **Goals:**

#### Medical Knowledge and Patient Care:

- Understand the physiology of esophageal cancer, staging and surgical principles in esophagectomy, both open and laparoscopic.
- Understand the physiology, treatment and surgical principles of reflux disease and hiatal/paraesophageal hernias.
- Understand the physiology, treatment, and surgical principles of colorectal cancer.
- Understand the physiology, treatment and surgical principles of breast cancer.
- Understand the physiology, treatment and surgical principles of melanoma.
- Understand the physiology, management and surgical principles of sentinel lymph node mapping for melanoma and breast cancer.
- Understand the chemotherapeutic and/or radiation treatments for colorectal and breast cancers.
- Understand the appropriate management and work up of a complicated pre-operative surgical patient with elements of CAD, DM, CVA, DVT, pulmonary dysfunction.
- Become proficient in not only doing an operation, but in set up, exposure and teaching of procedures to a junior resident.
- Understand pitfalls or areas of complications in assessing abilities of your team.
- Understand different bariatric procedures and advantages/disadvantages of each procedure based on patients.

#### Professionalism:

- no additions

#### Interpersonal and Communications Skills:

- Develop effective strategies for running a general surgery team and checking on assignments that have been delegated.

#### Practice-Based Learning:

- Develop an understanding of systems and patterns for recognizing common complications and management of complicated patients based on experiences of previous years.

#### Systems-Based Learning

- Understand the elements other than medical and surgical knowledge and abilities that can contribute to complications.

## **Educational Objectives for Chief:**

### **Medical Knowledge and Patient Care:**

- Describe and demonstrate in the OR the above listed operations, with appropriate technique, tissue handling, avoidance of potential complications at the various stages of the operation.
- List the chemotherapies and appropriate stage indications for chemotherapy and radiation therapy of colorectal and breast patients.
- Describe management and work up of all pre-operative surgical patients with an understanding of their disease processes, on every elective patient scheduled for the week at our Indications conference. Be ready to justify care plans and delineate any ethical issues that may exist.
- Take junior residents through an uncomplicated bowel operation or cholecystectomy, or interns through a hernia case, appendectomy, or I&D of abscess, demonstrating ability to instruct, knowledge of pitfalls in the case, and where complications can develop and set up of an operation.
- Give 2-3 talks in two months during Resident education conference that highlights general surgery topic and issues, becoming a mini-expert in the field and literature on the topic.
- Present all VA M&M cases for the service monthly with explanation of medical surgical aspects of the patient.
- Supervise ward and ICU rounds and consults and confer with an attending on all cases.
- Assess consults with junior resident.
- Communicate plans and care with attending, particularly for changes in course.
- Present cases at attending rounds and display knowledge of patient disease and synthesis of information with plans and justifications of decisions.
- Demonstrate bariatric procedures in OR with Dr. McConnell on obese patients.
- Describe unique bariatric patient peri-operative concerns.

### **Professionalism:**

- Assist in running service in compliance with duty hours.

### **Interpersonal and Communications Skills:**

- Knowing knowledge of patients and laboratory or radiologic findings, check with junior and intern residents to which tasks have been delegated in order to verify abilities of team members and areas they excel or may need guidance.
- After input from team member presentations, make clear plans and assignments at morning rounds to team members.
- Discuss management of patients with staff, keeping in mind their preferences, but voicing other strategies if they can be backed up with literature.
- Communicate and document with ECU and be sure junior lists staff and chief involved in care.
- Communicate OR preferences and needs to OR nurse attending Indications conference. (ex: positioning, obtaining of the Navigator for SLN cases, etc).
- Communicate additions and non-elective cases to facilitator at Indications conference and as they arise.

## Practice-Based Learning:

-Keep a file of dictations of complicated cases and literature on the topics.

## Systems-Based Learning:

-Present monthly VA M&Ms with evaluation of system problems or good systems.

## **Evaluation Tools:**

-We will continue the use of The OHSU Department of Surgery rotation evaluations for staff summative evaluations of the rotations on each resident. See forms for specific elements.

-Verbal feedback and teaching will be given by surgery faculty at Indications Conference after the chief has presented the work up and operative plans for each particular patient.

-Verbal feedback and teaching will be given by surgery faculty after presentation of patients by residents at Attending Rounds.

## **Suggested reading for General Surgery Residents while rotating at the VA**

### Chief Residents:

What's new in Surgical Oncology, K M McMasters, J Am Coll Surg, 201, 449-453, 2005

What's New in General Surgery: Burns and Metabolism, J Am Coll Surg, 200, 607-615, 2005

Alterations in Gastrointestinal Physiology after Roux-En-Y Gastric Bypass, J Am Coll Surg, 201, 125-131, 2005

Part 1: Surgical Palliation of Advanced Illness-What's New, What's Helpful, J Am Coll Surg, 200, 115-127, 2005

Part 2: J Am Col Surg, 200, 281-290, 2005

Part 3: J Am Coll Surg, 200, 457-466, 2005

2004 ASBS Consensus Conference: Postoperative complications in the context of risk:benefit, R Brolin, SOARD, 1, 343-347, 2005

The Science of Stapling Leaks, Baker et al, Obesity Surgery, 14, 1290-1298, 2004

[www.nccn.org](http://www.nccn.org)

## **Junior Residents**

Guidelines for the Selection of Anti-infective Agents for Complicated Intra-abdominal Infections, Solomkin et al, Clin Infect Dis, 37: 997-1005, 2003

Transfusions in Surgical Patients, Englesbe et al, J Am Coll Surg, 200, 249-254, 2005

Current Concepts in Critical Care, Hashmi and Rodgers, J Am Coll Surg, 200, 88-95, 2005

Intensive Care Medicine, Rippe, Irwin, Fink, and Cerra, Volume I, 1-305, 1996 (Intensive Care Procedures)

Derivation and Prospective Validation of a Simple Index for Prediction of Cardiac Risk of Major Noncardiac Surgery, Circulation, 100: 1043-1049, 1999

Schwartz, Principles of Surgery, Chapter 28, Colon, Rectum and Anus, 1055-1118

## **Interns**

Schwartz, Principles of Surgery, Chapters 1-14, 8 th edition.