

I. FOREWORD

On behalf of the faculty of the Division of Pediatric Surgery at Oregon Health And Science University, we would like to welcome you to the training program in Pediatric Surgery. The handbook you have received contains information you will find helpful during your training in Pediatric Surgery.

Training in Pediatric Surgery and the practice of Pediatric Surgery is a privilege. During your training and career you will be entrusted with the lives, confidences, and hopes of children and their families. This duty should motivate us to learn, work, and teach each day so that we can become more skilled and compassionate surgeons. The purpose of this training period is to build upon the skills and knowledge you have gained during your general surgery training so that you achieve competence in Pediatric Surgery.

The attached manual contains educational materials and objectives to help guide your learning process during the next two years. One underlying objective of the training period is for the faculty to help you achieve independence in patient care and operative activity. Although independent performance is a stated goal of our training program, continuing education after completion of your training is essential to maintain the skills necessary for the competent practice of Pediatric Surgery. As such, another important objective of the training period is for you to learn strategies for life-long learning.

The faculty would like to welcome you and express our commitment to enhancing your learning experience and maximizing your potential as a Pediatric Surgeon.

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II. THE RESIDENCY IN PEDIATRIC SURGERY

1. CLINICAL EXPERIENCE

Oregon Health & Sciences University (OHSU) and the Legacy Health System welcome you to your Pediatric Surgery residency. Your responsibilities will be primarily at Doernbecher Children's Hospital/OHSU (DCH) and at Legacy Emanuel Children's Hospital (LECH). The Pediatric Surgery residents and general surgery residents are governed by the rules and regulations of OHSU and the Legacy Health System as well as the ACGME. The content of this handbook is intended to supplement these policies, but

if there is any disagreement between these two policies, then the rules of the institutions and ACGME will be followed. A copy of the policies can be found in the program directors office or at the web site at www.ohsu.edu/som/gme.

OHSU- Doernbecher Children's Hospital

This hospital has a full service Pediatric Surgery unit, including the Miniature Access Surgery Center. It also offers an array of specialty services that focus on the diseases of children and mothers-to-be. Maternity services are covered in the OHSU Hospital.

Legacy- Emanuel Children's Hospital

This hospital has a full service Pediatric Surgery unit, including the Miniature Access Surgery Center. It also offers an array of specialty services that focus on the diseases of children and mothers-to-be. Maternity services are covered in the Legacy Emanuel Hospital.

The clinical experience available during your training will give you an in-depth education in the health care disciplines that fall under the broad definition of Pediatric Surgery. Also, it will be necessary for you to have some experience in specialized pediatric disciplines such as neonatology, critical care and pediatric urology. You should familiarize yourself with the general principles of each of these disciplines through your reading and clinical experience. Furthermore, the ACGME has put forth a set of program requirements to ensure the adequate training of Pediatric Surgery residents. These requirements can be found in **attachment 1**.

2. ROTATION PLAN OF PEDIATRIC SURGERY

The first month of the Pediatric Surgery residency will be spent on the Pediatric Surgery service at DCH. Month two will be split between the pediatric ICU and the neonatal ICU at DCH. Months three to six will be back on the Pediatric Surgery service at DCH. Month seven will be a rotation with the Pediatric Urology department at DCH. The last five months of the first year will be on the Pediatric Surgery service at LECH. The second year of the residency will be spent almost entirely on the Pediatric Surgery service. The first six months will be at LECH. There will then be a one month elective of any specialty and/or clinical research. Finally, the last five months will be back on the Pediatric Surgery service at DCH. The last three months of the first year will be spent on the Pediatric Surgery service at DCH. Away rotations at affiliated facilities or electives designed to enhance the resident's training may be set up at the discretion of the program director.

3. ORGANIZATION OF TRAINING

The Pediatric Surgery service will consist of the Pediatric Surgery resident, general surgery residents, a pediatric nurse practitioner and medical students. Each member of the team has specific duties. Surgeons are leaders of intricate teams of professionals all striving for a higher level of quality and knowledge in patient care. The Pediatric Surgery resident should be able to integrate into and, act as leader of the team in a calm, smooth manner. Your sense of humor will be stretched during residency: keep it in good working order.

3.1 TEACHING SERVICE

There is a teaching service at both OHSU and Emanuel. These services have both attending surgeons and program faculty. The Pediatric Surgery resident at the site is the chief of the teaching service.

3.2 SENIOR PEDIATRIC SURGERY RESIDENT

The senior Pediatric Surgery resident is responsible for the smooth conduct of the teaching service. Among other duties the senior Pediatric Surgery resident works with the faculty to structure and organize teaching rounds, is responsible for the organization of M&M (QA review) and all educational conferences in concert with faculty surgeons, assigns operating room responsibilities, allocates general surgery residents as appropriate, and manages the patients on the service as deemed fit by the appropriate attending surgeon. They will be involved in organizing and managing non-operative care in those patients not needing surgery.

3.3 JUNIOR PEDIATRIC SURGERY RESIDENT

The responsibilities of the junior Pediatric Surgery resident are to ensure the smooth conduct of the teaching service at their institution. They will be responsible for the allocation of residents, management of the patients on their service as deemed fit by the appropriate attending service, and to assist the senior Pediatric Surgery resident in his or her duties as they are needed.

3.4 TRAINING PROGRAM ATTENDING SURGEONS AND PROGRAM FACULTY

Any attending surgeon who is a member of the medical staff at OHSU, has a university appointment and has been designated by the program director can participate in the training program. Program faculty are those attending staff with university appointments who have assumed leadership roles and responsibilities in the training program. All of the full time

faculty in the division of Pediatric Surgery are trained in the specialty of Pediatric Surgery and are the core teaching faculty of the Pediatric Surgery program

3.5 GENERAL SURGERY RESIDENT

The general surgery resident experience focuses on preoperative and postoperative care and selective operative experiences. This includes writing an admission history and physical examination, admission orders, daily progress notes, and pre- and post-operative notes. The general surgery resident is responsible for recognizing situations in which he/she needs help in managing the patient and should notify the Pediatric Surgery resident of any change in condition of the patient. The general surgery resident shall (1) keep a log of all cases in which he/she is operating surgeon or first assistant and communicate to the Pediatric Surgery residents or attendings if they are not completing the required number of RRC pediatric surgical cases, (2) submit data for all clinical cases to the ACGME, (3) participate in the academic credentialing activities, (4) provide documentation for this experience and (5) dictate a discharge summary on the patients he/she discharges (6) see consults and notify the appropriate Pediatric Surgery resident in a timely fashion of the consult.

3.6 SUPERVISION

Throughout the training program, all Pediatric Surgery residents require supervision by the attending surgeon with a chain of command that emphasizes graded authority and increased responsibility as experience is gained. Supervision may be direct or indirect.

3.6.1 Direct Supervision

Direct supervision for surgical procedures requires that the attending must be immediately available to furnish supervision during the procedure. This requires the physical presence of the attending surgeon on site. All procedures performed in the operating room or procedure rooms require direct supervision.

3.6.2 Indirect Supervision

In indirect supervision, the attending surgeon must be available and able to come to the hospital in accordance with all legal and medical staff guidelines, 24 hours-a-day, seven days a week.

Indirect supervision of the pre and post operative care of a patient does not require that the supervising physician be present in person, but should be

available via telephone as long as the resident is able to perform the procedure or assessment.

3.6.3 Supervisory Roles

An attending surgeon supervises the Pediatric Surgery residents. Each is expected to advise the attending surgeon of admissions, make rounds and follow up on the condition of the patients.

General surgery residents are either supervised by a Pediatric Surgery resident or an attending surgeon. If there is any doubt in the Pediatric Surgery resident's or junior resident's mind as to how to handle a problem, he/she should call a senior Pediatric Surgery resident or attending surgeon.

The attending surgeon must be in direct supervision of all cases in the operating room. A Pediatric Surgery resident may also be in a supervisory or teaching position, but this does not negate the direct supervision responsibility of the attending surgeon.

Attending surgeons must review all hospital admissions, round with the Pediatric Surgery residents and/or residents, review progress notes, discuss and review all discharge plans and sign discharge summaries written by residents. Patient progress and treatment plans must be reviewed during daily rounds.

3.6.4 Critical Care Supervision

Patients in intensive care units are managed in a team effort. The control of these patients belongs to the Pediatric Surgery service. However, the Pediatric Surgery team will work with either the neonatology team or ICU team in a joint effort to take care of the critically ill children.

3.6.5 Clinic Supervision

Pediatric Surgery residents and residents will be assigned to clinics as necessary to provide an adequate outpatient experience. These shall be attended by the Pediatric Surgery residents unless they are occupied with other clinical or team related responsibilities. The on-call general surgery resident shall also attend clinic unless they are occupied with another clinical activity.

4. PEDIATRIC SURGERY CURRICULUM, GOALS AND OBJECTIVES

Education in surgery is designed to develop cognitive knowledge, surgical judgment, technical ability and teaching skills. The practice of surgery requires the application of

clinical data and technical skills. Surgical judgment is that combination of knowledge, confidence, ability, and compassion that leads to a successful practice. During the period of training, the pediatric surgical resident is expected to complete a curriculum that will give them the in-depth knowledge that is required to be a successful pediatric surgeon. This curriculum includes rotations on other services important to the care of the pediatric surgical patient. In addition to the routine issues surrounding the operative management of Pediatric Surgery patients that the resident will be exposed to on a day-to-day basis, there are specific areas that deserve special focus. For this reason a curriculum has been created to emphasize these areas in Pediatric Surgery that might otherwise not receive the attention they warrant. This curriculum is based on hands on training, didactic lectures and self-learning.

4.1 Pediatric Surgery

The ACGME requires eight hundred surgical procedures and a specific number of surgical procedures that are index cases. While the completion of these cases is important, the ability to function as an independent pediatric surgeon requires completion of the entire program and designation by the Program Director. Before program completion, all Pediatric Surgery residents can only work with direct or indirect supervision from the attending surgeons

The surgical Pediatric Surgery resident is responsible for recording all surgical procedures with which they were involved. These cases must then be entered into the ACGME web site (www.acgme.org). It is the responsibility of the Pediatric Surgery resident to keep an up to date and accurate record of these cases. The program director will request every 6 months a list of these cases for the purpose of assessing the Pediatric Surgery resident's progress in attaining the necessary number of index cases. Please see **attachment 1** for specific competencies as placed into the five ACGME categories: patient care competency, medical knowledge competency, practice based learning and improvement competency, communications skill competency, professionalism competency and systems-based practice competency.

4.2 Oncology

The importance of the understanding of oncology is fundamental to the practice of Pediatric Surgery. In addition to textbook reading, the Pediatric Surgery resident is expected to read the relevant chapters from the NIH website www.cancer.gov. These are provided in a separate handbook. A

core curriculum of lectures will be provided at the weekly grand rounds to supplement this information.

4.3 Urology

While the modern practice of Pediatric Surgery does not routinely include urological procedures, a basic understanding of these operations is important. The resident will be required to do a one month rotation on Pediatric Urology under the direction of Dr. Steven Skoog. The learning objectives are outlined in **attachment 2**.

4.4 Pediatric Critical Care

The importance to understanding of critical care of the pediatric patient is fundamental to the care of pediatric surgical patient. The Pediatric Surgery resident will rotate on the PICU service for 2 weeks. The learning objectives are outlined in **attachment 3**.

4.5 Neonatology

The importance to understanding of critical care of the pediatric patient is fundamental to the care of pediatric surgical patient. The Pediatric Surgery resident will rotate on the NICU service for 2 weeks. The learning objectives are outlined in **attachment 4**.

4.6 Laparoscopy

Miniature access surgery is becoming increasingly important in the practice of Pediatric Surgery. Miniature access surgery in little children requires an advanced set of laparoscopic skills. It has become apparent that the skill levels of residents graduating from general surgery programs is varied. In order to standardize the skills of the pediatric surgical resident, a core set of objectives has been devised that will encompass computer simulations and CD ROM trainers. The fellows will be sent to specific Pediatric Surgery resident laparoscopic training courses.

4.7 Lectures

A series of conferences based on the specific curriculum requirements set out by the Association of Pediatric Surgery Training Program Directors has been established to ensure a broad exposure to pediatric surgical issues

(attachment 5). There will be a core set of interdepartmental multidisciplinary conferences such as Surg/Path/Radiology conference, GI/Surgery conference and Tumor Board interspersed with routine departmental conferences such as M&M and a Pediatric Surgery textbook-based conference. In turn, these conferences will be augmented by specific other lectures that will rotate on a two year basis to ensure that the resident is exposed to all the areas designated as important by the program directors. By utilizing experts in various Pediatric subspecialties, these lectures will provide learning above the textbook level.

5. EVALUATIONS

Evaluation of performance is a necessary part of education. Evaluations include comments on professional behavior, leadership, communication skills, surgical technique, and teaching ability. Program faculty evaluates the Pediatric Surgery resident's progress and written summaries are available for review. Surgical technique and knowledge comprise only part of the assessment. Teaching abilities, communication skills, professional behavior and relationships with patients and staff are equally important. Each Pediatric Surgery resident is requested to review his/her file at least twice a year with the Program Director.

5.1 Pediatric Surgery resident evaluations by Program Faculty, supporting staff and rotating residents

Each Pediatric Surgery resident is evaluated at regular intervals. Program faculty, ICU faculty, ICN faculty, pediatric nurse practitioners and the rotating general surgery residents are asked to evaluate the Pediatric Surgery residents at regular intervals (**see attachment 6**). After the evaluations are completed, the form is placed in the Pediatric Surgery resident's department file. Pediatric Surgery resident files are available for review during regular business hours. There are mandated times for file review as determined by the program director. All Pediatric Surgery residents are required to participate. Failure to do so will result in an administrative warning. Repeat offenses will result in probation and possible dismissal. These evaluations are used to guide Pediatric Surgery resident development and will be used for decisions on contract renewal.

5.2 Evaluations by Pediatric Surgery residents

Each Pediatric Surgery resident is required to complete evaluations periodically (**see attachment 6**) To insure confidentiality, the Residency Coordinator is the only one with access to these completed evaluations. Both Pediatric Surgery resident and general surgery resident evaluations will be combined and then distributed in order to maintain anonymity.

5.2.1 Self Evaluations

Each Pediatric Surgery resident is required to evaluate his/her clinical experience. They are used to provide feedback. The data is abstracted and collated before it is shared with the program faculty.

5.2.2 Attending Evaluations

Each Pediatric Surgery resident is required to evaluate the attending surgeons at regular intervals. The data are abstracted, collated, and shared with the attending surgeons.

5.2.3 Resident Evaluators

Each Pediatric Surgery resident is required to periodically evaluate the resident of the service. The data are abstracted, collated and sent to the resident's advisor at least quarterly and are to be used as a teaching tool in the development of the resident's administrative and supervisory skills.

6. ROUNDS

The smooth running of the team requires making rounds twice daily. Morning rounds should be completed before procedures or morning conferences begin. On these rounds patients are seen and examined, and decisions concerning patient care are made. The chief Pediatric Surgery resident assigns work that will be performed that day.

7. PEDIATRIC SURGERY WORK HOURS

All Pediatric Surgery residents must comply with the requirements for work hours and supervision found in the ACGME standards (please refer to the **Resident Policies Section**). In order to comply with these regulations while maintaining an effective training program, Pediatric Surgery residents should make every attempt to leave work in the evening when their clinical responsibilities are completed so as not to exceed the 80 hour work week. Pediatric Surgery residents will take home call in a primary or back up supervisory role. On the weekends Pediatric Surgery residents who are not post-call or on-call will not round with the team. Residents who are too overly fatigued during a period of call due to unusually heavy patient work load may contact the on-call attending to make arrangement to be relieved.

8. AMERICAN BOARD OF SURGERY IN-SERVICE TRAINING EXAM

The American Board of Surgery Basic Science and In-Service Training Examination (ABSITE) is required each year. This multiple choice test is not the sole method used for

advancement but does alert the Faculty to areas of needed emphasis and is an indirect indicator of the level of commitment and discipline of the Pediatric Surgery resident. Pediatric Surgery residents who perform poorly may be required to perform a remedial educational program.

9. PROFESSIONAL DEVELOPMENT AND CLINICAL EXPERIENCE

The Department of Pediatric Surgery has various responsibilities. One is to give each Pediatric Surgery resident optimal surgical training. Another is to insure that its graduates have the necessary qualities to practice Pediatric Surgery in the complicated world of medicine. These require an assessment of each Pediatric Surgery resident's cognitive and professional abilities.

Unprofessional behavior and slipshod patient care will be reason for appropriate discipline as determined by the program director. Professional behavior is required at all times and the ability of Pediatric Surgery residents to conduct themselves in a manner consistent with surgical excellence and successful independent practice will be closely monitored.

10. ADVANCEMENT

Entry into the program does not guarantee completion. The length of the education program is two years. Entry into the senior Pediatric Surgery resident year will be allowed only after the Faculty has declared that the Pediatric Surgery resident is ready for practice at this level of supervision. Each Pediatric Surgery resident's progress is reviewed yearly. Advancement is based on achieving the goals of the educational experience. The advancement process uses periodic evaluations of clinical performance, ABSITE scores and probationary concerns to decide whether a Pediatric Surgery resident should be advanced to the next level of responsibility.

11. Change in Training Status

11.1 Voluntary Changes

Voluntary changes in status may include a request to leave active training to due to the decision to pursue another area of interest; disability; or spousal, maternity, grieving or sickness leaves. All requests for voluntary change in training status should be filed, in writing, with the Program Director.

11.1.1 Medical / Maternity Leave, etc

The Department participates in the University wide activities for medical leave, family leave, etc. Requests for information should be forwarded to the Program Coordinator. Please see the

OHSU policy manual for further details. These can be found at www.ohsu.edu/som/gme/.

11.2 Involuntary Changes

Involuntary changes in status may include non-continuation of the Pediatric Surgery resident's contract, probation, suspension or termination. All Pediatric Surgery residents being considered for an involuntary change in status will be required to attend their disciplinary meeting where the presentation is being made.

11.2.1 Probation:

Any modification of training status that does not include suspension, termination or non-continuation of contract is considered probation. There are three types of probation: academic, administrative and clinical. Each is a focused event that is designed to improve a Pediatric Surgery resident's activity in a specific area. A Pediatric Surgery resident will be placed on academic probation if he/she continuously and repeatedly fails to meet academic expectations. A Pediatric Surgery resident will be placed on administrative probation if he/she repeatedly and continuously fails to perform the normal administrative duties. These can include failure to complete medical records, tardiness, unexplained absences, etc. A Pediatric Surgery resident will be placed on clinical probation if he/she continuously and repeatedly fails to meet clinical expectations. These can include procedural, knowledge and attitudinal inadequacies or unprofessional behavior. Each type of probation may be subject to OHSU grievance guidelines, must be presented to Department's committee, and requires a compliance plan and period review of activity.

11.2.2 Non-Continuation of a Pediatric Surgery resident's Contract:

The Department decides not continue the Pediatric Surgery resident's contract into the next academic year for any reason.

11.2.3 Suspension or Termination: All educational and clinical activity cease.

Issues that can result in suspension or termination include: failure to seek adequate supervision, placing a patient in clinical jeopardy, criminal offenses, non compliance with Pediatric Surgery resident

work hours regulations, and any event that meets the termination criteria of OHSU or LECH.

12. DRESS AND BEHAVIOR CODE

There is no set dress code for Pediatric Surgery residents. Still, the Department of Pediatric Surgery expects that each Pediatric Surgery resident will be clean, neat and presentable. Pediatric Surgery residents may wear a beard as long as it is kept trimmed and can be accommodated in sterile technique. All Pediatric Surgery residents may wear their hair at any length as long as it is kept clean and neat and fits under the caps used during procedures and operations. In the operating room, the Pediatric Surgery resident should wear appropriate scrub attire. If the Pediatric Surgery resident must leave the operating room in this attire, he/she should wear a lab coat over the scrub attire and change into fresh scrubs when he/she returns to the operating room. Pediatric Surgery residents are encouraged to wear dress clothes for rounds and clinic, but call and OR duties may make this impractical at times. Please see web site www.ohsu.edu/som/gme for the specific University policy.

13. CONSULTATIONS

After notification by a junior resident, consultations should be seen promptly by a Pediatric Surgery resident and must be discussed with the attending staff in a timely manner. When the consultation is complete, a call to the person requesting the consultation is a useful and courteous addition to the full consultation note. The report of the consultation can be dictated or hand written. If, for reasons of incomplete data, a full consult is delayed, a short note indicating that the patient has been seen and that a follow-up will be forthcoming is necessary. A phone call will serve to keep lines of communication open and will enhance the stream of consultations to the service. Remember, physicians who answer routine consults immediately and emergency consults even sooner have superior operative case lists in both quantity and quality.

When consultations are seen in the Emergency Department, the evaluation should be designed to render an opinion in one hour or less. It is far better to admit a patient and complete the evaluation in the hospital than to prolong the stay in the emergency department. Bickering over which service will admit the patient will not be tolerated. If there is any question, it is better to admit the patient to the surgical service where he can be more closely observed. All this being said the attending surgeon needs to be advised prior to any admission and the decision for admission is that of the attending surgeon.

14. OPERATING ROOM SCHEDULING, CONDUCT AND RESPONSIBILITY

The scheduling of an operative procedure requires the input of the supervising attending surgeon and cooperation between the Pediatric Surgery resident and attending staffs. Completion of the consent, marking the operative site, pre-operative assessments, etc. are the surgeon's responsibility and require the cooperation of the resident.

Coordination of resident assignments to procedures is the responsibility of the chief Pediatric Surgery resident. A realistic appraisal of the patient's age and condition, the urgency of the procedure (is the operation elective, urgent, or emergency?), and the operation required, should be used to help guide assignments. All pediatric surgical index cases must be performed by a Pediatric Surgery resident. It is important to ensure that the general surgical residents have a quality rotation and as many cases that are appropriate for their level of training should be assigned to and performed by the residents. No procedure is to begin without the presence of an attending surgeon, except when necessary as a life saving procedure.

15. COMMUNICATIONS

Communication with other members of the team is very important. All Pediatric Surgery residents and residents are expected to call the supervising resident and/or attending surgeon with questions or concerns regarding patient care. The attending surgeon shall be notified of any change in patient status before any new intervention is instituted. A "significant change" in patient status is defined as any change in the level of care, any unplanned discharge, any admission, or any change in the patient's clinical condition that has physiologic or anatomic consequences. No patient shall be discharged without the approval of the attending surgeon.

15. THE MEDICAL RECORD

The medical record in its entirety is a reflection of the quality of care that a patient received and is a legal document. To that end, all notations in the medical record should be legible, pertinent, and timely. Each should include the date and time that the notation is made. All patients should have a written history and physical examination or an admission note by a surgical resident or Pediatric Surgery resident. Progress notes should be legible and pertinent. Clinically relevant notes with conclusions drawn from selected data and a daily plan of action are more valuable and readable. The resident who will be the surgeon must write a pre-operative note. A resident involved in the operation must write a post-operative note. The most important parts of the medical record, HP, procedure notes, consultations and discharge summaries should be dictated whenever possible.

The discharge summary should be completed at the time of discharge by the resident or Pediatric Surgery resident. The formal dictations of these encounters must be completed within 24 hours of the activity.

The timely completion of medical records is a reflection on both the resident staff and the whole surgical service. Since the completion of records bears directly on hospital reimbursement, (and, thus, on resident salaries) regularly scheduled visits to the records department are necessary. General surgery residents or Pediatric Surgery residents with persistently incomplete records will be reported to the Program Director's office. These

individuals receive a warning. Repeat offenders will be placed on administrative probation until their records are complete.

15.1 Chart Notations

All notations of patient encounters must be written according to national standards (HCFA).

16. PROGRAM CONFERENCES

Pediatric Surgery residents are expected to attend and actively participate in conferences that are pertinent to their assigned service. Every effort should be made to attend other departmental conferences, particularly those that feature a visiting professor as the speaker.

17. TEACHING

Teaching is inseparable from the practice of surgery. Even if your practice is far from a medical school, you will teach your patients, colleagues, interested lay people and other professionals. The ability to teach and be an effective role model is an absolute requirement for progress in the program. This is especially important for our medical students. The time must be used efficiently and effectively. In addition, Pediatric Surgery residents will be expected to teach and lead General Surgery residents.

17.1 GRAND ROUNDS

Pediatric Surgery Grand rounds take place on Wednesday mornings. The conferences will consist of the lectures outlined previously in **attachment 5**. The senior Pediatric Surgery resident is responsible for their content, but will be assisted by the faculty in scheduling speakers and helping to plan the curriculum. Attendance and records of the M&M portion will be kept by the senior Pediatric Surgery resident. In addition to the Pediatric Surgery divisional meetings, the Departments of Surgery at both OHSU and Emanuel Hospitals have Surgery Grand Rounds and M&M conferences as outlined on the conference schedules in **attachment 5**.

18. RESEARCH EXPERIENCE OPPORTUNITIES

Most training is committed to patient care, teaching, and systematic study of the surgical disciplines. While research is encouraged, realistically there is little free time to participate in basic science research. However, Pediatric Surgery residents will have

ample opportunities to participate in clinical research projects and may at times be asked to supervise medical students or residents involved in clinical research.

19. OUT OF TOWN CONFERENCES

Pediatric Surgery residents are encouraged to submit to meetings. Pediatric Surgery residents will be sponsored to attend Program director approved meetings if their material is accepted for oral presentation. During their two years, Pediatric Surgery residents will be sponsored to attend the Pena course on anorectal malformations, either the AAP or APSA meetings and the annual Pediatric Surgery resident laparoscopic meeting.

20. VACATION TIME

Each resident will have vacation time yearly in accordance with the OHSU policies. Policy designates 21 work days per academic year. Meetings and interviewing do not count as vacation time, but if they are taken excessively then the Program Director may make an exception to this rule.

22. ABSENCES FROM RESIDENCY

All absences from clinical assignments must be cleared through the Department office. Short unplanned absences for sickness, etc., may be handled by phone. All planned absences including interviewing, regardless of duration, should be requested with as much notice as possible before the interview. The request should be made to the Program Director.

23. LICENSURE

The training program does not require that each Pediatric Surgery resident obtain a medical license.

24. MOONLIGHTING

Residents will not be allowed to moonlight while they are actively engaged in clinical duties as this would be a violation of the work hour regulations.

Attachment 1:

Goals and Objectives

PEDIATRIC SURGERY

ACGME PATIENT CARE COMPETENCY

Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Content and Procedures	Educational Strategies	Evaluation Methods	Outcome Measures
<p>Core Skills</p> <p>Gather essential and accurate information about the patient</p> <p>Medical interviewing</p> <p>Physical examination</p> <p>Diagnostic studies</p> <p>Make informed diagnostic and therapeutic decisions based on patient information, current scientific evidence, and clinical judgment by:</p> <p>Effective, appropriate clinical problem-solving</p> <p>Understanding limits of one's knowledge & expertise</p> <p>Appropriate use of consultants</p> <p>Develop and carry out patient care management plans</p> <p>Prescribe and perform competently all medical procedures (invasive and noninvasive) considered essential for scope of practice (see below)</p> <p>Counsel patients and families and provide care that is sensitive to each patient's cultural, economic, and social circumstances (see Communication & Professionalism Competencies)</p> <p>Use information technology to optimize patient care</p>	<p>Minimum #s</p> <p>Major operations – 800</p> <p>*Major trauma – non-operative – 90</p> <p>Tumors – 25</p> <p>Important Cases – 55</p> <p>Neonate Cases – 75</p> <p>Surgery Clinic</p> <p>OR experience, both main OR and outpatient surgery</p> <p>Inpatient care of patients</p>	<p>Operative Logs</p> <p>Faculty feedback after OR cases.</p> <p>Written evaluation provided for major cases (see OR evaluation)</p> <p>Faculty evaluations (see global evaluation)</p> <p>Quarterly written evaluation by program director</p> <p>Tracking of customer services comments from CHI patient satisfaction survey</p> <p>360° feedback</p>	<p>Board pass rate</p> <p>Sentinel events, lawsuits, or other adverse outcomes</p> <p>Follow-up with graduates and their future practice</p> <p>Annual report which identifies changes in the program</p> <p>Annual interviews with DME</p>
<p>Procedures/Cases</p>	<p>Maximize residents operative experience in the</p>	<p>Continual tracking of cases via the resident's</p>	<p>Periodic review of case logs by program</p>

Tumors	core pediatric surgical cases	ACGME surgical log	director
Cystic hygroma/lymphangioma			
Excision of mediastinal tumor			
Excision of neuroblastoma/adrenal/ other retroperitoneal			
Major hepatic resection/repair: tumor			
Major tumor (head & neck)			
Nephrectomy (total or partial)			
Oophorectomy (partial or total)			
Important General Pediatric Cases			
Esophageal resection or replacement			
Excision of mediastinal cyst			
Orchiopexy: open or scope			
Perineal procedure for imperforate anus			
Procedures for intersex: vaginal reconstruction			
Hirschsprung's: open or scope			
Pulmonary resection tumor, congenital malformation			
Repair chest wall deformity			
Neonatal Cases			
Omphalocele			
Gastroschisis			
Excision of sacrococcygeal teratoma			
Ostomy: anorectal malformation or Hirschsprung's			
Operation for malrotation			

Repair of diaphragmatic hernia			
Repair esophageal atresia and/or TEF			
Repair of intestinal atresia, stenosis, or web			
Resection/repair/ostomy for NEC			

ACGME MEDICAL KNOWLEDGE COMPETENCY

Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Content and Procedures	Educational Strategies	Evaluation Methods	Outcome Measures
General Skills Investigatory and analytic thinking Knowledge & application of basic sciences in decision making Primary Trauma - initial assessment & priorities of the injured child Airway Breathing Circulation Neurological Organ Systems Burns	List appropriate conferences , e.g., M & M, Journal Club Conduct at least one practice-based improvement Participate in the internal review of the residency program Participate in the development of clinical protocols and order sets Teach students and residents in the clinical setting as well as didactic lectures	Discussion-based assessment with case presentations & written feedback by attending Demonstrated competency in conducting a literature search Evaluations of presentations by residents and faculty Evaluation of clinical teaching by residents Faculty evaluations (see global evaluation) Quarterly written evaluation by program director Identification of practice improvement associated with at least one case per month. Reviewed with Program Director at quarterly evaluation 360° feedback	Annual report which identifies changes in the program Resident participation in conferences Presentations at national meetings and publications

Child Abuse			
Tumors			
General			
Renal			
Adrenal			
Neuroblastoma			
Hepatic			
Soft Tissue			
Teratoma			
Lymphoma, Leukemia			
Bone			
Gonadal			
Abdomen			
GI			
Hepatobiliary			
Pancreas			
Adrenal			
Thoracic/Airway			
Chest Wall Deformities			
Lobar Emphysema			
Cystic Adenomatoid Malformation			
Pulmonary Sequestration			
Tracheal & Bronchial Abnormalities			
Mediastinal Cysts &			

Tumors			
Laryngoscopy & Bronchoscopy			
Empyema & Pulmonary Abscess			
Chylothorax			
Breast			
Abdominal Wall, Diaphragm, Peritoneum			
Diaphragmatic Hernia, Eventration			
Abdominal Wall Defects			
Genitourinary			
Inguinal Hernia & Hydrocele			
Undescended Testes			
Torsion's			
Ambiguous Genitalia			
Ovary			
Vaginal Atresia, Hydrometrocolpos			
Circumcision			
Head & Neck			
Congenital Lesions			
Salivary Glands			

PEDIATRIC SURGERY

ACGME INTERPERSONAL/COMMUNICATION SKILLS COMPETENCY

Interpersonal and communication skills that result in effective information exchange and teaching with patients, their families, and other health professionals.

Content	Educational Strategies	Evaluation Methods	Outcome Measures
<p>Communicate effectively with patients and families to create and sustain a professional and therapeutic relationship</p> <p>Listening skills</p> <p>Explaining skills</p> <p>Interaction skills</p> <p>Communicate effectively with physicians, other health professionals, and health-related agencies</p> <p>Work effectively as a member or leader of a health care team (including both interdisciplinary and inter-professional collaboration) or organization</p> <p>Be able to act in a consultative role to other physicians and health professionals</p> <p>Maintain comprehensive, timely, and legible medical records</p> <p>Counsel patients and families</p> <p>Take measures needed to enhance or maintain health and function and prevent disease and injury</p> <p>Encourage active participation in their care</p> <p>Provide information that will foster increased independence and compliance</p> <p>Provide information necessary to enable patients and families to understand the illness and treatment, share decisions, and give informed consent</p>	<p>Surgery Clinic</p> <p>Pre- and Post-Op patient care</p> <p>ED and Trauma Room</p>	<p>Observation with focused evaluation of resident describing complex surgical procedure and obtaining informed consent</p> <p>Faculty evaluations</p> <p>Semiannual evaluation by program director</p> <p>Tracking of customer services comments from CHI patient satisfaction survey</p> <p>360° feedback evaluation</p>	<p>Tracking of sentinel events, lawsuits, or other adverse outcomes</p> <p>Tracking of patient satisfaction results</p>

<p>Provide “bad news” in a compassionate manner, allowing families time to grieve and adjust</p> <p>Identify and effectively utilize other resources, e.g., case managers, pastoral care</p> <p>Provide care that is sensitive to each patient’s cultural, economic, and social circumstances</p> <p>Sensitivity to age, gender, culture, and ethnicity</p> <p>Appreciation of the economic factors that influence decision making and impact of such factors on families</p> <p>Demonstrate competency in meeting the unique needs of pediatric patients and their families</p> <p>Psychological needs</p> <p>Multiple family structures</p> <p>Special needs of children with complex congenital abnormalities</p>			
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PEDIATRIC SURGERY

ACGME PROFESSIONALISM COMPETENCY

Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse population.

Content	Educational Strategies	Evaluation Methods	Outcome Measures
Respectful of all patients and families as well as colleagues who are different with respect to age, culture, disabilities, ethnicity, gender, and/or sexual orientation	Discussion of ethical issues at case conferences	Ethics case vignettes	Tracking of patient complaints and adverse events
Acceptance of responsibility for patient care, including continuity of care	Role modeling by faculty within program and within institution	360° feedback evaluation Global	

Ethics knowledge and consistent demonstrate of ethically sound practice		evaluation by faculty	
Professional behaviors		Patient satisfaction surveys	
Integrity			
Honesty			
Compassion			
Empathy			
Dependability			
Commitment			

PEDIATRIC SURGERY

ACGME SYSTEMS-BASED PRACTICE COMPETENCY

Systems-based practice, as manifested by actions that demonstrate an awareness of, and responsiveness to, the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Content	Educational Strategies	Evaluation Methods	Outcome Measures
Advocacy for patients	Trauma Conference	360° feedback evaluation	Practice performance measures – payor denials, reimbursement
Effective participation in health care teams and alternative health care settings	Center for Childhood Injury Prevention	Global evaluation by faculty	Annual resident interviews with program director
Awareness of cost of diagnostic tests, procedures and medications	Awareness and/or participation in advocacy activities	Cost of care summary for random selection of one patient per month	Annual report which identifies changes in the program
Advocacy for quality	Review of practice management components		

<p>patient care and optimal patient care systems</p> <p>Health promotion and prevention of disease and injury</p> <p>Knowledge of basic principles of practice management</p> <p>Interaction between practices and larger health care system</p> <p>Models of practice and delivery systems</p> <p>Basic principles of health care reimbursement and billing and coding</p>	<p>of Medical Leadership Program</p> <p>Lecture on billing and coding in surgical practices</p>		
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Attachment 2:

Elective Rotation in Pediatric Urology

The resident is expected to acquire knowledge and skills in the following general aspects of pediatric urology: (1) Radiologic evaluation of the pediatric urinary system; (2) Pathophysiology and clinical manifestations of the major urologic anomalies; (3) Performance of cystoscopy; and (4) Knowledge of the major urologic operations for children, including ureteral reimplantation, pyeloplasty, bladder augmentation, and procedures for reflux and incontinence; and (5) Knowledge of behavioral management techniques for enuresis and other voiding disturbances.

Attachment 3:

Elective Rotation in Pediatric Critical Care Unit

The two week experience in PICU adheres to the six core ACGME competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal/communication skills, professionalism, and systems-based practice).

Patient Care/Medical Knowledge

1. Gather essential information about the unique aspects of the extremely

Sick babies and children as related to thermoregulation, cardiorespiratory physiology and pathophysiology, nutritional requirements, susceptibility to infection, and pain management.
2. Gather essential information about the ventilatory management of an

children, including conventional techniques, nitric oxide, and oscillatory/high frequency ventilation.
3. Gather essential information about nutritional care for the extremely

sick child, including parenteral and enteral techniques, specialized infant formulas, and normal growth parameters.
4. Gather essential information about the management of the renal system of the extremely sick child, including fluids/electrolyte management.

Practice-Based Learning and Improvement

1. Develop an understanding of current national clinical trials for the care of the sick child.
2. Develop and understanding of the morbidity of prematurity, as it

Presents later in life including bronchopulmonary dysplasia.

Interpersonal/Communication Skills

1. Develop an understanding of the unique aspects of communication with the parents of an extremely sick child, including the risks of a “bad” outcome, an uncertain prognosis, and dependency on medical technology for life support.

2. Develop an understanding of the unique challenges for families with cultural, social, economic, and other barriers in caring for an infant or child with special medical needs.
3. Develop an understanding of the role of nurses, social services, and other support professionals in the care of sick children.
4. Develop an understanding of the educational needs of parents and families who have a sick child.

Professionalism

1. Develop an understanding of the unique ethical aspects of caring for the extremely sick child.
2. Develop skill in communicating with parents and families of sick children.

Systems-Based Practice

1. Develop an understanding of the regionalization of care for sick children.
2. Develop an understanding of resource utilization for the

transport of sick children to specialized centers.

3. Develop an understanding of the discharge planning process, including community resources and communication with primary care providers.

Attachment 4:

Elective Rotation in Neonatology

The two week experience in neonatology adheres to the six core ACGME competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal/communication skills, professionalism, and systems-based practice).

Patient Care/Medical Knowledge

5. Gather essential information about the unique aspects of the extremely premature neonate as related to thermoregulation, cardiorespiratory physiology and pathophysiology, nutritional requirements, susceptibility to infection, and pain management.
6. Gather essential information about the ventilatory management of an extremely premature neonate, including conventional techniques, nitric oxide, and oscillatory/high frequency ventilation. Gather essential knowledge of the role of ECMO in the care of infants with respiratory failure.
7. Gather essential information about nutritional care for the extremely premature neonate, including parenteral and enteral techniques, specialized infant formulas, and normal growth parameters.

8. Gather essential information about the unique aspects of the nervous system of the extremely premature neonate, potential for intracranial hemorrhage, and appropriate preventive measures.
9. Gather essential information about the immaturity of the renal system of the extremely premature neonate, including fluids/electrolyte management.

Practice-Based Learning and Improvement

3. Develop an understanding of current national clinical trials for the care of premature and imperiled newborns.
4. Develop an understanding of the morbidity of prematurity, including bronchopulmonary dysplasia, developmental delay, retinopathy of prematurity, and skeletal/bone growth delay.

Interpersonal/Communication Skills

5. Develop an understanding of the unique aspects of communication with the parents of an extremely premature neonate, including the risks of a “bad” outcome, an uncertain prognosis, and dependency on medical technology for life support.
6. Develop an understanding of the unique challenges for families with cultural, social, economic, and other barriers in caring for

an infant with special medical needs.

7. Develop an understanding of the role of nurses, social services, and other support professionals in the care of imperiled infants.
8. Develop an understanding of the educational needs of parents and families who have an imperiled newborn.

Professionalism

3. Develop an understanding of the unique ethical aspects of caring for the extremely premature neonate.
4. Develop skill in communicating with parents and families of imperiled newborns.

Systems-Based Practice

4. Develop an understanding of the regionalization of care for neonates.
5. Develop an understanding of resource utilization for the transport of neonates to specialized centers.
6. Develop an understanding of the discharge planning process, including community resources and communication with primary care providers.