

# **Components of the Kaiser/St Vincent's Rotation Syllabi - Revised 6/8/07**

## **I. Orientation Guide to the Service**

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## **Kaiser Westside Surgical Service**

### **I. Orientation Guide to the Service**

#### **A. Composition of the Service: Lines of Supervision**

1. The Kaiser/St Vincent's rotation includes a senior resident (PGY-4) and an intern (PGY-1) as well as an occasional medical student. In addition, there is a chief resident overseeing the entire Kaiser/St Vincent contingent of residents but this person has little to do with day to day service management. Residents are supervised by 6 attending physicians with direct responsibility for the patients on the service.
2. Residents are responsible for day-to-day care of all Kaiser Surgery patients under supervision of the faculty. Residents are responsible for communicating to the individual directly senior to them all admissions, consultations, and significant changes in the condition of all inpatients and of all outpatients who may call with problems. On this service, all patient calls should go directly through the attending. Please let the attending know should a call be directed to the resident by mistake. Monday through Friday residents should communicate directly with the attending responsible for each patient. On weekends, problems should be addressed with the on-call group member.

#### **B. Roles and Responsibilities of Each Team Member**

1. One team member is responsible for signing out all patients on the service for whom

they have responsibility to the night float residents by 6:00 pm Monday through Friday and before noon on Saturdays, Sundays, or holidays. The time for sign-out is under constant revision and should be reviewed with the exiting residents for current times.

2. The division of labor on this two person team is fluid depending on the composition of the service. In general, the intern takes ward calls and the senior is responsible for ICU management. The service is light on ICU patients and therefore patient care is often divided by patients on whom the residents have operated. The senior should always be available for guidance in management of in house patients.

3. Any care issues or questions should be taken up directly with the responsible attending. If there is a problem with communication at any time the residency director should be contacted.

#### C. General Surgery Kaiser/St Vincent's Weekly Schedule

##### 1. MONDAY

0715-1000 Grand Rounds and Resident Conference-all students and residents. Old Library Auditorium.

##### 2. TUESDAY

08:45-12:00 Senior Clinic, MJP

##### 3. WEDNESDAY

Noon – Dr Alberty conference

##### 4. THURSDAY

0700 M&M conference

0800 Grand rounds or tumor board or department meeting

#### D. Policies

1. All patients, admissions and consults, must have a complete history and physical examination both by an intern or resident (an MD) and an attending physician

DICTATED IN THEIR CHART within 24 hours of admission. Medical

Student history and physicals do not meet this standard. All dictations should be done on the St Vincent's priority line. This is necessary for documentation of supervision. The Kaiser Health Record Number must be included in EVERY dictation

2. All patients should have daily progress notes written by 0900 that include the physical assessment, progress, and plan of care. Active consult patients should have a daily note. Inactive consults may have QOD notes.

3. All patients undergoing operations should have a pre-operative check that their work-up, orders, consent, and laboratory work is completed and satisfactory for them to proceed with surgery.

4. All patients should have a brief operative note documented in the medical record immediately after their operations. All operative reports should be dictated in the OR or perioperative areas immediately following the completion of the procedure. Clarify with your attending if you are responsible for the dictation.

5. All inpatients undergoing surgery should have a post-operative check documented in their medical record on the evening of their operation.

6. Discharge summaries should optimally be dictated within 24 hours before discharge but should in no case be dictated later than 24 hours after discharge.
7. Residents should report to the OR prepared with appropriate knowledge of the patients' clinical history, relevant imaging studies, and operative strategies.
8. Appropriate professional dress and demeanor are expected at all times.
9. Residents are expected to attend required department and service conferences.
10. Residents are required to comply with ACGME mandated duty hours standards.
11. 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.
12. Most ICU patients with >24 hour stays anticipated will be followed by the Kaiser intensivist.

## **Kaiser/St Vincent's Curriculum**

### **PSVMC General Surgery Service Curriculum and Objectives**

#### **II. Curriculum**

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

##### **A. Goals**

##### **1. Medical Knowledge**

- a. Understand the pathophysiology and clinical presentation of the following surgical problems:
  1. appendicitis
  2. bowel obstruction
  3. cholecystitis
  4. colonic diverticulitis
  5. soft tissue infection (uncomplicated, non-necrotizing)
  6. hernias of the abdominal wall
- 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.
- c. Understand appropriate initial nonoperative management of:
  1. partial small bowel obstruction
  2. uncomplicated diverticulitis
  3. cellulitis

d. Develop technical skills for common procedures and operations encountered on the service appropriate for the intern level of training, specifically abdominal wall hernias, appendectomy, abscess drainage, and excisional biopsy or lumpectomy of the breast.

### **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.
- f. > 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.
- g. > 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.
- h. > 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
- i. > Explain the risk factors, pathophysiology, and clinical presentation of patients with abdominal wall hernias.

## 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 and laparoscopic appendectomy
2. open gastrostomy
3. open feeding jejunostomy
4. abscess drainage (including perirectal)
5. central line placement
6. opening of an infected postoperative wound
7. open and laparoscopic groin, umbilical, and incisional hernia repair

### **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.

# **SENIOR RESIDENT (PGY-4)**

## **A. GOALS**

### **1. Medical Knowledge**

- a. Understand the pathophysiology and clinical presentation of the following 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)
  - pancreatitis (uncomplicated versus complicated)
  - intra-abdominal abscess
  - hernias of the abdominal wall
  - colorectal cancer
  - breast cancer and other breast diseases

- 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)
  - pancreatitis (uncomplicated versus complicated)
  - intra-abdominal abscess
- d. Understand the general principles of wound care.
- e. 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
- d. Develop technical skills for common procedures and operations encountered on the service appropriate for the PGY-4 level, including open and laparoscopic small and large bowel resection, laparoscopic cholecystectomy, open and laparoscopic hernia repairs, lumpectomy, sentinel node excision for breast cancer and melanoma.

## **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 PGY-1 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.
- > Describe the risk factors for development of abdominal wall hernias and indications for their repair.
- 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. > Describe the symptoms and signs of cancer arising in the right and left colon and rectum.
- > Outline the appropriate workup for cancers arising in the right and left colon and rectum.

## 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
  - Laparoscopic appendectomy
  - Laparoscopic and open cholecystectomy
  - Lysis of adhesions
  - Colostomy
  - Debridement of necrotic soft tissue
  - Lumpectomy and sentinel lymph node excision
  - Open and laparoscopic hernia repair
- g. Develop technical skills for laparoscopic Nissen fundoplication, small and large bowel resection, open and laparoscopic

### **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.

## **Reading**

Schwartz, Principles of Surgery, 8<sup>th</sup> edition, Chapters 5, 16, 24, 27, 28, 29, 31, 32, 34, 36.

# Performance Rating for Laparoscopic Inguinal Hernia Repair

Resident:

Staff:

Date:

Circle the number corresponding to the resident's performance regardless of level of training

## Indications:

| 1  | 2 | 3  | 4 | 5   |
|--|---|--|---|---|
| Cannot explain indications for Lap vs open technique |   | Can describe basic rules for Patient selection |   | Can describe in detail the ideal patient, Contraindications, etc. |

## Exposure of preperitoneal space:

| 1   | 2 | 3  | 4 | 5  |
|---|---|--|---|--|
| Cannot describe the anatomy of abdominal wall/poor technique for obtaining pneumoperitoneum |   | Can describe anatomy, planes to be accessed for preperitoneum. |   | Excellent understanding of tissue planes and successful establishment of pneumoperitoneum. |

## Location of spermatic cord, vessels:

| 1   | 2 | 3  | 4 | 5  |
|---|---|--|---|--|
| Cannot find these structures, poor understanding of where they should be located. |   | Demonstrates verbally knowledge of structures and their locations, aware of dissection pitfalls. |   | Excellent demonstration of anatomy, landmarks, progression of case.. |

## Principles of mesh placement:

| 1  | 2 | 3  | 4 | 5   |
|--|---|--|---|---|
| Cannot describe mesh options, size, landmarks for placement. |   | Can describe mesh options, goals of placement. |   | Excellent description of use of mesh, need for fixation, options for fixation, goals of coverage. |

## Alternative approaches (different port placement options, bleeding, pneumoperitoneum)

| 1   | 2 | 3   | 4 | 5  |
|---|---|---|---|--|
| Frustrated and poor adaptation when initial approaches failed |   | Remained calm but some difficulty in modifying technique when unsuccessful. |   | Remained calm with excellent adaptati initial operative approaches failed. |

## Respect for tissue:

| 1  | 2 | 3   | 4 | 5  |
|--|---|---|---|--|
| Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments |   | Careful handling of tissue but occasionally caused inadvertent damage |   | Consistently handled tissue appropriately with minimal damage to tissue. |

## Time and Motion:

| 1                       | 2 | 3   | 4 | 5   |
|-------------------------|---|---|---|---|
| Many unnecessary moves. |   | Efficient time/motion but some unnecessary moves. |   | Clear economy of movement and maximum efficiency. |

## Flow of operation:

| 1  | 2 | 3  | 4 | 5   |
|--|---|--|---|---|
| Frequently stopped operating and seemed unsure of next move. |   | Demonstrated some forward planning with reasonable progression of procedure. |   | Obviously planned course of operation with effortless flow from one move to the next. |

## OVERALL PERFORMANCE:

| 1         | 2 | 3         | 4 | 5                |
|-----------|---|-----------|---|------------------|
| Very Poor |   | Competent |   | Clearly superior |

Items 6 through 9 adopted from University of Toronto

Return completed form to Robin Alton at fax (503) 494-5615.

# Performance Rating for Resection of Melanoma

Resident:

Staff:

Date:

Circle the number corresponding to the resident's performance regardless of level of training

Sentinel node:

| 1   | 2 | 3  | 4 | 5   |
|---|---|--|---|---|
| Cannot describe rationale for SLNBx, appropriate use. |   | Can describe how to do sentinel LN biopsy. |   | Demonstrates full grasp of lymphatic mapping, SLNBx, indications. |

Principles of wide excision:

| 1  | 2 | 3  | 4 | 5  |
|--|---|--|---|--|
| Cannot list margin widths and how to measure them. |   | Can describe principles of wide local excision for various anatomic locations. |   | Describes fully the margin criteria for different histologic subtypes and locations. |

Gamma Probe:

| 1   | 2 | 3  | 4 | 5  |
|---|---|--|---|--|
| Cannot describe function/settings of gamma probe. |   | Can describe basic principles/use of gamma probe, may not know how to operate machine. |   | Can explain gamma probe functioning in entirety, troubleshoots without difficulty. |

Wound closure:

| 1   | 2 | 3   | 4 | 5   |
|---|---|---|---|---|
| Does not know options for closing large skin defects. |   | Knows measures for mobilizing skin, incision placement. |   | Demonstrates proper use of grafting, flaps, closure techniques, temporizing or permanent. |

Alternative approaches (unable to locate sentinel node, wound unable to be closed)

| 1   | 2 | 3   | 4 | 5  |
|---|---|---|---|--|
| Frustrated and poor adaptation when initial approaches failed |   | Remained calm but some difficulty in modifying technique when unsuccessful. |   | Remained calm with excellent adaptati initial operative approaches failed. |

Respect for tissue:

| 1  | 2 | 3   | 4 | 5  |
|--|---|---|---|--|
| Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments |   | Careful handling of tissue but occasionally caused inadvertent damage |   | Consistently handled tissue appropriately with minimal damage to tissue. |

Time and Motion:

| 1                       | 2 | 3   | 4 | 5   |
|-------------------------|---|---|---|---|
| Many unnecessary moves. |   | Efficient time/motion but some unnecessary moves. |   | Clear economy of movement and maximum efficiency. |

Flow of operation:

| 1  | 2 | 3  | 4 | 5   |
|--|---|--|---|---|
| Frequently stopped operating and seemed unsure of next move. |   | Demonstrated some forward planning with reasonable progression of procedure. |   | Obviously planned course of operation with effortless flow from one move to the next. |

OVERALL PERFORMANCE:

| 1         | 2 | 3         | 4 | 5                |
|-----------|---|-----------|---|------------------|
| Very Poor |   | Competent |   | Clearly superior |

Items 6 through 9 adopted from University of Toronto

Return completed form to Robin Alton at fax (503) 494-5615.

# Performance Rating for Laparoscopic Nissen

Resident:

Staff:

Date:

Circle the number corresponding to the resident's performance regardless of level of training

## Preop evaluation:

| 1  | 2 | 3   | 4 | 5   |
|--|---|---|---|---|
| Cannot describe necessary workup (motility, pH, endoscopy, etc.) |   | Can describe rudimentary testing requirements, findings |   | Can list appropriate steps in workup prior to Nissen. |

## Port placement:

| 1   | 2 | 3                                    | 4 | 5   |
|---|---|--------------------------------------|---|---|
| Cannot demonstrate technique or geometry of port placement. |   | Can demonstrate safe port placement. |   | Can demonstrate safe port placement with geometry based on each individual patient. |

## Operative anatomy:

| 1                                      | 2 | 3  | 4 | 5  |
|--|---|--|---|--|
| Cannot identify structures encountered |   | Identifies stomach, esophagus, liver, crura, short gastrics. |   | Describes anatomic variants, nerves, hernia sac. |

## Steps in surgery:

| 1  | 2 | 3  | 4 | 5  |
|--|---|--|---|--|
| Cannot describe steps in procedure or demonstrate intracorporeal suturing. |   | Can perform basic intracorporeal knot tying, knows possible crural closures, knows bougie indications. |   | Can perform steps in wrap, suturing skills, appropriate fixation suture placement. |

## Handling complications:

| 1  | 2 | 3  | 4 | 5   |
|--|---|--|---|---|
| Does not recognize or effectively deal with intraoperative problems. |   | Can describe and deal with basic complications of gastric injury, bradycardia, retraction and exposure problems. |   | Can fully describe and deal with complications of large hiatal hernia, short esophagus, bleeding, injury. |

## Alternative approaches:

| 1   | 2 | 3   | 4 | 5   |
|---|---|---|---|---|
| Frustrated and poor adaptation when initial approaches failed |   | Remained calm but some difficulty in modifying technique when unsuccessful. |   | Remained calm with excellent adaptation when initial operative approaches failed. |

## Respect for tissue:

| 1  | 2 | 3   | 4 | 5  |
|--|---|---|---|--|
| Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments |   | Careful handling of tissue but occasionally caused inadvertent damage |   | Consistently handled tissue appropriately with minimal damage to tissue. |

## Time and Motion:

| 1                       | 2 | 3   | 4 | 5   |
|-------------------------|---|---|---|---|
| Many unnecessary moves. |   | Efficient time/motion but some unnecessary moves. |   | Clear economy of movement and maximum efficiency. |

## Flow of operation:

| 1  | 2 | 3  | 4 | 5   |
|--|---|--|---|---|
| Frequently stopped operating and seemed unsure of next move. |   | Demonstrated some forward planning with reasonable progression of procedure. |   | Obviously planned course of operation with effortless flow from one move to the next. |

## OVERALL PERFORMANCE:

| 1         | 2 | 3         | 4 | 5                |
|-----------|---|-----------|---|------------------|
| Very Poor |   | Competent |   | Clearly superior |

Items 6 through 9 adopted from University of Toronto.

Return completed form to Robin Alton at fax (503) 494-5615.

# PERFORMANCE RATING FOR EXCISIONAL BIOPSY (skin, soft tissue, breast)

Resident \_\_\_\_\_ Faculty \_\_\_\_\_ Date \_\_\_\_\_

Circle the number corresponding to the resident's performance regardless of the level of training.

## Planning of incision

|                        |          |  |          |   |
|------------------------|----------|--|----------|---|
| <b>1</b>               | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>  |
| Poor incision planning |          | Understands most principles in planning & drawing incision |          | Excellent planning of incision & drew incision with marking pen |

## Margins of excision

|   |          |                              |          |   |
|---|----------|------------------------------|----------|---|
| <b>1</b>  | <b>2</b> | <b>3</b>                     | <b>4</b> | <b>5</b>  |
| Inappropriate margins and/or lesion entered during dissection |          | Adequate margins of excision |          | Excellent technique in assuring appropriate margins of excision |

## Handling of instruments

|  |          |   |          |  |
|--|----------|---|----------|--|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Repeatedly makes tentative or awkward moves with instruments through inappropriate use |          | Competent use of instruments but occasionally appeared stiff or awkward |          | Fluid movements with instruments & no stiffness or awkwardness |

## Suturing technique

|  |          |   |          |   |
|--|----------|---|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>  |
| Poor placement of sutures & knot tying technique |          | Satisfactory placement of sutures with only occasional failures in providing square knots |          | Excellent suture placement with appropriate tension & consistently square knots |

## Utilization of pathology

|  |          |  |          |  |
|--|----------|--|----------|--|
| <b>1</b>   | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>   |
| Poor understanding of when to use pathology & how to utilize results in workup & intraoperative management |          | Moderate understanding of when to use pathology & how to utilize results in workup & intraoperative management |          | Excellent understanding of when to use pathology & how to use the information provided |

## Prevention of complications (wound dehiscence, wound infection, poor cosmesis)

|   |          |   |          |  |
|---|----------|---|----------|--|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Poor knowledge of techniques to prevent complications |          | Aware of most techniques to prevent complications utilized somewhat inefficiently |          | Excellent awareness of techniques to prevent complications intraperitoneal contamination |

## Respect for Tissue

|  |          |   |          |   |
|--|----------|---|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>  |
| Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments |          | Careful handling of tissue but occasionally caused inadvertent damage |          | Consistently handled tissue appropriately with minimal damage to tissue |

## Time and motion

|                        |          |  |          |  |
|------------------------|----------|--|----------|--|
| <b>1</b>               | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>                                       |
| Many unnecessary moves |          | Efficient time/motion but some unnecessary moves |          | Clear economy of movement & maximum efficiency |

## Flow of operation

|   |          |   |          |  |
|---|----------|---|----------|--|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Frequently stopped operating & seemed unsure of next move |          | Demonstrated some forward planning with reasonable progression of procedure |          | Obviously planned course of operation with effortless flow from one move to the next |

## OVERALL PERFORMANCE

|           |          |           |          |                  |
|-----------|----------|-----------|----------|------------------|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>         |
| Very poor |          | Competent |          | Clearly superior |

# PERFORMANCE RATING FOR LAPAROSCOPIC CHOLECYSTECTOMY

Resident \_\_\_\_\_ Faculty \_\_\_\_\_ Date \_\_\_\_\_

Circle the number corresponding to the resident's performance regardless of the level of training.

## Port management

|  |          |  |          |   |
|--|----------|--|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>  |
| Poor technique in placement and removal of ports |          | Satisfactory technique in port placement and removal |          | Excellent technique in port placement and removal |

## Cystic duct dissection

|  |          |  |          |  |
|--|----------|--|----------|--|
| <b>1</b>   | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>   |
| Poor and inefficient dissection, division of cystic duct |          | Maintained consistent lateral retraction but occasionally inefficient cystic duct dissection, division |          | Maintained lateral retraction, careful and expedient dissection, division of cystic duct |

## Cystic artery dissection

|  |          |  |          |   |
|--|----------|--|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>  |
| Poor dissection technique and/or inadvertent injury of cystic artery |          | Cystic artery appropriately identified, dissected, and clipped, but with some inefficiency |          | Excellent and expedient dissection, division of cystic artery |

## Gallbladder dissection

|  |          |  |          |   |
|--|----------|--|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>  |
| Poor and inefficient dissection technique with bile spillage |          | Satisfactory although somewhat inefficient gallbladder dissection with minimal or no bile spillage |          | Excellent technique in gallbladder dissection with no bile spillage or liver bed injury |

## Decision making for cholangiography

|   |          |  |          |   |
|---|----------|--|----------|---|
| <b>1</b>  | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>  |
| Poorly understood criteria for intraoperative cholangiography |          | Understood most of the criteria for intraoperative cholangiography; if performed, competent but somewhat inefficient |          | Understood all criteria for intraoperative cholangiography; if performed, excellent and efficient technique |

## Alternative approaches (i.e. unable to use Varies needle, port site air leak, unexpected bleeding, conversion to open procedure)

|   |          |  |          |  |
|---|----------|--|----------|--|
| <b>1</b>  | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>   |
| Frustrated and poor adaptation when initial approaches failed |          | Remained calm but some difficulty in modifying technique when unsuccessful |          | Remained calm with excellent adaptation when initial operative approaches failed |

## Respect for tissue

|  |          |   |          |   |
|--|----------|---|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>  |
| Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments |          | Careful handling of tissue but occasionally caused inadvertent damage |          | Consistently handled tissue appropriately with minimal damage to tissue |

## Time and motion

|                        |          |  |          |  |
|------------------------|----------|--|----------|--|
| <b>1</b>               | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>   |
| Many unnecessary moves |          | Efficient time/motion but some unnecessary moves |          | Clear economy of movement and maximum efficiency |

## Flow of operation

|   |          |   |          |  |
|---|----------|---|----------|--|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Frequently stopped operating and seemed unsure of next move |          | Demonstrated some forward planning with reasonable progression of procedure |          | Obviously planned course of operation with effortless flow from one move to the next |

## OVERALL PERFORMANCE

|           |          |           |          |                  |
|-----------|----------|-----------|----------|------------------|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>         |
| Very poor |          | Competent |          | Clearly superior |

Return completed form to Robin Alton at fax (503) 494-5615.

Rev: 6/07 by Amy Morris, MD aln

# PERFORMANCE RATING FOR LUMPECTOMY & AXILLARY LYMPH NODE MANAGEMENT

Resident \_\_\_\_\_ Faculty \_\_\_\_\_ Date \_\_\_\_\_

Circle the number corresponding to the resident's performance regardless of the level of training.

## Placement of incisions

|  |          |   |          |  |
|--|----------|---|----------|--|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Poor understanding of incision placement for lumpectomy and axillary node management |          | Understood most criteria for incision placement |          | Excellent understanding of key issues for incision placement |

## Tumor Dissection

|  |          |   |          |   |
|--|----------|---|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>  |
| Poor technique & inefficiency in tumor dissection and Specimen orientation |          | Satisfactory tumor dissection but with inadequate tumor margins gross satisfactory Specimen orientation |          | Excellent technique in tumor dissection with good gross margins on initial specimen; appropriate specimen orientation |

## Sentinel lymph node mapping (if performed)

|   |          |  |          |                               |
|---|----------|--|----------|-------------------------------|
| <b>1</b>                                  | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>                      |
| Poor knowledge & technique in SLN mapping |          | Utilized scintigraphy to identify SLN (s) but with some inefficiencies |          | Rapid & efficient SLN mapping |

## Nerve identification in axillary dissection (if performed)

|  |          |   |          |  |
|--|----------|---|----------|--|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Poor knowledge of anatomy & technique in nerve identification & preservation |          | good knowledge of nerve anatomy but some lapses in technique for identification & avoidance of injury |          | Excellent knowledge of anatomy & precise technique in identifying nerves & avoiding injury |

## Utilization of pathology

|  |          |  |          |  |
|--|----------|--|----------|--|
| <b>1</b>   | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>   |
| Poor understanding of when to use pathology & how to utilize results in workup & intraoperative management |          | Moderate understanding of when to use pathology & how to utilize results in workup & intraoperative management |          | Excellent understanding of when to use pathology & how to use the information provided |

## Limits of breast preservation

|   |          |   |          |   |
|---|----------|---|----------|---|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>  |
| Poor understanding of criteria which would require mastectomy |          | Demonstrated understanding of most of the criteria which would require mastectomy |          | Excellent understanding of criteria that would require mastectomy |

## Respect for tissue

|  |          |   |          |   |
|--|----------|---|----------|---|
| <b>1</b>   | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>  |
| Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments |          | Careful handling of tissue but occasionally caused inadvertent damage |          | Consistently handled tissue appropriately with minimal damage to tissue |

## Time and motion

|                        |          |  |          |  |
|------------------------|----------|--|----------|--|
| <b>1</b>               | <b>2</b> | <b>3</b>   | <b>4</b> | <b>5</b>                                       |
| Many unnecessary moves |          | Efficient time/motion but some unnecessary moves |          | Clear economy of movement & maximum efficiency |

## Flow of operation

|   |          |   |          |  |
|---|----------|---|----------|--|
| <b>1</b>  | <b>2</b> | <b>3</b>  | <b>4</b> | <b>5</b>   |
| Frequently stopped operating & seemed unsure of next move |          | Demonstrated some forward planning with reasonable progression of procedure |          | Obviously planned course of operation with effortless flow from one move to the next |

## OVERALL PERFORMANCE

|                  |          |                  |          |                         |
|------------------|----------|------------------|----------|-------------------------|
| <b>1</b>         | <b>2</b> | <b>3</b>         | <b>4</b> | <b>5</b>                |
| <b>Very poor</b> |          | <b>Competent</b> |          | <b>Clearly superior</b> |

# SVMC GENERAL SURGERY PROCEDURAL SKILLS PERFORMANCE RATINGS

Resident \_\_\_\_\_ Training Level (Please circle one):

PGY-1

PGY-2

PGY-3

PGY-4

PGY-5

Procedure:

- \_\_\_\_ Open groin hernia repair (PGY-1 – PGY-4)
- \_\_\_\_ Appendectomy (PGY1 – PGY-4)
- \_\_\_\_ Laparoscopic cholecystectomy (PGY-2, PGY-3, PGY-4)
- \_\_\_\_ Colectomy (PGY-2, PGY-3, PGY-4)
- \_\_\_\_ Low anterior resection (PGY-4, PGY-5)

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                  | Showed little evidence of preparation  | Adequate job  | Confident & well prepared                           |
| 2. Technical Operative Skills                  | Fumbles; deficient knot-tying and instrument handling                            | Average operative skills  | Technically gifted                                  |
| 3. Adaptability to Unexpected Events in the OR | Is unable to react quickly when the unexpected occurs                            | Can react appropriately to unexpected events                                    | Handles bleeding, unexpected events with ease       |
| 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 |

Faculty \_\_\_\_\_ Date: \_\_\_\_\_

Return completed form to Robin Alton at fax (503) 494-5615.