

Louisiana State University
Health New Orleans



Department of Surgery
2020-2021
House Officer Manual

Departmental Policies

Residency Selection Policy

Graduates of all Liaison Committee on Medical Education (LCME) schools in the United States and Canada are invited to submit applications through the Electronic Resident Application System (ERAS). Additionally, applications are also accepted from Foreign Medical Graduates meeting the Educational Commission for Foreign Medical Graduates (ECFMG) criteria and submitted through ERAS. The Department of Surgery does not support Visas. If a foreign medical graduate matches with our program, they must be registered and certified through the before beginning their residency training. All applicants must also meet the requirements for licensure through the Louisiana State Board of Medical Examiners (LSBME) – either an intern card, which will eventually lead to an unrestricted license or a Graduate Education Training Permit (GETP) given to foreign medical graduates.

Submitted applications are then reviewed by the Coordinator, Program Director, and other faculty. Criteria for interview involve an academic score based on the United States Medical Licensing Exam (USMLE Step) 1 and 2, School Transcripts, Letters of Recommendation, Dean's Letter, Curriculum Vitae (CV), and the ERAS application.

Interviews take place annually in November, December, and January. Applicants are interviewed by the interview committee (approximately 6 faculty) with interviews lasting about 20 minutes long. All applicants will meet with the Program Director. There is also an informal group interview with the chairman and 3-6 applicants. A ranking meeting is held at the completion of each interview day and based on both objective and subjective information. A draft ranking list is developed at the end of the day.

At the completion of the interview process in January, faculty, chief residents, the program director, and the chairman meet to create the final ranking list to submit to the National Resident Match Program (NRMP).

Resident Promotion Policy

Milestone progression determined from evaluations by faculty, peers, and students, along with an assessment of academic performance (e.g. American Board of Surgery In-Training Examination (ABSITE) scores, attendance to weekly resident education conference, mock oral exam performance, etc.) play a determining role in resident promotion. At the end of each evaluation form, the faculty member is asked if they think that the resident should be promoted to the next level. All residents are critically evaluated by members of the Clinical Competency Committee (CCC) two times a year. Based off data collected, CCC members will classify each resident into either a "green," "yellow," or "red bucket". If a resident is classified as "red bucket" or "yellow bucket" during the mid-year or end-of-year CCC meeting, their performance will be re-evaluated in between the bi-annual CCC meetings.

There is a check box for promotion or remediation in which the faculty member has a chance to respond with their opinion. Each resident is discussed by faculty and chief residents four times a year during the Resident Evaluation Meeting and decisions are made for promotion of each into the next level. **Residents must pass USMLE Step 3 in order to advance to the PGY 2 level.**

Resident Dismissal Policy

The Department of Surgery adheres to the Institutional Policy of non-renewal of agreement of appointment which ensures that the resident receive notification of non-renewal of appointment *no later than four months* prior to the end of the resident's current agreement of appointment. If the primary reason for the non-renewal occurs within the four months prior to the end of the agreement of appointment, the institution must ensure that the program provide their residents with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement of appointment. Residents must be allowed to implement the institution's grievance procedures when they have received a written notice of intent not to renew their agreements of appointment. Refer to the LSU House Officer Manual for steps for appeal process.

Professionalism and Learning Environment

The Department of Surgery wishes to ensure:

1. Patients receive safe, quality care in the teaching setting of today.
2. Graduating residents provide safe, high quality patient care in the unsupervised practice of surgery in the future.
3. Residents learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment.

Important aspects of the learning environment include:

1. Professionalism including accepting responsibility for patient safety
2. Alertness management
3. Proper supervision
4. Effective transitions of care
5. Clinical responsibilities
6. Communication / teamwork

Residents must take personal responsibility for and faculty must model behaviors that promote:

1. Assurance for fitness of duty
2. Assurance of the safety and welfare of patients entrusted in their care
3. Management of their time before, during, and after clinical assignments
4. Recognition of impairment (e.g. illness or fatigue) in self and peers
5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

The institution further supports an environment of safety and professionalism by:

1. Providing and monitoring a standard Transitions Policy.
2. Providing and monitoring a standard policy for Duty Hours.

3. Providing and monitoring a standard Supervision Policy.
4. Providing and monitoring a standard master scheduling policy and process in New Innovations.
5. Adopting an institution wide policy that all residents and faculty must inform patients of their role in the patient's care.
6. Providing and monitoring a policy on Alertness Management and Fatigue Mitigation that includes:
 - a. On line modules for faculty and residents on signs of fatigue.
 - b. Fatigue mitigation, and alertness management including pocket cards, back up call schedules, and promotion of strategic napping.
7. Assurance of available and adequate sleeping quarters when needed.
8. Requiring that programs define what situations or conditions require communication with the attending physician.

Process for Implementing Professionalism Policy

Our program assures implementation of the Professionalism Policy by the following:

1. Core Modules for residents on Professionalism, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and Substance Abuse and Impairment.
2. Required LSBME Orientation.
3. Institutional Fitness for Duty and Drug Free Workplace policies.
4. Institutional Duty Hours Policy reflecting the ACGME Duty Hour.
5. Language added specifically to the Policy and Procedure Manual, the House Officer manual and the Resident Contract regarding Duty Hours Policies and the responsibility for and consequences of not reporting Duty Hours accurately.
6. Orientation presentations on Professionalism, Transitions, Fatigue Recognition and Mitigation, and Alertness Management.

Policy on Social Media Usage

All residents within the LSU Health New Orleans Department of Surgery Residency Programs agree to abide by the institutional policy and guidelines on social media. Institutional Guidelines can be found [here](#).

Policy on Hurricane Evacuation

Our program follows the policy of the hospital where the residents are rotating. During onboarding to a particular hospital, the resident will receive the hurricane evacuation policy and must abide by the mandates during hurricane evacuations.

Monitoring Implementation of the Policy on Professionalism

The program and institution will monitor implementation and effectiveness of the Professionalism Policy by the following:

1. Evaluation of residents and faculty including:
 - a. Observation of the resident in the patient care setting.
 - b. Evaluation of the residents' ability to communicate and interact with other members of the health care team by faculty, nurses, patients where applicable, and other members of the team.
 - c. Monthly and semi-annual competency based evaluation of the residents.
 - d. By the institution in Annual Reviews of Programs and Internal Reviews.
 - e. By successful completion of modules for faculty and residents on Professionalism, Impairment, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and others.
 - f. Program and Institutional monitoring of duty hours and procedure logging as well as duty hour violations in New Innovations.

LSU Policy on Diversity and Inclusion

The Louisiana State University School of Medicine at New Orleans believes that diversity among leadership, faculty, and learners is essential to fulfilling the institution's academic mission. The contributions of individuals with diverse backgrounds and perspectives enriches the educational experience for all learners, enables us to better address health care inequities, increases cultural competency in clinical care, improves service to our community, and expands the scope of our scholarship.

A diverse environment also fosters learner understanding, and effective delivery of care to individuals of diverse backgrounds, which is integral to the mission of the school. As an inclusive community, we embrace the full range of human difference: race, gender, ethnicity, age, culture, national origin, religious belief, physical ability, sexual orientation, gender identity, socioeconomic class, and political convictions.

We are committed to fostering growth in the matriculation of African-American, Hispanic, Vietnamese, LGBT students as well as students from underserved rural regions of Louisiana.

Institutional efforts to qualitatively strengthen the climate of inclusion and diversity of our learning community are inclusive of a focus on the development of effective pipelines for recruitment of students and residents from communities which are underrepresented in our region's health professions workforce. The institutional mission of advancing the quality of the educational climate, promoting effectiveness of health equity research, and fully engaging equitable clinical service is supported by a focus on the recruitment and development of basic science and clinical faculty, and senior academic leadership who are underrepresented in our region's academic medical community with an emphasis on women, African American, Hispanic, Vietnamese, and LGBT faculty.

The effectiveness and progress of our pipeline program development will be evaluated through the implementation of systematic approaches to monitor trends in recruitment of students, residents, and faculty from target underrepresented communities. It is recognized that the creation of greater campus diversity may not be readily reflected among groups that are not easily measured. We will assess the impact of our outreach efforts within diverse target communities in terms of the quality of outreach messaging and programming. As we accept the opportunities to demonstrate leadership in our community in advancing health equity, we embrace the importance and value of continued growth of institutional diversity as an essential element of success in fulfilling this mission

General Surgery Policy on Diversity and Inclusion

LSU General Surgery Department embraces diversity and recognizes our responsibility to foster an open environment where students and faculty of all backgrounds can collaboratively learn and work. We value the benefits that arise from diversity, and we are committed to inclusion. Our department values diversity, and we understand how it enriches our program. We are committed to responding to the changing realities of our communities. We will strive to work together to address the challenges by removing barriers to success through compassion and mutual respect. We will develop and cultivate relationships with undergraduate institutions to encourage students to consider a career in medicine.

Grievance Procedures, Sexual Harassment, Equal Opportunity, and Drug Free Workplace

The department follows the Louisiana State University's GME Handbook regarding the above noted topics. The department strives to create a professional work environment, regardless of gender and ethnicity. If questions arise regarding sexual harassment, please feel free to contact Dr. Lance Stuke (lstuke@lsuhsc.edu), Dr. Meg Moore (mmoo19@lsuhsc.edu), or London Guidry (London.Guidry@fmolhs.org). If questions arise regarding possible racial discrimination, please feel free to contact Dr. Lance Stuke (lstuke@lsuhsc.edu).

Policy on Effective Transitions

Effective transitions are facilitated by:

1. Provision of complete and accurate rotational schedules in New Innovations
2. Backup plan where a resident is unable to complete their duties.
3. The ability of any residents to be able to freely and without fear of retribution report their inability to carry out their responsibilities due to fatigue or other causes.

Policy and Process

Residents receive educational material on Transitions in Orientation and as a Core Module.

In any instance where care of a patient is transferred to another member of the health care team, an adequate transition must be used. Although transitions may require additional reporting the minimum standard for transitions must include the following information:

1. Demographics
 - a. Name, Age, Medical Record Number
 - b. Unit/room number
 - c. Attending physician – Phone numbers of covering physician
2. History and Problem List
 - a. Primary diagnoses
 - b. Chronic problems (pertinent to this admission/shift)
3. Current condition/status
4. System based
 - a. Pertinent Medications and Treatments
5. Pertinent lab data
6. To do list: Check x-ray, labs, wean treatments, etc. - rationale
7. Contingency Planning – What may go wrong and what to do
8. Code status/family situations

Rotation faculty will periodically observe resident transitions, on their services. Their assessment of how effectively a resident performs a transition will become a part of your evaluation for the rotation.

Policy on Alertness Management / Fatigue Mitigation Strategies

Policy and Process

Residents and faculty are educated about alertness management and fatigue mitigation strategies via on line modules and in departmental conferences. Some suggestions included are:

1. Warning Signs
 - a. Falling asleep at Conference/Rounds
 - b. Restless, Irritable w/ Staff, Colleagues, Family
 - c. Rechecking your work constantly
 - d. Difficulty Focusing on Care of the Patient
 - e. Feeling Like you Just Don't Care
2. SLEEP STRATEGIES FOR HOUSESTAFF
 - a. Pre/On-Call Residents
 1. Tell Chief/ Faculty, if too sleepy to work! Sleep prior to call & avoid ETOH
 2. Nap whenever you can > 30 min or < 2°)
 3. BEST Circadian Window 2PM-5PM & 2AM- 5AM
 4. AVOID Heavy Meal
 5. Strategic Consumption of Coffee (t ½ 3-7 hours)
 6. Know your own alertness/Sleep Pattern!
 - c. Post-Call Residents
 1. Lowest Alertness 6AM –11AM after being up all night
 2. Full Recovery from Sleep Deficit takes 2 nights
 3. Never drive while drowsy. 20 min. nap/Cup Coffee 30 min before driving.

How Monitored:

The institution and program monitor successful completion of the online modules. Residents are encouraged to discuss any issues related to fatigue and alertness with supervisory residents, chief residents, and the program administration. Supervisory residents will monitor lower level residents during any in house call periods for signs of fatigue. Adequate facilities for sleep during day and night periods are available at all rotation sights and residents are required to notify Chief Residents and program administration if those facilities are not available as needed or properly maintained. At all transition periods, supervisory residents and faculty will monitor lower level residents for signs of fatigue during the hand off. The institution will monitor implementation of this indirectly via monitoring of duty hours violations in New Innovations, the Annual Resident Survey (administered by the institution to all residents and as part of the annual review of programs) and the Internal Review process.

Supervision and Progressive Responsibility Policy

Policy and Process:

Several of the essential elements of supervision are contained in the Policy of Professionalism detailed elsewhere in this document. The specific policies for supervision are outlined below:

Faculty Responsibilities for Supervision and Graded Responsibility:

Residents in the General Surgery Program must be supervised in such a way that they assume progressive responsibility as they progress in their educational program. Progressive responsibility is determined in a number of ways including:

1. Graduate Medical Education (GME) faculty on each service determine what level of autonomy each resident may have that ensures growth of the resident and patient safety.
2. The Program Director and Chief Residents assess each residents' level of competence in frequent personal observation and semi-annual review of each resident.
3. Rotation specific progressive responsibility may be based on specific metrics such as participation in simulation labs, faculty observation of a given procedure, etc.

The expected components of supervision include:

1. Defining educational objectives.
2. The faculty or senior resident observing/assessing the skill level of the resident by direct observation.
3. The faculty or senior resident defines the course of progressive responsibility allowed starting with close supervision and progressing to independence as the skill is mastered.
4. Documentation of supervision by the involved supervising faculty must be customized to the settings based on guidelines for best practice and regulations from the ACGME, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other regulatory bodies. Documentation should generally include but not be limited to:
 - a. progress notes in the chart written by or signed by the faculty
 - b. addendum to resident's notes where needed
 - c. counter-signature of notes by faculty
 - d. a medical record entry indicating the name of the supervisory faculty.
5. In addition to close observation, faculty are encouraged to give frequent formative feedback and required to give formal summative written feedback that is competency based and includes evaluation of both professionalism and effectiveness of transitions.

The levels of supervision are defined as follows:

- **Direct Supervision by Faculty** - faculty is physically present with the resident being supervised.
- **Direct Supervision by Senior Resident** – same as above but resident is supervisor.

- **Indirect with Direct Supervision IMMEDIATELY Available – Faculty** – the supervising physician is physically present within the hospital or other site of patient care and is **immediately** available to provide Direct Supervision.
- **Indirect with Direct Supervision IMMEDIATELY Available – Resident** - same but supervisor is resident.
- **Indirect with Direct Supervision Available** - the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- **Oversight** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Program Supervision Requirements: The program has delineated a set of minimal supervision requirements by the type of care rendered. This may be augmented by any given attending or institution which the residents rotate through and are listed below:

Inpatient Services

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available - residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I				X	X	X
II				X	X	X
III					X	X
IV					X	X
V					X	X

Intensive Care Units

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available - residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I		X			X	X
II		X			X	X
III					X	X
IV					X	X
V					X	X

Ambulatory Settings

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available - residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I		X			X	X
II		X			X	X
III					X	X
IV					X	X
V					X	X

Consult Services

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available - residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I				X	X	X
II				X	X	X
III					X	X
IV					X	X
V					X	X

Operating Rooms:

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available – residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I		X			X	X
II		X			X	X
III		X			X	X
IV					X	X
V					X	X

Procedure Rotations

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available – residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I		X			X	X
II				X	X	X
III					X	X
IV					X	X
V					X	X

PGY 1 residents may not be unsupervised by either faculty or more senior residents in the hospital setting.

How Monitored:

The institution will monitor implementation of the policies through Annual Review of Programs and Special Focused Program Reviews. Furthermore, the institution monitors supervision through a series of questions in the Annual Resident Survey. The program will monitor this through feedback from residents and monitoring by Chief Residents and Program Directors. Supervision will be added to the annual review of programs.

Policy on Mandatory Notification of Faculty

Policy and Process

In certain cases, faculty or a senior resident must be notified of a change in patient status or condition. The table below outlines those instances in which faculty must be called by PGY level.

Condition	PGY 1	PGY2	PGY 3 and above
Care of complex patient	X	X	
Transfer to ICU	X	X	
DNR or other end of life decision	X	X	X
Emergency surgery	X	X	X
Acute drastic change in course	X	X	X
Unanticipated invasive or diagnostic procedure	X	X	X

How monitored

Chief Residents, faculty, and programs will monitor by checking for proper implementation on daily rounds, morning reports, and other venues as well as solicitation of reports from faculty on lack of appropriate use of the policy.

Policy on Continuity of Care (Resident unable to perform duties)

Residents may be unable to perform duties for a variety of reasons ranging from sleep deprivation to emergency family leave. The rotation faculty supervisor is best suited to deal with these occasions. The faculty supervisor may reassign resident duties within the rotation, ranging from operating room coverage to on-call duty to maintain adequate resident coverage. This reassignment must still comply with the duty hours regulations. The faculty supervisor may request additional resident coverage from the program director to meet long absences or insufficient resident coverage for other reasons.

Administrative Information

Rotation Schedules

Resident rotation schedules are prepared by the Chief Resident, Program Director, and Chairman with input from the faculty and resident staff. The full five-year curriculum has been created to ensure equivalent experience and provide full access to all segments of our program for all our residents. Included in the experience are mandatory rotations on General Surgery, Pediatric Surgery, Transplant Surgery, Cardio Thoracic Surgery, Plastic Surgery, Laparoscopic Surgery, Trauma Surgery, Vascular Surgery, Hepatobiliary Surgery, Bariatric Surgery, and the SICU.

The staff has made every effort to provide residents with as many of their requests as possible, but May not always possible. After assignments are distributed, **NO CHANGES SHOULD BE MADE WITHOUT APPROVAL FROM THE PROGRAM DIRECTOR.**

Research Laboratory

Selected residents will be assigned to the research laboratory after the third year. The usual laboratory rotation is for 1-2 years. Residents who think they might be interested in such a rotation should discuss this possibility with the Program Director 6 months prior to the development of the schedule during their second year. Consideration is given based on a resident's academic and clinical performance and planned research projects.

Moonlighting

The following guidelines have been set forth by the Department with regard to a resident's work hours outside their regularly assigned clinical and research duties:

1. No moonlighting is allowed for residents on clinical rotations.
2. Residents may moonlight under the following circumstances (with Program Director approval):
 - a. Research elective
 - b. Vacation
3. Research residents should not allow their moonlighting to interfere with ongoing research projects. Under no circumstance is moonlighting permitted during the work week (Monday-Friday, 8:00 a.m.-5:00 p.m.).
4. Failure to comply with these guidelines will be grounds for probation. Repeated offense will result in dismissal from the program.
5. Please refer to the Liability Insurance Section of the GME Policy and Procedures Manual. Moonlighting is NOT covered by your LSU malpractice insurance.

Evaluations – Faculty and Resident

General Surgery Milestones - Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. There will be two reporting periods – December and June. For each reporting period, review and reporting will involve selecting the level of milestones that best describes the resident's current performance level in relation to milestones, using evidence from multi-source feedback, tests, and record reviews. The milestones are changed on July 1, 2019 to include a level 5.

Resident Evaluation by Faculty – All residents are evaluated at the end of each rotation by the staff members they worked under. The goals & objectives are rotation and level specific and should be reviewed by the resident before starting the rotation. This evaluation becomes part of the permanent file and will be used at the bi-annual Clinical Competency Committee meeting by the faculty members as a means of determining the ACGME Milestone progression. These evaluations plus the ABSITE examination (a yearly in-training examination administered in late January of each year by the American Board of Surgery), plus comments from the staff are the basis for renewal of contracts and promotions as well as recommendation to sit for the qualifying examination of the American Board of Surgery (ABS).

Peer Evaluations – Residents complete evaluations of the peers on their service at the completion of each rotation. These evaluations are confidential and part of each resident's record. The evaluations are not released to the residents on New Innovations to maintain anonymity; they are reviewed with the Program Director during the bi-annual performance review meeting.

Faculty Evaluation by Residents – Just as the faculty have an opportunity to evaluate house officers, house officers are provided the opportunity to anonymously evaluate individual staff members with whom they have worked. These evaluation forms will be completed via New Innovations upon the completion of the rotation. **In efforts to maintain anonymity, the faculty member will not have immediate access to the anonymous evaluations.** Residents are encouraged to be completely honest in their assessments. All staff members receive a typed, anonymous cumulative report of their evaluations at the end of the year. The staff members cannot trace information back to the individual residents. The Chairman also receives a copy of each faculty member's cumulative evaluation report.

Residents **must** complete evaluations of the faculty after they complete their service on that rotations. Completion faculty evaluations by residents will be part of the CCC and influence the bucket (status) denoting the resident's compliance to program rules and progress as a professional.

Rotation Evaluations - Residents will evaluate their rotation experience upon completion of the rotation. These evaluations are anonymous and will be summarized into a single report to be

utilized by the Program Evaluation Committee (PEC) as an assessment tool and as a basis for program development and change. To maintain anonymity, individual rotation evaluations will not be released to faculty or staff.

Annual Program Evaluations – All residents will complete an anonymous and comprehensive program evaluation in May or June of each year. The results of this evaluation will be synthesized and reviewed by the Program Evaluation Committee (PEC) to determine program strengths and weaknesses and as a basis for program development and change.

Statement on Oversight and Liaison

The Program Director maintains contact with faculty members placed in positions of supervision and oversight of residency training. Faculty members are encouraged to discuss resident issues with the Program Director in personal interviews and at the monthly faculty meetings. The Program Director also meets with the faculty members four times a year during the resident evaluation meetings. At this time, any aspect of the training program is open for discussion.

Resident Training Liaison and Oversight

Training Site	Liaison and Oversight
Medical Center of Louisiana – New Orleans	John Hunt, M.D.
Children’s Hospital	David Yu, M.D.
University Medical Center	Charlie Chappuis, M.D.
Our Lady of the Lake Regional Medical Center	V. Keith Rhynes, M.D.
Baton Rouge General	London Guidry, M.D.
West Jefferson Medical Center	Malachi Sheahan, M.D.
Ochsner Medical Center – Kenner	J. Philip Boudreaux, M.D.
Touro Medical Center – New Orleans	Ian Hodgdon, M.D.
Tulane University Medical Center	Anil Paramesh, M.D.
Veterans Administration Medical Center	Dino Sarcino, M.D.

Six General Competencies

ACGME has implemented the requirement of six general competencies into the curriculum of all accredited programs. These competencies will be used as an evaluation tool for faculty evaluating residents on each rotation, the definition of each is outlined on the below:

- 1. Patient Care** – Compassionate, appropriate and effective for treatment and prevention of disease.
- 2. Medical Knowledge** – About established and evolving sciences and their application to patient care.
- 3. Interpersonal and Communication Skills** – Effective information exchange and cooperative “learning”.

4. **Professionalism** – Commitment to professional responsibilities, ethical principles and sensitivity to diverse patient populations.

5. **Practice-Based Learning and Improvement** – Investigate and evaluate practice patterns and improve patient care.

6. **Systems-Based Practice** – Demonstrate an awareness of and responsiveness to the larger context and system of health care.

Dress Code

As medical professionals, your appearance says a lot about who you are. Patients, families, and staff expect physicians to be dressed in a professional manner. Whenever possible, residents should appear at conferences, clinics, and rounds in appropriate attire. Wearing scrubs is acceptable for residents who are on trauma call or who are going in and out of the operating room. Please remember that wearing scrubs outside of the hospital is **unacceptable**. Particular dress requirements may be service specific and will be elaborated at the beginning of the rotation by the service chiefs.

Vacation

How it works, in summary:

- Vacation requests are accepted twice a year.
 - o **Deadline 1: July 15** (of that academic year) for requested time from August 1, – January 31st.
 - o **Deadline 2: December 1** for requested time from February 1st – May 31st
- Vacations are not permitted in June or July (with the exception of graduating PGY 5's).
- Requests must be submitted to your coordinator and approved by the Chief on the rotation. Include the rotation you will be on for the requested vacation.
- Requests must be 7 consecutive days (including weekends) from a Monday to a Sunday.

Vacation Guidelines

- Vacations are to be taken in 7 day increments from Monday – Sunday (exceptions made by Dr. Stuke and/or administration on staff).
- No vacation requests will be honored for June or July except with special permission from Dr. Stuke, Dr. Chappuis, and/or Dr. Rhynes
- Before making your vacation request, please ensure approval has been received from both the head faculty and chief resident at your rotation **30 days in advance of your vacation.**
- Changes to vacation dates will not be permitted.
- If you are on vascular service, you must have your vacation approved by Dr. Marie Unruh (munruh@lsuhsc.edu).

- If you are on the OLOL trauma service, your vacation must be approved by Drs. Jacome (tjacom@lsuhsc.edu) and Taghavi (staghavi@tulane.edu).

Vacation Days per PGY

- Prelims & PGY 1 – 21 days (including weekends) of non-cumulative vacation per year
- PGY 2 – 5 – 28 days (including weekends) of non-cumulative vacation per year
- Off service at Tulane/Ochsner must let Dr. Stuke/faculty know 60 days in advanced.
- Vacation is allocated per year. Any vacation not used during that time will not carry over to the next academic year

How to submit a vacation request

Contact the appropriate coordinator:

- TBD – Prelims & PGY 1
- Allen Alongi – PGY 2 – 5

In your email to request vacation, CC or include the email showing approval from both the head faculty and chief resident on your rotation.

Head Faculty by City

Baton Rouge – Keith Rhynes, Vernon.rhynes@fmolhs.org

Lafayette – Charles Chappuis, surgcwc@lsuhsc.edu

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- Faculty and 5th Year Residents will approve the final vacation schedule across all rotations.
- The schedule will be published by Mid-July/Mid-Jan to the Residency core.
- **Changes to vacation dates will NOT BE permitted.**

Going on Interviews?

- Take note of the time period in which you will interviewing (e.g. Nov/Dec or March/April)
- You may use 7 vacation days plus 5 educational days for the time period in which you are interviewing.
- These days do not need to be consecutive.
- Extra time away for interviews will be recorded as leave without pay; you will not receive pay for this time.
- You will still submit a request by the appropriate deadline providing the following information:
 - The specialty in which you are interviewing
 - The time frame you expect to be traveling for interviews
 - The rotation(s) in which you are scheduled during the time of interviews.

FAQs

- **I'm an intern, how many vacation days do I get?**
Each House Officer at PGY I is entitled to twenty-one (21) days (including weekends) of non-cumulative vacation per year.
- **I'm a PGY II/III/IV/V. how many vacation days do I get?**
Each House Officer at PGY 2-5 is entitled to twenty eight (28) days (including weekends) of non-cumulative vacation per year.
- **How often should I take my vacation?**
Each resident should take one week of vacation (7 days) per quarter. This is a rough estimate since you technically only have 10 months to take 3 (PGY 1 only) or 4 weeks of vacation. Two in the fall and two in the spring are permitted.
I've submitted my request on time and it was approved. I'm all set?
Not quite; it is your responsibility to communicate with the service chief and/or faculty at least 30 days in advance to remind them you have an approved vacation coming up. Do not wait until after call schedules are made.
- **Can I save my days and take two weeks off in later in the year?**
No. If you choose not to use your vacation time, you lose it. No banking it.
- **I'm graduating in June, am I guaranteed the final week off after graduation?**
No. All PGY 5s must save one week of vacation for the end of June.
- **What if I get sick?**
You have 14 days of sick leave.
- **What if I have a family emergency?**
It is understood that specials situations will arise, in such cases, please contact the Program Director, Service Chief, and Resident Coordinator as soon as possible.
- **What if I need more time off for interviews?**
You can go on leave without pay.
- **What is leave without pay?**
Exactly as it sounds. Permission to take leave without pay must be granted by the Program Director. Additionally, taking leave without pay may jeopardize your ability to sit for the American Board of Surgery Qualifying Examination (applicants must acquire no fewer than 48 weeks of full-time experience in each residency year. This is required regardless of the amount of operative experience obtained).
- **What if I decide to change my vacation dates? My chief/staff approved it, no big deal...right?**
Wrong. Any deviations from the original vacation request will be charged as *leave without pay*.
Changes to vacation dates will not be permitted.
- **Can I take vacation over Cohn-Rives weekend?**
Attendance is required by all residents, unless granted by the Program Director.
- **What is educational leave?**

Residents are allowed five days of educational leave per year for interviewing and/or to attend/present at scientific meetings and conferences. Any additional time will be recorded as leave without pay.

Payroll

Payroll is automatically deposited on a semi-monthly basis. It is mandatory that you sign up for direct deposit. Electronic paycheck stubs can be accessed online.

Insurance Coverage

Please see the GME House Officer Manual on Policies and Procedures for information on health, life, and malpractice insurance as well as disability coverage.

INSTITUTIONAL/PROGRAM POLICY ON DUTY HOURS

The program and institution supports the spirit and letter of the ACGME Duty Hour Requirements. Though learning occurs in part through clinical service, the training programs are primarily educational. As such, work requirements including patient care, educational activities, and administrative duties should not prevent adequate rest. The program and institution has developed policies and procedures to assure the specific ACGME policies relating to duty hours are successfully implemented and monitored. They are summarized as:

Maximum House of Work Per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day in seven free of free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Duty Period Length

Duty periods of all residents and above may be scheduled to a maximum of 24 + 4 hours averaged over 80 hours (averaged over 4 weeks) hours of continuous duty in the hospital.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, for no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Mandatory Free Time (Short Break)

Residents should have 8 hours off between scheduled clinical work and education periods. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. This will be monitored by the program director.

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

Maximum In-House On-Call Frequency

Residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

At-Home Call

Time spent in the hospital by residents on at-home call **must** count towards the 80-hours maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but it must satisfy the requirement for on-day-in-seven free of duty, when averaged over four weeks.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

Residents are required to log all duty hours in New Innovations Software Program. Those who fail to log duty hours or log erroneous duty hours are subject to disciplinary action. This applies to every site where trainees rotate.

****Duty Hours will be monitored through New Innovations and should be completed by the end of each week. If a resident is more than 2 weeks behind in completing their duty hours, the resident may be placed upon unpaid leave until the duty hours are updated.**

Work hour Types Are Set up in New Innovations.

At home call – not called in – to be used when at home during home call. Any hours logged on this duty type does NOT count towards the 80 hour week.

At home call – called in – to be used when called in to work during at home call. Any hours logged on this duty type DO count towards the 80 hour work week.

- Home call at Our Lady of the Lake and Lafayette General Acute Care call- The resident is expected to abide by 24+4 hours. In-house call counts.

Break/Not working: to be used for short breaks throughout the day. This should be used to fill in gaps in working time to prevent a “Short Break” violation. Any time recorded with this work type counts towards the 24 maximum shift length and 80 hour week limits.

Call – to be used when doing overnight call.

Clinic – to be used when working in a clinic.

Conference – to be used when attending conferences, journal clubs, didactics, and other educational events.

Continuity Clinic – to be used when working at a continuity clinic.

Moonlighting: to be used when moonlighting, either internal or external.

Night Float – to be used when working night float rotation or shift.

Post Call – to be used after a 24 hour overnight call to complete paperwork and patient transition activities.

Shift - Regular working hours that do not fit any of the other work hour types.

Vacation/Leave – Vacation, sick leave, educational leave. Days scheduled as Vacation/Leave are not counted as days off for day off requirements.

Computers and Libraries

Computers and medical libraries are available to residents at all hospitals.

User ID's and passwords are assigned by Computer Services after completing paperwork given to you during GME intern orientation. **All residents are given an email account through LSU and are required to check it daily. This is the primary way in which information concerning the residency program will be distributed. Failure to respond to email after 72 hours may result in disciplinary action. Non-response is viewed as poor professionalism.**

Resident Responsibilities

It has been said that in order to be a successful physician, one must display three vital characteristics: *availability*, *affability*, and just plain *ability*. (Dr. R.J. Lousteau, 1987). In the department of Surgery, these essential qualities will be expected of every resident, without exception.

Availability: Our department has proudly observed a long tradition of service, and here at LSU we have a reputation of being ready and willing to provide that service to anyone in need. Thus, we make it a policy to be available at all times, and to answer all calls promptly. The doctors listed in the call schedules must regard their on-call days and nights as serious responsibilities that are not to be taken lightly. If at any time a resident is unable to fulfill the demands of being on call, he or she must immediately notify the other resident members of the team so that alternative coverage may be arranged.

It is the resident's responsibility to be sure that beepers and telephones are in working order and that the hospital operators, emergency rooms, and ward know how to reach him/her at all times. Furthermore, it is the responsibility of all residents to be "geographically positioned" in the community so that responses to hospital calls can be made within a reasonable time. Remember that in a real emergency, someone's life may depend on how far away you are. As a general rule, residents on call should be reachable by beeper and telephone within five minutes, and when taking calls from outside of the hospital, must be able to get to the hospital within 15 to 20 minutes.

Affability: Our policy toward consultations, whether from primary care physicians, emergency rooms or other services, is to be courteous and "glad to be of assistance". Remember that few other medical professions have any in-depth training in surgery, and no matter how simple or how complex the patient's problem may be you are being called to provide help in solving it. We will therefore project a pleasant, outgoing attitude in answering all calls for help from other services. Your demeanor is a reflection of your Department!

Ability: Every resident in our program will be expected to perform at the very highest level he or she is capable of attaining. By virtue of your acceptance into this training program, you have demonstrated the basic skills necessary to become a fine surgeon. While the Department will provide an excellent foundation for developing those skills, each resident will be expected to devote the time and energy necessary to hone them finely through a combination of didactic study, clinical observation, and one-on-one contact with faculty.

The three factors mentioned above are the foundations of professionalism. Implicit, of course, in this concept of professionalism are the qualities of personal integrity, responsibility, and honesty. It should go without saying that these qualities will be expected from each and every resident at all times. By embracing these ideals, we all strive to provide the best of care for our patients as well as the spirit of cooperation and concern for our colleagues.

As the residents progress through the program, they will be expected to grow emotionally, technically and intellectually. Individual responsibilities will increase yearly in a graduated fashion. Every resident should recognize that he/she is part of the LSU General Surgery Program for an entire year. Those residents taking one or two years of general surgery prior to a surgical specialty residency are still considered part of our department and are expected to meet all the requirements of our department. All problems experienced while part of the Department of Surgery will be resolved within the Department of Surgery.

Loss of hospital privileges at one hospital may result in dismissal as the resident will not be able to fulfill residency requirements.

Medical Licensure

Every resident is required to hold a Louisiana medical license. A copy must be provided to the Department upon initial receipt and upon renewal each year.

All interns are required to take USMLE Step 3 by the end of the intern year. Interns should plan to apply for permanent licensure before the end of postgraduate year one, as soon as the USMLE Step 3 is completed. **Once you have passed, you must notify your coordinator and submit a copy of your scores to the department.** If you cannot obtain a license by the start of postgraduate year 2 you must renew your Intern Card and provide the Department with a copy. You must obtain a full Louisiana Medical license at your postgraduate year 2 to be promoted to the postgraduate year 3. All US graduates must have a permanent Louisiana medical license to begin post graduate year 3. This is a state licensure requirement. If you do not have a license, you cannot continue in the residency. It is the resident's responsibility to ensure licenses are renewed. Renewals must be turned in to the coordinator by the deadline, which is the beginning of March.

Specific licensure information should be obtained directly from the Louisiana State Board of Medical Examiners. www.lsbme.louisiana.gov or you can call them at 504.568.6820

Research Project

Each categorical resident will be required to complete one research project and manuscript suitable for publication in a major national journal. The manuscript should be submitted to the Program Director and the project presented at one of the end of year resident research meetings. Whether the paper is of acceptable quality will be determined by the Program Director and Faculty who contributed. **This requirement should be completed by the end of fourth year and promotion to PGY 5 will be dependent upon fulfilling this requirement. Failure to do so will affect promotion. The project must be presented on Resident Research Day (in early June).**

Case reviews are not permitted for presentation. Start early. It is suggested that interns have their project chosen by the middle of their first year.

Residents should not submit papers, abstracts or any other materials to any meeting, journal or society unless it has been reviewed by the staff. Residents may request reimbursement for

expenses incurred while presenting a paper at a major meeting within the 48 contiguous states. Reimbursement will fall within state guidelines if adequate advance notice is given and the trip has been approved.

Meetings

The Department of Surgery will fund meetings in which the resident has had an abstract/paper accepted for presentation as either an oral or poster format. Prior to submitting the paper, the appropriate staff should verify that the paper is in an appropriate format and approve submission.

Residents need (email) approval by the Program Director prior to submission to secure funding. Failure to let the PD know will result in non-reimbursement of funding. Once the paper is accepted, the resident needs to comply with all state travel guidelines in effective at the time. In addition, appropriate work hour rules and time off from clinical duties regulations must be followed. Deviation from the accepted guidelines can result in non-reimbursement of travel expenses.

Faculty Expectations of Residents

1. The Chief Resident speak for all residents in the program and is responsible for the overall management of resident activities within the program. The Chief Resident will be the resident to whom the Chairman and Program Director will communicate all problems within the program.
2. The senior level residents (PGY V & PGY IV) are responsible for the running of their service and the authority to maintain discipline. The senior resident on each service will be expected to make daily rounds on the entire service so that he/she may be aware of any problems or complications that occur and communicate with the attending staff on a regular basis.
3. Senior residents should remember that the staff attendings hold the chief resident on each service responsible for complications, deaths, clinical decisions, and any other incidents that occur on the service under his/her direction.
4. Residents need to recognize the hierarchy of the training program. Junior residents report to senior residents who report to attending staff.
5. When a resident is planning to do an operation, he/she needs to know the details of the History and Physical (H&P) on the patient, have a plan for the operation, and communicate with the attending regarding the conduct of operation. If the resident is unprepared, the attending staff may choose not to allow him/her to perform the operation.
6. After performing an operation on a patient, the resident needs to take ownership of the patient and stay involved in the decision-making and care regarding the patient.
7. Each resident should be prepared to present his/her cases at the appropriate conference (e.g. M&M, pre-operative conference, and grand rounds).
8. Senior residents are expected to pay full attention to their clinical responsibilities, which include supervising junior residents in the operating room, making rounds with junior residents regularly, being knowledgeable about all patients on the service, seeing postoperative patients in the morning before going to the operating room, and being available at all times to provide care to patients on the service.

9. Residents must arrange for adequate coverage if they aren't available (interviews, vacation, etc.). Key Attending staff on the service (or Chief of Service) must also be notified.

Departmental Expectations for promotion to the next PGY level:

PGY1:

- Must take and pass ACLS online before entering the program
- Must take and pass ATLS
- Must take and pass Robotics training- online and robotics modules
- Must take and pass STEP 3 and submit scores to coordinator

PGY 2:

- Must take and pass FLS

PGY 3

- Must take and pass FLS

PGY 4

- Must present on a Grand Rounds Day
- Must participate in research and present finding on annual Resident Research Day
- Research must be publishable quality

PGY 5

- Must have minimum of all categories of ACGME required surgeries

American Board of Surgery In-Training Examination

On the last Saturday of January each year, the American Board of Surgery In-Training Examination (ABSITE) is administered. The examination consists of approximately 225 questions covering both basic and clinical sciences. All residents, regardless of the hospital to which they are assigned at the time of the examination, will take the examination.

The ABSITE is extremely important. It gives both you and the department an idea of your strengths and weaknesses. It also gives you experience in taking exams administered by the American Board of Surgery. The Department gives serious consideration to your scores on the ABSITE when considering individuals for promotion in the program.

Residents scoring **below the 20th percentile*** will be required to participate in academic remediation program. This program is direct mentorship with a paired mentor to discuss areas of improvement and individual goals. Failure to actively attempt to improve his/her in-service score

over a two-year period, regardless of the percentile correct, may result in dismissal. Residents should develop and maintain a daily study routine to ensure the highest possible score.

* Any resident may participate in the remediation program despite previous scores, however this is **required** for those who previously scored below the 20th percentile.

Medical Records

Residents are responsible for dictating and signing medical records on all patients they are responsible for. Operative notes must be dictated immediately after the operation. Admission history, physical exams, consults and discharge summaries should also be dictated immediately so they appear in the patient's chart in a timely manner. It is the resident's responsibility to visit medical records weekly and sign off on all notes. If you do not sign off on notes in a timely manner you will be placed on the delinquent list, which will ultimately lead to a suspension of privileges without pay. It is extremely important that residents complete all documentation prior to changing rotations, especially when going out of town on rotation. If your dictations are not complete you will be required to return and complete them. Timely completion of medical records is a cornerstone of professionalism. Your performance in this area will be considered in your advancing through the program.

Dictating Notes for Medical Records

The operative report is one of the most important pieces of information in a patient's medical record. The text of the report should be organized, clear and carefully dictated. The operative report is a legal document. Therefore, it is imperative that the report is so accurate that someone reading the report in the future will know exactly what happened in the operating room. You should read the report after transcription to check for errors; draw a single line through any errors and insert the corrected text above the errors. Make sure you initial any corrections. A basic format should be followed when dictating operative reports. Some modifications can be made depending on the surgeon's preference, but the following information must be included:

YOUR NAME

PATIENT NAME – First and last name; spell any names which may confuse the transcriber

MEDICAL RECORD NUMBER – The eight digit number following the patient's school designation

(T for Tulane or L for LSU)

DATE OF OPERATION – month, day, year

PRE-OPERATIVE DIAGNOSIS – The actual or presumed diagnosis which prompts the surgery. Multiple diagnoses may be included. Terms such as "breast mass" or "colonic neoplasm" should be used for tumors with indeterminate pathology. Be as specific as possible.

POST OPERATIVE DIAGNOSIS – Be as specific as possible. Multiple diagnoses can and should be listed if appropriate. Terms such as "rectal neoplasm" or "adrenal mass" should be used if the diagnosis is dependent on a final pathology report.

PROCEDURE – List all procedures performed and be sure the list coincides with the "Report of Operation" (see below). Accuracy and clarity are extremely important here.

ATTENDING SURGEON – All operations are supervised by an attending surgeon on the LSU faculty. His/her name must appear in the report for legal reasons; it is necessary to obtain reimbursement for our patients from third party payers. A senior or chief resident may not be listed as the attending surgeon; a senior or chief may be listed as a first assistant or teaching assistant.

RESIDENT – usually the physician that dictated the report. You may list the first assistant or teaching assistant here. For legal and reimbursement reasons, the distinction between “attending surgeon” and resident must be clear.

ANESTHESIA – You only need note the type used (general, spinal, monitored, etc.); you need not detail each drug utilized.

ESTIMATED BLOOD LOSS – Confer with the anesthesiologist and examine suction containers, lap sponges, etc. to get an idea of the amount of blood loss for the case.

SPECIMENS – List any specimen that was sent to Pathology or Microbiology, as well as the source of the specimen (e.g. “hepatic nodule”, “intra-abdominal abscess”, “product of left modified radical mastectomy”, etc.) Be specific and use anatomical terms.

INTRA-OPERATIVE FINDINGS – A short paragraph which summarizes pathologic findings and any sequela of the pathologic process. Procedural and technical details will be included in the “Report of Operation” and should not be included here. Some surgeons do not create a separate section for intra-operative findings and instead include them in the “Report of Operation”. That is completely acceptable.

INDICATION FOR PROCEDURE – This should be a short paragraph that includes and pertinent history, physical findings, diagnostic studies or identifiable problem that led to the surgery. Do not repeat the admission H&P. Most surgeons restate that the patient and been informed of the risks, benefits and therapeutic alternatives and has given consent.

REPORT OF OPERATION – This is the body of the report and should be descriptive, detailed and accurate. Descriptions should be illustrative and clear; the credibility of the report suffers from a surgeon’s editorializing. Describing the appendix as “the biggest I’ve ever seen” is not quite as clear as a description as “six centimeters long with an erythematous tip”. It is important to be objective.

ECONOMY OF WORDS – The amount of detail included in the report does not have to be painful. For instance, it is simpler and more direct to indicate that “the abdomen was entered through a midline incision” instead of saying “a number 10 scalpel was used to make an incision in the skin in the patient’s abdomen, going from a starting point about halfway between the umbilicus and the pubic symphysis, followed by the Bovie electrocautery, which was set on 30/30.

ACCURACY – Do not say the small bowel spontaneously erupted if you made an enterotomy while opening the abdomen. Always be honest.

SIGNING OFF – Include the statement “(Attending surgeon) was present for (the key portion or the entire operation)”.

INPATIENT DISCHARGE SUMMARY

ADMISSION DATE:

DISCHARGE/TRANSFER DATE:

ATTENDING/RESIDENT:

DIAGNOSIS:
COMORBIDITIES:
OPERATIONS/PROCEDURES:
DISCHARGE/TRANSFER MEDICATIONS:
ALLERGIES/SENSITIVITIES:
CONDITION OF PATIENT AT DISCHARGE/TRANSFER:
BRIEF SUMMARY OF HISTORY & PHYSICAL:

BRIEF HOSPITAL COURSE:

SIGNIFICANT EVENTS:

PERTINENT CLINICAL FINDINGS/LABS:
RESPONSE TO TREATMENT:
COMPLICATIONS:
DISCHARGED TO:
TEST RESULTS AT TIME OF DISCHARGE:
DISCHARGE PLAN/INSTRUCTIONS:
HOME CARE SERVICES:

FOLLOW UP:

Surgical Case Logs

The following are requirements posted by the American Board of Surgery:

- All residents (categorical, designated preliminary, and non-designated preliminary) must enter their operative experience concurrently during each year of the residency in the ACGME case log system.
- A resident may be considered the surgeon only when he or she can document a significant role in the following aspects of management:
 - determination or confirmation of the diagnosis,
 - provision of preoperative care,
 - selection and accomplishment of the appropriate procedure, and
 - direction of the postoperative care.
- When justified by experience (completion of the required minimum in the particular defined category) a PGY 4 or 5 resident may act as teaching assistant (TA) to a more junior resident with appropriate faculty supervision.

ACGME required 200 cases logged during the Chief Resident Year. In addition, 25 cases must be logged as a Teaching Assistant. LSU has different requirements for cases outlined in the next sections.

The following information is required for each case entered on the ACGME site:

Resident

Attending

Institution

Resident's role

Surgeon Chief (SC) – Residents in their chief year (PG5)

Surgeon Junior (SJ) – Residents in years 1-4 (PG1 – PG4)

Teaching Assistant (TA) – A PG 4 or 5 who has completed the minimum in the particular defined category

First Assistant (FA) – A resident other than SC, SJ, or TA assisting in the case

Rotation

Patient type – adult or pediatric

Procedure date

Case ID (patient's hospital number)

If the patient was involved in trauma it must be indicated

CPT Code (More than one CPT code may be entered. However only one may be marked for credit)

There is an outcome section (not required) where you may enter anything you wish to note about the case.

The Residency Review Committee (RRC), ACGME, and the American Board of Surgery require that all residents participate in a minimum number of operative cases in certain “defined categories”. Please refer to the following pages for the minimum numbers and for the procedures that count in each defined category. There are no exceptions to these minimum numbers. Residents must continue to record cases even after finishing the minimum numbers.

Please contact your coordinators if you have any problems logging into the ACGME case log system.

Your ACGME case log will be routinely monitored by the Program Director and Program Coordinators.

Documentation of Critical Care Experience

A minimum of 40 surgical critical care index cases is required. Each of the 40 should have at least two of the seven critical care conditions. The CPT code will map to all seven of the critical care conditions. CPT code will allow credit to be taken for multiple procedures on the same patient on the same day. You still need to mark one of the codes for credit, but on the report, they will be counted equally. After adding the second code, you will be prompted that the code is already in the selection list, simply click “OK” to proceed.

Do not submit 40 of the same conditions. The completed logs should include experience with at least one patient in all seven of the categories.

The seven critical care conditions are as follows:

Ventilatory Management (>24 hours on ventilator)
Bleeding (non-trauma patient >3 units)
Hemodynamic instability (Required inotropic/pressor support)
Organ dysfunction (renal, hepatic, cardiac failure)
Dysrhythmias (required drug management)
Invasive line management/monitoring (Swan-Ganz, catheter, arterial lines, etc)
Parenteral/enteral nutrition

Program Requirements

- **All our chief residents will be required to have a minimum of 225 cases as Surgeon Chief and 75 cases as teaching assistant.**
- **Total Major Case Requirements by finishing year: 1100 Major Cases**

The chief resident should involve himself/herself in the operative management of cases and document this activity for future reference. Chief residents should not give all their cases to those residents below them but should share cases appropriately.

American Board of Surgery requirements specify that you must identify and list those patients, particularly trauma cases, who are followed on the service but do not require operations.

Your role as the surgeon or assistant should be clearly identified in your own list. Each resident should keep a copy of his/her operative dictations. In addition, each resident should keep a book of cases in which they were involved. The computer system will act as a check and balance for each residents log book. We will attempt to track the operative experience for every resident and hospital in the program, but the ultimate responsibility falls with each individual resident.

Take note: PGY-4's and 5's must have a record of experience with non-operative trauma and ICU/critical care. To graduate you must have 40 cases in the management of non-operative trauma and 40 (10 must be logged in as team leader resuscitation) cases in Critical Care.

It is also essential that you record all cases you scrub on while on the Transplant service, even if you scrub in as First Assistant; you must have experience in transplant cases in order to complete your residency and sit for the American Board of Surgery.

Surgery RRC Defined Categories & Minimal Requirements

The numbers listed are the minimum requirements you must meet for each category during your five years of training. A lesser amount will not be accepted. You must maintain complete records

of all the cases in which you participate. **Continue recording cases even after you've reached the required minimum. You will be held to these as well as the Program case requirements**

SKIN AND SOFT TISSUES-25

BREAST – 40

Mastectomy-5

Axilla-5

HEAD AND NECK – 25

ALIMENTARY TRACT - 180

Esophagus- 5

Stomach- 15

Small intestine-25

Large intestine-40

Appendix- 40

Anorectal- 20

ABDOMINAL - 250

Biliary- 85

Hernia- 85

Liver-5

Pancreas-5

VASCULAR –50

Access- 10

Anastomosis, Repair, Exposure, or

Endarterectomy-10

ENDOCRINE – 15

Thyroid or parathyroid- 10

OPERATIVE TRAUMA – 10

NON-OPERATIVE TRAUMA – 40

THORACIC – 20

Open Thoracotomy- 5

PEDIATRIC – 20

PLASTIC – 10

SURGICAL CRITICAL CARE- 40

LAPAROSCOPIC BASIC– 100

ENDOSCOPY – 85

Upper Endoscopy- 35

Colonoscopy- 50

LAPAROSCOPIC-Complex- 75

TOTAL MAJOR CASES- 850

Surgeon Chief- 200

Teaching Assistant- 25

ALL FIVE YEAR- 1100 minimum

CHIEF YEAR- 225 minimum

Conferences

All conferences meet year around and are rarely cancelled. Residents are expected to attend all conferences and arrive on time (attendance is kept and reported to the RRC). Rounds are not to be made during conferences. Attendance at less than 80% of teaching conferences and 80% of M&M conferences will be regarded as inadequate and will be grounds for dismissal.

- Residents rotating at Kenner, West Jefferson, Touro, and Children's Hospital should attend, at minimum, the weekly M&M and Grand Rounds conference.
- Residents rotating out of town are excused from conferences in New Orleans but should attend regularly scheduled conferences at OLOL and UHC/LGMC.

Morbidity and Mortality Conference

The LSU General Surgery Morbidity and Mortality Conference (M&M) is held weekly and the time will depend on which rotation you are on. All complications that occur on all patients on the general surgery services the preceding week (Sunday 7:00 a.m.-Sunday 6:59 a.m.) will be presented. **All complications should be submitted to the Chief Resident on service.** Presentations are given by residents to the department heads, faculty and other residents. All complications from the previous week are presented and a healthy and positive dialogue is encouraged, with emphasis on how to avoid future complications. Participation in discussion is encouraged by all.

For M&M Conference, the following applies:

- The resident associated with the care of the patient will present the patient.
- The presentation should be researched, concise, and rehearsed. Residents presenting at conferences should know the patient's history, physical examination, laboratory data and hospital course.
- All pertinent studies are expected to be available for viewing. Patient confidentiality should be protected and all identifying information should be blacked out.
- Residents should be prepared to answer questions from staff members about the case.
- Resident assignments for each conference will be circulated in advance. Attendings should be notified if their case is being presented.
- Complications should be classified by the Clavian Dindo Classification:
 - 'Error in diagnosis'
 - 'Error in Judgment',
 - 'Error in Technique', or
 - 'Disease Progression'
- A literature review and discussion pertinent to the complication is expected

When holiday's or other activities interfere with the conference schedule, all complications for the interrupted week will be presented at the next available conference date, along with the presentations scheduled for that date.

If the Associated Resident rotates to an out-of-town hospital, the Chief Resident of that service will be responsible for presenting that particular complication. Minutes will be recorded for each presentation and will include results, conclusions, recommendations, corrective action and follow-up and re-assessment when appropriate.

Attire for M&M is encouraged to be professional for all presenters. Scrubs are acceptable only for residents on trauma call.

Grand Rounds

Grand rounds consist of a 45 minute presentation by an invited guest, faculty member, or residents. The information presented can be cutting edge research or evidence based clinical discussions designed to stimulate interest in the area presented. The content will reflect the "Topic of the Month" as outlined in the curriculum. The conference will be organized by the faculty of the month.

Basic Science Conference

The basic science curriculum follows the topic of the month format and consists of lectures in the basic science related to the topic of the month. The conference is done 1-2 times per month depending on the basic science content of the particular topic of the month. Both faculty and residents can be presenters.

Surgical Skills

A surgical skills lab that will cover surgical, laparoscopic, and team training skills is held monthly under the direction of a faculty member. As space is limited, residents should make every effort to attend their assigned sessions.

Cohn Rives Conference

The Cohn-Rives Society, as its members refer to it, is the official alumni organization of the New Orleans LSU Department of Surgery. The Cohn-Rives Society was also established to promote the advancement of knowledge, practice and teaching of surgery. Every spring the Society holds an annual conference in which all residents are required to attend.

Claude C. Craighead MD Lectureship Conference

Claude C. Craighead MD Lectureship Conference is geared towards providing a better understanding and information regarding Cardiothoracic Surgery in the New Orleans area. It is held in the spring replacing Ground Rounds. Residents in New Orleans are required to attend, but out of town residents are encouraged to attend, if possible.

Surgical Council on Resident Education (SCORE)

GENERAL SURGERY RESIDENCY Patient Care Curriculum

SCORE has links to readings that support the learning objectives considered essential by the RRC in Surgery of the ACGME and the Association of Program Directors in Surgery (APDS) and the American Board of Surgery. SCORE is available but not required.

Academic Outline 2019-2020

New Orleans

	Week 1	Week 2	Week 3	Week 4/5
7-8 am	M&M	M&M	M&M	M&M
8-9 am	Grand Rounds	Grand Rounds	Grand Rounds	Grand Rounds
9-10 am	Mock Orals	FES	Mock Orals	FLS
5:30-6:30 pm	Tuesdays Resident Education Conference			
6-8 pm	Journal Club (Wed)			

Baton Rouge

	Week 1	Week 2	Week 3	Week 4/5
3-4 pm	Resident Education	Resident Education	Resident Education	Resident Education
4-5 pm	M&M	M&M	M&M	M&M

5:30-6:30 pm	Tuesdays Resident Education Conference
6-8 pm	Journal Club (Wed)

Lafayette

	Week 1	Week 2	Week 3	Week 4/5
7-8 am	Thursday (M & M)	Thursday (M & M)	Thursday (M & M)	Thursday (M & M)
8-9 am	Grand Rounds/Science Review	Grand Rounds/Science Review	Grand Rounds/Science Review	Grand Rounds/Science Review
5:30-6:30 pm	Tuesdays Resident Education Conference			
6-8 pm	Journal Club (Wed)			

Schwartz is the official text book for the program. **The book is available free of charge on Access Surgery.**

Scheduled Events- Dates to be announced.

- 1) Intern Boot Camp – July
- 2) Rives Conference - March.
- 3) Mock Orals (for PGY 4 and 5).- April/May
- 4) Laparoscopic Pig lab at BR.
- 5) FLS testing – April. (Contact Dr. Hodgdon)

Online resources

Access Surgery

- 1) Fundamentals of Surgery course
- 2) SCORE Patient Care Curriculum

M&M Report (New Orleans)

Patient Initials, Age, Sex, Medical Record Number:

Admit Date:

Admission Diagnosis:

Operations/Dates:

Primary Surgeon:

Resident Presenting Case/Attending staff:

Complications(s)/Dates(s):

Complication Type & Final Outcome (still in the hospital, date discharged, or died):

PROGRAM EDUCATIONAL GOALS

LSU GENERAL SURGERY RESIDENCY

The primary goal of the general surgery residency at the Louisiana State University School of Medicine is to produce, at the completion of the five year program, physicians who will successfully complete the Qualifying and Certifying Examinations of the American Board of Surgery and who will function as practitioners of surgery at the high level of performance expected of a board certified specialist. The surgical residency program encompasses education in the basic sciences, cognitive, affective and technical skills, and development of clinical knowledge, surgical judgment, and maturity.

During the first post graduate year the resident has a wide exposure to surgery in various hospital and ambulatory settings, building on the knowledge gained in medical school of anatomy, physiology and pathology. The majority of this year is spent in the area of general surgery including trauma, oncologic surgery, critical care, cardiothoracic, burns, vascular and general surgery. Skills learned during this year include the placement of central lines and their monitoring, chest tube placement, tracheal intubation, basic surgical skills, surgical assisting, anesthesia (regional and general), and the assessment and management of clinical problems.

The second post graduate year consists of rotations in general, pediatric, burns, and vascular surgery. Also, during this year, residents participate in the educative process of the interns and medical students. The residents initiate treatment, make diagnoses and decisions with direct supervision. Medical and surgical skills continue as well those cognitive and affective skills necessary for exemplary patient management.

The third post graduate year is spent in general, cardiothoracic, vascular and oncologic surgical rotations. Operating skills and experiences in the operating theater increase during this year. The third year resident also takes an active role in the teaching process by giving presentations in surgery and specialty conferences, as well as morbidity and mortality conference.

The fourth year resident can function as the chief resident on some of the specialty services. Technical skills are further enhanced by acting as primary surgeon on most operative cases. Cognitive and affective skills are developed by presentations at grand rounds, and other surgical conferences as well as the teaching resident on various operative cases. The fourth year resident rotates through a wide variety of surgical specialties including pediatric surgery, oncologic surgery, hepatobiliary, transplant, bariatric, thoracic, trauma, and general surgery.

The fifth post graduate year is spent as chief on various general surgery and trauma services. The administrative chief is available as liaison between hospital, faculty, departmental personnel and the residents.

At the completion of the general surgery residency program the resident will be able to manage surgical disorders based on knowledge of basic and clinical sciences, demonstrate competency in those surgical techniques required of the qualified surgeon, use critical thinking when making effective decisions for patient and family management, make sound ethical and legal judgments, collaborate effectively with colleagues and other health professionals, teach and share knowledge with colleagues, residents, students and other health care providers, be responsible for teaching patients and families of all age groups in accord with their health care needs, value continuing education as a lifelong process which facilitates personal and professional growth, conduct and evaluate independent research, demonstrate leadership in and

management of complex programs and organizations, provide cost-effective care to surgical patients and families within the community and respect the religious needs of patients and their families and provide surgical care in accord with those needs.

FIRST YEAR PROGRAM OBJECTIVES

Upon completion of the first post graduate year, the resident will be able to:

Cognitive:

- Develop strategies for imparting medical information to those around them
- Develop and enhance the knowledge base begun in medical school.
- Begin to understand the tasks associated with making a differential diagnosis
- Share with colleagues data obtained from comprehensive physical assessment.
- Discuss types of decision making required of the surgeon and principles upon which the decisions are made.
- Use available resources to survey and participate in current surgical and basic clinical research.
- Recognize and develop leadership principles that relate to management of patient care.

Technical:

- Use sterile techniques when assisting with operative procedures.
- Observe and participate in pre and post-operative care.
- Participate as assistant during operative procedures.

Affective:

- Recognize, explore and develop basic ethical principles inherent in surgical practice.
- Identify individual goals that promote personal and professional growth.
- Become cognizant of the socioeconomic, cultural, and managerial factors inherent in providing cost-effective health care.

SECOND YEAR PROGRAM OBJECTIVES

In addition to those objectives realized and enhanced during the first post graduate year, upon completion of the second year the resident will be able to:

Cognitive:

- Enhance those strategies developed in the first year for imparting medical information to those around them.
- Use available data from basic and social sciences when planning pre and postoperative care for newly admitted patients.
- Relate scientific knowledge and research findings to care of patients.
- Participate in and evaluate current research and its relationship to medical sciences.
- Continue building basic science and clinical knowledge base through reading of pertinent literature.
- Function in leadership role by using the problem solving approach in planning care for patients and families.

Technical:

- Become an active participant in preoperative, operative and postoperative care of patients.
- Continue to develop technical skills using aseptic operative techniques.
- Be aware of cost involved in diagnostic technology when examining surgical patient.

Affective:

- Discuss with team members the ethical aspects of surgical intervention.
- Discuss with peers and faculty collaborative roles of the surgical resident.
- Begin to demonstrate responsibility for providing health care teaching to patients scheduled for surgical intervention.
- Begin to teach students and first year residents management of surgical patients.
- Demonstrate progress toward achievement of goals for personal and professional growth and development.

THIRD YEAR PROGRAM OBJECTIVES

In addition to those objectives realized and enhanced during the preceding two years, upon completion of the third post graduate year, the resident will be able to:

Cognitive:

Continue to develop those strategies necessary for imparting medical information to those around them.

Manage patients having more complicated surgical conditions including those in the intensive care unit.

Use critical thinking skills in making decisions about management of care.

Analyze resources available for providing continued learning experiences.

Develop research proposals to promote improvements in medical and surgical care.

Continue expanding knowledge base in clinical and basic sciences.

Technical:

Act as primary surgeon in more complicated surgical intervention.

Apply technical skills required of first assistant to practicing surgeon.

Continue to enhance surgical technical skills.

Affective:

Incorporate ethical concepts in the plan of pre-, intra-, and postoperative care of patients and families.

Collaborate with patient and family when planning operative procedure and postoperative care.

Provide pre and postoperative teaching to families and patients requiring surgical intervention.

Demonstrate pre- and postoperative teaching skills to junior residents and medical students.

Use leadership strategies in the implementation of health care to patients and families.

Explain to patient and family the costs involved in surgical care being planned.

Begin to supervise and teach junior residents in basic surgical procedures

FOURTH YEAR PROGRAM OBJECTIVES

In addition to those objectives realized and enhanced during the previous years of training, upon completion of the fourth post graduate year, the resident will be able to:

Cognitive:

- Conduct experimental research studies in the laboratory or in clinical settings.
- Assist junior residents in assuming, planning and managing pre and postoperative care for patients with common surgical disorders.
- Guide junior residents in making decisions about findings on history and physical examination and management of pre and postoperative care.
- Develop a deeper, more complex knowledge base in the basic and clinical sciences
- Enhance information gathering strategies and the ability to impart that information to those around them.
- Develop an appreciation for outcomes research as applied to surgical procedures.

Technical:

- Perform more complex surgery under appropriate supervision.
- Evaluate standards for surgical practice.

Affective:

- Incorporate appropriate ethical principles when presenting patient care studies.
- Evaluate achievement of identified goals for personal and professional growth.
- Understand impact of health legislation concerning DRG=s, Medicare and third-party payers on cost of surgical care for individuals and families.
- Collaborate with residents, faculty and other health professionals in providing safe and appropriate health care for patients.
- Implement leadership role in planning changes for improving and managing care of patients in a variety of settings.

FIFTH YEAR PROGRAM OBJECTIVES

At the completion of the fifth post graduate year, the resident will be able to synthesize and utilize all the skills and objectives gained over the five years of training. In addition to these, the resident will be able to:

Cognitive:

- Demonstrate effective information gathering and decision making in the management of care for all types of surgical patients and their families.
- Evaluate knowledge gained from continuing education and its relationship to professional development.
- Conduct independent research in the clinical and basic sciences.
- Assist junior residents in planning clinical research proposals.
- Enhance and build knowledge base through reading, attendance at conferences and academic meetings.
- Be cognizant of the number and variety of cases necessary for Board certification in Surgery.

Technical:

- Demonstrate high level of scientific, clinical and technical knowledge during operative procedures throughout the spectrum of vascular and non-cardiac thoracic cases.
- Demonstrate the ability to operate independently.

Affective:

- Supervise junior residents in caring for patients with complex surgical conditions.
- Discuss with junior residents and medical students the ethical issues related to surgical practice.
- Demonstrate to junior residents the collaborative role of the surgeon in the practice of surgery in the community.
- Evaluate the cost-effectiveness of present and future surgical care of patients and families.
- Provide leadership to medical students and junior residents in management of complex programs involving health care.
- Assume responsibility for evaluating teaching strategies used by junior residents.

GOALS AND OBJECTIVES FOR SURGICAL RESIDENCY

1. Burn Rotation – UMC
2. Cardiothoracic Rotation – LGMC/UMC
3. Colorectal Rotation – Our Lady of the Lake/UMC
4. LSU Service Our Lady of the Lake – Baton Rouge
5. Trauma Rotation – UMC/OLOL
6. Laparoscopic Surgery Rotation – Our Lady of the Lake Hospital
7. Pediatric Surgery Rotation – Our Lady of the Lake/Children's Hospital
8. Plastic Surgery Rotation – UMC/ West Jefferson
9. SICU Rotation – UMC/Ochsner
10. Transplant Surgery – Tulane University
11. General Surgery Rotation – Lafayette UHC/LGMC
12. Vascular Surgery Rotation – Our Lady of the Lake/ West Jefferson/UMC
13. Bariatric- UMC

GOALS AND OBJECTIVES FOR ACUTE CARE & BURN SURGERY SERVICE (HO 1-2)

Patient Care – The resident should be able to:

- 1) Communicate effectively and demonstrate caring and respectful behaviors to patients and families
- 2) Gather essential/pertinent and accurate information during history-taking and performing physical exam.
- 3) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences
- 4) Understand and practice the principles of Advanced Burn/Trauma Life Support including airway management and management of shock
- 5) Appropriately prioritize injury and triage complex patients to critical care areas
- 6) Master rudimentary procedures including:
 - Arterial and venapuncture
 - Insertion of nasogastric tube and foley catheter
 - Insertion of central venous line
 - Tube thoracostomy
 - Wound care
 - Suturing
 - Percutaneous tracheostomy
 - Percutaneous Endoscopic Gastrostomy
 - Burn Escharotomy/Fasciotomy
- 7) Perform a Burn/trauma tertiary survey, record an accurate injury list and management plan, maintains an accurate and up to date medical record

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations.
- 2) Apply basic and clinically supportive sciences to clinical situations including knowledge of
 - Anatomy – Relationships of aero-digestive, bony, neurologic, and vascular structures in the
 - Head and neck
 - Thorax
 - Abdomen
 - Pelvis
 - Extremities
 - Anatomy of burned tissue and associated pathophysiologic consequences
 - Physiology – Pathophysiology of distributive and neurogenic shock, principles of resuscitation
 - Pathophysiology and management of inhalation injury and compartment syndrome
- 3) Know and apply Advanced Burn/Trauma Life Support protocol in the acute triage and management of injured patients
- 4) Apply knowledge of diagnostic modalities to acutely injured patients with blunt or penetrating trauma including:
 - Angiography and Interventional Radiology
 - CT scans
 - Laboratory studies
 - Plain x-rays
- 5) Know the indications for operation in the acutely injured burn/acute care surgery patient.
- 6) Demonstrate proficiency in seeking consultation from and communicating with other services
- 7) Appreciate the continuum of care issues specific to trauma patients (rehab, long-term acute care, disability).
- 8) Perform burn wound assessment and develop a plan of clinical care based on this assessment.
- 9) Describe the indications and perform burn surgery including the harvesting, application, immobilization and postoperative care of auto-,homo-,xeno-grafts as well as management of contractures.
- 10) Summarize the activities of the comprehensive team of ancillary staff required in the pre and post burn patients to continue convalescence, rehabilitation and return to livelihood.
- 11) Exposure to pediatric burn patient and the differences in acute management and rehabilitation.
- 12) Apply knowledge regarding various mechanisms of burn injury and their respective management.

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as a member of the trauma team and as a member of the broader hospital community
- 4) Pass on important patient information to his senior residents or faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Does the resident demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities?
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the interrelationships between their practice and the larger system of the trauma center and the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients, i.e. acute resuscitation, operation, critical care, physical therapy, mental health, discharge, follow-up, and rehabilitation.

GOALS AND OBJECTIVES FOR CARDIOTHORACIC SURGERY ROTATION (HO 3, 4)

Medical Knowledge Objectives for HO 3, 4:

1. Interpretation of chest CT scan
2. Antibiotic use in thoracic surgery
3. Treatment of pulmonary emboli
4. Staging and treatment of lung and esophageal carcinomas
5. Recognition and treatment of supraventricular and ventricular arrhythmias
6. Interpretation of Swan-Ganz hemodynamic data
7. Indications for and management of inotropic agents
8. Understanding of the stages of wound healing
9. Knowledge of nutritional principles relevant to the cardiac surgical patient; enteral and parenteral feedings alternatives for cardiac patients

Patient Care Objectives for HO 3, 4:

1. Open pleural biopsy
2. Sternotomy and lateral thoracotomy
3. Wedge resection of the lung
4. Insertion of PA catheter
5. Insertion of radial and femoral arterial lines
6. Pulmonary decortication
7. Management of aortic augmentation balloon (IABP)
8. Management of the ventilator in the postoperative cardiac surgical patient

Interpersonal and Communication Skills Objectives for HO 3, 4:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as the leader of the team and as a member of the broader hospital community
- 4) Pass on important patient information to his /her faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 3, 4:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 3, 4:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 3, 4:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care

- 2) Understand the interrelationships between their practice and the larger system of the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients.

GOALS AND OBJECTIVES FOR COLORECTAL SERVICE (HO 1, 2 and HO 3, 4)

Medical Knowledge Objectives for HO 1, 2

1. Ability to take a complete history regarding colonic and ano-rectal conditions
2. Ability to formulate a differential diagnosis from the history
3. Understand basic pathophysiology of common ano-rectal conditions, such as hemorrhoids, fissures, and fistulae
4. Understand the presenting features of carcinoma of the colon and rectum
5. Learn the accepted staging systems for carcinoma of the colon and rectum

Patient Care Objectives for HO 1, 2

1. Ability to perform a competent abdominal and rectal examination
2. Ability to perform flexible sigmoidoscopy
3. Ability to use basic rectal retractors and instruments in ano-rectal procedures
4. Ability to perform colonoscopy with supervision.

Medical Knowledge Objectives for HO 3, 4

- 1... Understand the presenting features and pathophysiology of diverticular disease
2. Understand the approach to lower gastrointestinal bleeding
3. Acquire a basic knowledge of ulcerative colitis and Crohn's Disease, including their differences
4. Learn the different kinds of intestinal stomas and the basic principles of creating and managing them
5. Learn the indications for lower gastrointestinal endoscopy
6. Understand the potential complications of lower gastrointestinal endoscopy

Patient Care Objectives for HO 3, 4

1. Ability to perform intestinal anastomosis
2. Ability to use surgical stapling devices
3. Ability to utilize ancillary data (barium enema, CT scan, laboratory) in formulating a plan of care.
4. Ability to perform upper and lower endoscopy and polypectomy.

Interpersonal and Communication Skills Objectives for HO 1-4:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as the leader of the team and as a member of the broader hospital community
- 4) Pass on important patient information to his /her faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 1-4:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession

- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 1-4:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 1-4:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the interrelationships between their practice and the larger system of the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients.

GOALS AND OBJECTIVES FOR GENERAL SURGERY ROTATION (HO 1, 2, HO 3, HO 4, 5)

Goals and Objectives for General Surgery Rotation (HO 1-2)

Patient Care – The resident should be able to:

- 1) Gather essential / pertinent and accurate information during history-taking and physical examination
- 2) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences (order appropriate lab tests and order/interpret imaging studies)
- 3) Select appropriate patients for minor surgery procedures
- 4) Write preoperative and postoperative notes and orders, including:
 - Antibiotics
 - Pain management
 - DVT prophylaxis
 - Respiratory treatments
- 5) Master rudimentary procedures including:
 - Central line placement
 - Wound Care
 - Suturing
 - Tissue Handling
 - Chest tube placement
 - Hernia, appendectomy, minor surgery procedures

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Apply basic and clinically supportive sciences to clinical situations
- 3) Know and apply knowledge to the perioperative management of the surgical patient
- 4) Demonstrate knowledge of the anatomy relevant to hernia repair

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Provide discharge instructions effectively to patients including follow-up needs
- 3) Use effective listening skills and elicit and provide information using effective communication skills
- 4) Work effectively with others as a member of a health care team
- 5) Pass on pertinent information to his seniors in a timely manner
- 6) Respond in a timely manner to pages and requests for attention

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide care that is of optimal value
(use of consultants for outpatient and inpatient services)
- 2) Understand the interrelationships between their practice and the larger system of health care

Goals and Objectives for General Surgery Rotation (HO 3)

Patient Care – The resident should be able to:

- 1) Gather essential / pertinent and accurate information during history-taking
- 2) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences
- 3) Examine his/her patients frequently and note important changes in the patient's condition
- 4) Perform procedures appropriate to his/her level of training:
 - Laparotomy
 - Laparoscopic cholecystectomy and common duct exploration
 - Mastectomy and axillary dissection
 - Anatomic resection and gastrointestinal anastomosis (gastric resection, small bowel resection, and colon resection)
 - Thyroid and parathyroid surgery
 - EGD and colonoscopy
- 5) Demonstrate appropriate knowledge and skills managing patients in the intensive care unit (with supervision)
- 6) Triage and manage acutely injured patients including:
 - Resuscitation
 - Interpretation of blood gases
 - Mechanical ventilation modes and uses
 - PA catheter use and interpretation
 - Medications used in the ICU Setting

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Apply basic and clinically supportive sciences appropriate to his/her level of training
- 3) Understand the pharmacology and interactions of commonly used drugs in the intensive care unit
- 4) Understand the various modes of mechanical ventilation
- 5) Understand the anatomy and physiology relevant to thyroid and parathyroid surgery
- 6) Articulate a plan of care for a hemodynamically unstable patient

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills

- 3) Work effectively with others as a member (or leader) of a health care team
- 4) Pass on pertinent information to his seniors in a timely manner
- 5) Respond in a timely manner to pages and requests for attention

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide care that is of optimal value
- 2) Demonstrate the ability to provide delivery of cost effective, quality clinical care
- 3) Understand the interrelationships between their practice and the larger system of health care

Goals and Objectives for General Surgery Rotation (HO 4 or 5)

Patient Care – The resident should be able to:

- 1) Gather essential / pertinent and accurate information during history-taking and physical examination
- 2) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences
- 3) Independently design and execute an appropriate plan of care for surgical patients (preoperative workup, intraoperative technique, and appropriate postoperative follow-up)
- 4) Use of TMN classification models for purposes of staging and prognosis
- 5) Effectively perform procedures appropriate to his/her level of training:
 - Laparotomy
 - Thoracotomy and lung resection
 - Advanced laparoscopy procedures (hand assisted colectomy, ventral hernia repair)
 - Gastrointestinal cases including gastrectomy, low anterior resection, APR
 - Pancreatic and hepatobiliary procedures
 - Head and neck oncologic procedures
 - Vascular surgery

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Apply basic and clinically supportive sciences appropriate to their level of training
- 3) Understand pathophysiology principles of shock and resuscitation in a manner which allows effective management of critical patients
- 4) Demonstrate knowledge of head and neck anatomy relevant to the performance of major head and neck oncologic surgery
- 5) Demonstrate knowledge of TMN classification modes for staging and prognosis
- 6) Demonstrate knowledge of the indications and contraindications to basic and advanced laparoscopic procedures

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills
- 3) Work effectively with others as a member (or leader) of a health care team
- 4) Pass on pertinent information to his seniors in a timely manner
- 5) Respond in a timely manner to pages and requests for attention

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities
- 6) Demonstrate skill as a teaching assistant

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Understand the importance and the limitations of clinical research
- 2) Critically assess the medical literature
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide care that is of optimal value
- 2) Understand the interrelationships between their practice and the larger system of health care

GOALS AND OBJECTIVES FOR TRAUMA ROTATION (HO 1, 2)

Goals and Objectives for HO 1, 2:

Patient Care – The resident should be able to:

- 1) Communicate effectively and demonstrate caring and respectful behaviors to patients and families
- 2) Gather essential/pertinent and accurate information during history-taking
- 3) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences
- 4) Understand and practice the principles of Advanced Trauma Life Support including airway management and management of shock
- 5) Appropriately prioritize injury and triage complex patients to critical care areas
- 6) Master rudimentary procedures including:
 - Arterial and venapuncture
 - Insertion of nasogastric tube and foley catheter
 - Insertion of central venous line
 - Tube thoracostomy
 - Wound care
 - Suturing
- 7) Perform a trauma tertiary survey, record an accurate injury list and management plan, maintains an accurate and up to date medical record

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations?
- 2) Apply basic and clinically supportive sciences to clinical situations including knowledge of
 - Anatomy – Relationships of aero-digestive, bony, neurologic, and vascular structures in the
 - Head and neck
 - Thorax
 - Abdomen

Pelvis

Extremities

-Physiology – Pathophysiology of hemorrhagic and neurogenic shock, principles of resuscitation

3) Know and apply Advanced Trauma Life Support protocol in the acute triage and management of injured patients

4) Apply knowledge of diagnostic modalities to acutely injured patients with blunt or penetrating trauma including:

-Angiography and Interventional Radiology

-CT scans

-Laboratory studies

-Plain x-rays

5) Knows the indications for operation in the acutely injured trauma patient

6) Demonstrate proficiency in seeking consultation of other services

7) Demonstrate an understanding of the management of complex multiply injured patients

8) Appreciates the continuum of care issues specific for trauma patients (rehabilitation, long-term acute care, disability).

Interpersonal and Communication Skills – The resident should be able to:

1) Create and sustain a therapeutic and ethically sound relationship with patients

2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.

3) Work effectively with others as a member of the trauma team and as a member of the broader hospital community

4) Pass on important patient information to his senior residents or faculty in a timely manner

5) Respond appropriately and in a timely manner to pages, consults and requests for attention

6) Maintain accurate and up to date medical records.

Professionalism – The resident should be able to:

1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society

2) Demonstrate accountability to patients, society, and the medical profession

3) Maintain the confidentiality of patient information and provide informed consent

4) Understand and provide sound, ethical business practices

5) Does the resident demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities?

6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement – The resident should be able to:

1) Use systematic methodology for practice analysis and perform practice-based improvement.

2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.

3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice – The resident should be able to:

1) Demonstrate the ability to effectively call on system resources to provide optimal patient care

2) Understand the interrelationships between their practice and the larger system of the trauma center and the health care system as a whole.

3) Understand continuum of care issues specific to injured patients, i.e. acute resuscitation, operation, critical care, physical therapy, mental health, discharge, follow-up, and rehabilitation.

GOALS AND OBJECTIVES FOR TRAUMA ROTATION (HO 4 or HO 5)

Patient Care Objectives for HO 4 or HO 5:

- 1) Proficient in the implementation of ATLS protocols for the care of the injured patient as the team leader.
- 2) Performs major operative interventions for trauma under the direction of the trauma staff to the
 - ❖ Neck
 - ❖ Chest
 - ❖ Abdomen
 - ❖ Extremities
- 3) Effectively teaches basic skills to junior residents and students
- 4) Maintains accurate medical record
- 5) Provides a complete trauma presentation

Medical Knowledge Objectives for HO 4 or HO 5:

- 1) Able to function as an effective team leader of the trauma service.
- 2) Able to effectively educate other members of the Trauma Team.
- 3) Able to formulate and effectively implement a detailed work-up and plan of care for the acutely injured patient with blunt and/or penetrating trauma to the following regions
 - ❖ Head and Neck
 - ❖ Spine
 - ❖ Thorax
 - ❖ Abdomen
 - ❖ Pelvis
 - ❖ Extremities
- 4) Interpretation of diagnostic studies that apply to acutely injured patients with blunt and/or penetrating trauma.
 - ❖ Angiography and Interventional Radiology
 - ❖ Computed tomography scans
 - ❖ Laboratory studies
 - ❖ Plain X-rays
 - ❖ Ultrasound
- 5) Demonstrates proficiency setting priorities and coordinating the care of the injured patient involving multiple consultants during the patient's hospitalization.
- 6) Understands the management of injured patients with multiple co-morbidities (i.e. chronic lung disease, diabetes mellitus, renal failure)

Interpersonal and Communication Skills Objectives for HO 4 or HO 5:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as the leader of the trauma team and as a member of the broader hospital community
- 4) Pass on important patient information to his /her faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 4 or HO 5:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 4 or HO 5:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 4 or HO 5:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the interrelationships between their practice and the larger system of the trauma center and the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients, i.e. acute resuscitation, operation, critical care, physical therapy, mental health, discharge, follow-up, and rehabilitation.

GOALS AND OBJECTIVES FOR LAPAROSCOPIC SURGERY ROTATION (HO 2, HO 4)

Medical Knowledge Objectives for HO 2:

1. Fundamentals of patient evaluation
 - History taking
 - Physical examination
 - Ordering appropriate lab tests
 - Ordering and interpretation of imaging studies
2. Management of inpatient and outpatient uncomplicated postoperative care
3. Provision of discharge instructions/ follow-up needs
4. Use of consultants for outpatient and inpatient services
5. Anatomy of the inguinal region relevant to hernia repair

Patient Care Objectives for HO 2:

1. Performance of appropriate procedures
 - a. Central line placement
 - b. Uncomplicated, minor surgical procedures|
 - c Knot tying
 - d. Tissue handling
2. Skills of patient presentation
3. Write preoperative and postoperative notes and orders, including:
 - ❖ Antibiotics
 - ❖ Pain management
 - ❖ DVT prophylaxis
 - ❖ GI prophylaxis
 - ❖ Respiratory treatments
4. Patient selection for minor surgery procedures

Medical Knowledge Objectives for HO4:

1. Demonstrates adequate surgical judgment
2. Capability of primary operating room responsibility
3. Appreciation of the delivery of cost effective, quality clinical care

Patient Care Objectives for HO 4:

1. Cholecystectomy and common duct exploration
2. Anatomic resection and gastrointestinal anastomosis (laparoscopic)
 - ❖ Gastric bypass
 - ❖ Small bowel resection
 - ❖ Colon resection
3. Ability to critically assess the medical literature
4. Ability to understand the importance and the limitations of clinical research

Interpersonal and Communication Skills Objectives for HO 2 or HO 4:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as the leader of the team and as a member of the broader hospital community
- 4) Pass on important patient information to his /her faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 2 or HO 4:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 2 or HO 4:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 2 or HO 4:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the interrelationships between their practice and the larger system of the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients.

GOALS AND OBJECTIVES FOR PEDIATRIC SURGERY (HO 1, 2 and HO 4)

Pediatric Surgery HO 1, HO 2 Goals and Objectives

Patient Care Objectives –The resident should be able to:

- 1) Communicate effectively and demonstrate caring and respectful behaviors to pediatric patients and families
- 2) Gather essential/pertinent and accurate information including birth history during history taking
- 3) Make appropriate diagnostic and therapeutic decision based on patient information
- 4) Demonstrate skills in physical examinations and history taking that allows for identification and treatment of surgical pathology in pediatric patients
- 5) Provide preoperative assessment and postoperative care to the pediatric surgical patient
- 6) Participate in provision of care in pediatric surgical patient, including herniorrhaphy, circumcision, venous access, thoracotomy, wound care, suturing, nasogastric and foley catheter insertion

Medical Knowledge –The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Demonstrate and apply basic and clinically supportive sciences appropriate to their level of training
- 3) Develop and appropriate differential diagnosis of acute surgical pathology in the pediatric patient
- 4) Demonstrate an understanding of basic congenital anomalies relevant to evaluation of the pediatric patient
- 5) Know the indications for surgery in the acutely injured pediatric patient
- 6) Demonstrate a fundamental knowledge and understanding of the general pediatric surgical areas and disease processes outlined in Table I
- 7) Appreciate the continuum of care issues specific to pediatric special-needs patients (rehabilitation, long-term care, disability)

Interpersonal and Communications Skills –The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with pediatric patients and caregiver
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socioeconomic and cultural backgrounds
- 3) Work effectively with others as a member of a team and as a member of the broader hospital community, including consultant services
- 4) Pass on important information to senior residents and faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults, and requests for attention
- 6) Maintain accurate and up-to-date medical records

Professionalism -The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Does the resident demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Bases Practice –The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care

- 2) Understand the inter-relationships between their practice and the larger system of the children's center care system as a whole
- 3) Understand continuum of care issues specific to pediatric patients, i.e. acute resuscitation, operation, critical care, physical therapy, mental health, discharge, follow-up, and rehabilitation

Table 1

Each resident will be expected to demonstrate a fundamental knowledge and understanding of the following general areas and disease processes in pediatric surgery.

- a. Soft tissue infections – primary, secondary, including antibiotic and surgical therapy
- b. Hernias – inguinal, umbilical, epigastric
- c. Common surgical problems in the ED, including lacerations, burns and abscesses
- d. The acute abdomen
- e. Common neck masses
 - i. Lymphadenitis
 - ii. Lymphangioma
 - iii. Hemangioma
 - iv. Dermoid cyst
 - v. Thyroglossal duct cyst
 - vi. Torticollis
 - vii. Branchial remnants
 - viii. Lymphoma
- f. Umbilical disorders
- g. UGI bleeding
- h. Rectal bleeding
 - i. Fissure-in-ano
 - ii. Juvenile polyps
 - iii. Meckels remnants
- i. The constipated child
- j. Non-bilious vomiting – HPS, GERD
- k. The abdominal mass
 - i. Wilms'
 - ii. Neuroblastoma
 - iii. Others
- l. Other newborn problems
 - i. Bowel obstruction
 - ii. NEC
 - iii. Malrotation
 - iv. Hirschsprung's
 - v. Others such as cystic hygroma
- m. Disorders of the chest
 - i. PTX
 - ii. Empyema
 - iii. Pectus excavatum
 - iv. CDH
 - v. Common lung lesions
 - vi. Mediastinal masses
- n. Trauma
- o. Fluid, electrolytes, nutrition in such conditions as burns, HPS, SBO,

- p. Indications for and complications of central venous lines

Pediatric Surgery HO 4 Goals and Objectives

Patient Care Objectives – The resident should be able to:

- 1) Communicate effectively and demonstrate caring and respectful behaviors to pediatric patients and families
- 2) Gather essential/pertinent and accurate information including birth history during history taking
- 3) Make appropriate diagnostic and therapeutic decision based on patient information
- 4) Demonstrate skills in physical examinations and history taking that allows for identification and treatment of surgical pathology in pediatric patients
- 5) Provide preoperative assessment and postoperative care to the pediatric surgical patient
- 6) Participate in provision of care in pediatric surgical patient, including herniorrhaphy, circumcision, venous access, thoracotomy, wound care, suturing, nasogastric and foley catheter insertion

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Demonstrate and apply basic and clinically supportive sciences appropriate to their level of training
- 3) Develop and appropriate differential diagnosis of acute surgical pathology in the pediatric patient
- 4) Demonstrate an understanding of basic congenital anomalies relevant to evaluation of the pediatric patient
- 5) Know the indications for surgery in the acutely injured pediatric patient
- 6) Demonstrate a fundamental knowledge and understanding of the general pediatric surgical areas and disease processes outlined in Table I
- 7) Appreciate the continuum of care issues specific to pediatric special-needs patients (rehabilitation, long-term care, disability)
- 8) Understand and describe common congenital anomalies
- 9) Actively participate in care of the trauma patient
- 10) Actively participate in the care of the critically ill child (ICU)
- 11) Demonstrate proficiency in seeking consultation of other services
- 12) Evaluation and management of newborn and pediatric “index” cases
- 13) Advanced operative skills:
 - a. Minimally invasive procedures
 - b. Congenital anomalies
 - c. Oncology cases

Interpersonal and Communications Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with pediatric patients and caregiver
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socioeconomic and cultural backgrounds
- 3) Work effectively with others as a member of a team and as a member of the broader hospital community, including consultant services
- 4) Pass on important information to senior residents and faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults, and requests for attention
- 6) Maintain accurate and up-to-date medical records

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent

- 4) Understand and provide sound, ethical business practices
- 5) Does the resident demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities?
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Bases Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the inter-relationships between their practice and the larger system of the children's center care system as a whole
- 3) Understand continuum of care issues specific to pediatric patients, i.e. acute resuscitation, operation, critical care, physical therapy, mental health, discharge, follow-up, and rehabilitation

Table 1

Each resident will be expected to demonstrate a fundamental knowledge and understanding of the following general areas and disease processes in pediatric surgery.

- a. Soft tissue infections – primary, secondary, including antibiotic and surgical therapy
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 - v. Thyroglossal duct cyst
 - vi. Torticollis
 - vii. Branchial remnants
 - viii. Lymphoma
- f. Umbilical disorders
- g. UGI bleeding
- h. Rectal bleeding
 - ix. Fissure-in-ano
 - x. Juvenile polyps
 - xi. Meckels remnants
- i. The constipated child
- j. Non-bilious vomiting – HPS, GERD
- k. The abdominal mass
 - xii. Wilms'
 - xiii. Neuroblastoma
 - xiv. Others
- l. Other newborn problems
 - xv. Bowel obstruction
 - xvi. NEC
 - xvii. Malrotation
 - xviii. Hirschsprung's

- xix. Others such as cystic hygroma
- m. Disorders of the chest
 - xx. PTX
 - xxi. Empyema
 - xxii. Pectus excavatum
 - xxiii. CDH
 - xxiv. Common lung lesions
 - xxv. Mediastinal masses
- n. Trauma
- o. Fluid, electrolytes, nutrition in such conditions as burns, HPS, SBO,
- p. Indications for and complications of central venous lines

GOALS AND OBJECTIVES FOR PLASTIC SURGERY ROTATION (HO 1)

Medical Knowledge Objectives for HO 1:

1. Understand the principles of wound healing and wound care
2. Understand the principles of grafts and flaps
3. Ability to evaluate simple wounds
4. Recognition of common skin lesions

Patient Care Objectives for HO 1:

1. Wound care and debridement
2. Simple suture technique
3. Applications of splints/casts for common hand injuries
4. Basic examination of the hand
5. First assistant skills

Interpersonal and Communication Skills Objectives for HO 1:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as the leader of the team and as a member of the broader hospital community
- 4) Pass on important patient information to his /her faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 1:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 1:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.

- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 1:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the interrelationships between their practice and the larger system of the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients

GOALS AND OBJECTIVES FOR SURGICAL INTENSIVE CARE UNIT ROTATION (HO 1, 2)

Patient care – The resident should be able to:

- 1) Admit patients to the ICU and review orders to ensure appropriateness.
- 2) Take a leadership role in therapeutic interventions by appropriately changing fluid orders, ventilator settings, pharmacologic support drugs, etc.
- 3) Appropriately apply the principles of Basic Cardiac Life Support, Advanced Cardiac Life Support (ACLS), and Advanced Trauma Life Support (ATLS) to the critically ill and injured surgical ICU patient.
- 4) Actively direct the resuscitation of patients in shock.
- 5) Calculate nutritional requirements and provide appropriate nutritional support.
- 6) Properly interpret laboratory results and treat appropriately.
- 7) Appropriately evaluate and manage pain control and sedation.
- 8) Master common ICU procedures, including:
 - a. Arterial and venapuncture
 - b. Insertion of central venous line
 - c. Tube thoracotomy
 - d. Placement of pulmonary artery catheter with appropriate interpretation of the catheter readings
 - e. Intubation
- 9) Perform a tertiary trauma survey, record an accurate injury list and management plan, and maintain an accurate and up to date medical record.
- 10) Properly transfer the patient to the floor, including:
 - a. Writing a transfer note in the chart summarizing the patient's illness/injuries, ICU course, and active issues.
 - b. Notifying the primary team of the transfer and documenting this discussion in the transfer note.

Medical knowledge – The resident should be able to demonstrate an understanding of:

- 1) Cardiac physiology, including:
 - a. Preload, afterload, and myocardial contractility
 - b. Oxygen delivery and consumption
 - c. Interactions of the cardiorespiratory system
- 2) Respiratory physiology, including:
 - a. Shunt and V/Q mismatch concepts
 - b. Indications for intubation
 - c. Ventilator weaning strategies
 - d. Extubation criteria
 - e. Evaluation for respiratory difficulty
- 3) Pathophysiology and hemodynamic patterns of hemorrhagic, septic, neurogenic, hypovolemic, and cardiac shock.
- 4) Basic mechanisms of the inflammatory response.
- 5) Indications and uses of vasoactive medications (i.e., vasopressors, inotropes, vasodilators, and antiarrhythmic).

- 6) Indications for nutritional support and methods of providing this support.
- 7) Prophylactic measures used in the ICU (i.e. stress ulcer prophylaxis and DVT prophylaxis).
- 8) Causes of fever in the surgical patient.
- 9) Surgical infections and utilization of appropriate antibiotics.
- 10) Psychosocial needs of ICU patients and their families.
- 11) Ethical concerns of ICU patients and end of life decision making.
- 12) Role of the surgeon in the ICU.
- 13) Role of the consultant in the ICU.
- 14) Concept of multidisciplinary teamwork in the ICU.

Interpersonal and Communication Skills – The resident should be able to:

- 1) Work effectively with others as a member of the team and as a member of the broader hospital community.
- 2) Pass on important patient information to his/her senior residents, ICU fellows, and/or faculty in a timely manner.
- 3) Respond appropriately and in a timely fashion to pages, consults, and requests for attention.
- 4) Maintain accurate and up to date medical records.
- 5) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.

Professionalism – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients and their family.
- 2) Demonstrate accountability to patients, society, and the medical profession.
- 3) Maintain the confidentiality of patient information and provide informed consent.
- 4) Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and disabilities.
- 5) Maintain a professional demeanor in difficult or sensitive patient encounters.

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 2) Participate in or facilitate the learning of students and other health care professionals.
- 3) Use systemic methodology for practice analysis and perform practice-based improvement.

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively utilize system resources to provide optimal patient care.
- 2) Understand the interrelationships between the ICU and the larger system of the trauma center and the health care system as a whole.
- 3) Understand continuum of care issues specific to critically ill ICU patients, i.e. resuscitation, operations, post-operative care, physical therapy, mental health, and floor transfer.

GOALS AND OBJECTIVES FOR GENERAL SURGERY ROTATION /UMC (HO 1, 2, HO 3, HO 4, 5)

University Medical Center (HO 1-2)

Patient Care – The resident should be able to:

- 1) Gather essential / pertinent and accurate information during history-taking and physical examination
- 2) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences (order appropriate lab tests and order/interpret imaging studies)

- 3) Select appropriate patients for minor surgery procedures
- 4) Write preoperative and postoperative notes and orders, including:
 - Antibiotics
 - Pain management
 - DVT prophylaxis
 - Respiratory treatments
- 5) Master rudimentary procedures including:
 - Central line placement
 - Wound Care
 - Suturing
 - Tissue Handling
 - Chest tube placement
 - Hernia, appendectomy, minor surgery procedures

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Apply basic and clinically supportive sciences to clinical situations
- 3) Know and apply knowledge to the perioperative management of the surgical patient
- 4) Demonstrate knowledge of the anatomy relevant to hernia repair

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Provide discharge instructions effectively to patients including follow-up needs
- 3) Use effective listening skills and elicit and provide information using effective communication skills
- 4) Work effectively with others as a member of a health care team
- 5) Pass on pertinent information to his seniors in a timely manner
- 6) Respond in a timely manner to pages and requests for attention

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide care that is of optimal value
(use of consultants for outpatient and inpatient services)
- 2) Understand the interrelationships between their practice and the larger system of health care

University Medical Center (HO 3)

Patient Care – The resident should be able to:

- 1) Gather essential / pertinent and accurate information during history-taking
- 2) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences

- 3) Examine his/her patients frequently and note important changes in the patient's condition
- 4) Perform procedures appropriate to his/her level of training:
 - Laparotomy
 - Laparoscopic cholecystectomy and common duct exploration
 - Mastectomy and axillary dissection
 - Anatomic resection and gastrointestinal anastomosis (gastric resection, small bowel resection, and colon resection)
 - Thyroid and parathyroid surgery
 - EGD and colonoscopy
- 5) Demonstrate appropriate knowledge and skills managing patients in the intensive care unit (with supervision)
- 6) Triage and manage acutely injured patients including:
 - Resuscitation
 - Interpretation of blood gases
 - Mechanical ventilation modes and uses
 - PA catheter use and interpretation
 - Medications used in the ICU Setting

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Apply basic and clinically supportive sciences appropriate to his/her level of training
- 3) Understand the pharmacology and interactions of commonly used drugs in the intensive care unit
- 4) Understand the various modes of mechanical ventilation
- 5) Understand the anatomy and physiology relevant to thyroid and parathyroid surgery
- 6) Articulate a plan of care for a hemodynamically unstable patient

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills
- 3) Work effectively with others as a member (or leader) of a health care team
- 4) Pass on pertinent information to his seniors in a timely manner
- 5) Respond in a timely manner to pages and requests for attention

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities

Practice-Based Learning and Improvement – The resident should be able to:

- 4) Use systematic methodology for practice analysis and perform practice-based improvement
- 5) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems
- 6) Participate in or facilitate the learning of students and other health care professionals

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide care that is of optimal value
- 2) Demonstrate the ability to provide delivery of cost effective, quality clinical care
- 3) Understand the interrelationships between their practice and the larger system of health care

University Medical Center (HO 4 or 5)

Patient Care – The resident should be able to:

- 1) Gather essential / pertinent and accurate information during history-taking and physical examination
- 2) Make appropriate diagnostic and therapeutic decisions based on patient information and preferences
- 3) Independently design and execute an appropriate plan of care for surgical patients (preoperative workup, intraoperative technique, and appropriate postoperative follow-up)
- 4) Use of TMN classification models for purposes of staging and prognosis
- 5) Effectively perform procedures appropriate to his/her level of training:
 - Laparotomy
 - Thoracotomy and lung resection
 - Advanced laparoscopy procedures (hand assisted colectomy, ventral hernia repair)
 - Gastrointestinal cases including gastrectomy, low anterior resection, APR
 - Pancreatic and hepatobiliary procedures
 - Head and neck oncologic procedures
 - Vascular surgery

Medical Knowledge – The resident should be able to:

- 1) Demonstrate an investigatory and analytic thinking approach to clinical situations
- 2) Apply basic and clinically supportive sciences appropriate to their level of training
- 3) Understand pathophysiology principles of shock and resuscitation in a manner which allows effective management of critical patients
- 4) Demonstrate knowledge of head and neck anatomy relevant to the performance of major head and neck oncologic surgery
- 5) Demonstrate knowledge of TMN classification modes for staging and prognosis
- 6) Demonstrate knowledge of the indications and contraindications to basic and advanced laparoscopic procedures

Interpersonal and Communication Skills – The resident should be able to:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills
- 3) Work effectively with others as a member (or leader) of a health care team
- 4) Pass on pertinent information to his seniors in a timely manner
- 5) Respond in a timely manner to pages and requests for attention

Professionalism – The resident should be able to:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities
- 6) Demonstrate skill as a teaching assistant

Practice-Based Learning and Improvement – The resident should be able to:

- 1) Understand the importance and the limitations of clinical research
- 2) Critically assess the medical literature
- 3) Participate in or facilitate the learning of students and other health care professionals

Systems-Based Practice – The resident should be able to:

- 1) Demonstrate the ability to effectively call on system resources to provide care that is of optimal value
- 2) Understand the interrelationships between their practice and the larger system of health care

GOALS AND OBJECTIVES FOR VASCULAR SURGERY (HO 1, 2 and HO 4, 5)

Medical Knowledge Objectives for HO 1 or 2:

1. Describe arterial and venous anatomy
2. Understand risk factors for atherosclerosis
3. Understand risk factors for chronic venous insufficiency
4. Recognize signs and symptoms of acute and chronic arterial disease
5. Recognize signs and symptoms of acute thromboembolic disease
6. Differential diagnosis of a swollen extremity
7. Signs and symptoms of venous insufficiency
8. Signs and symptoms of lymphedema

Patient Care Objectives for HO 1 or 2:

1. Perform a focused history and physical for the vascular system.
2. Wound management: wet to dry dressings etc.
4. Obtain ankle brachial index (ABI)
6. Placement of central venous lines (femoral, jugular, subclavian)
7. Appropriate care of an ischemic limb
9. Digital amputation

Medical Knowledge Objectives for HO 4 or HO 5:

1. Understand the natural history of medically treated or untreated vascular disease:
 - carotid artery stenosis
 - abdominal aortic aneurysm
 - femoral artery occlusive disease
2. Summarize principles for preoperative assessment and postoperative care of patients undergoing major vascular surgical procedures
3. Describe the indications for:
 - balloon angioplasty
 - arterial stent placement
 - inferior cava filter placement
4. Describe the indications for operative intervention:
 - claudication
 - rest pain
 - abdominal aortic aneurysm
 - TIA and stroke
 - asymptomatic carotid stenosis
 - varicose veins
 - venous stasis ulcer

Patient Care Objectives for HO 4 or HO 5:

1. Perform:

- carotid endarterectomy
- repair of aortic aneurysm
- aortic reconstruction for occlusive disease
- femoral distal bypass
- extra-anatomic reconstruction

Interpersonal and Communication Skills Objectives for HO 1, HO 2, HO 4 or HO 5:

- 1) Create and sustain a therapeutic and ethically sound relationship with patients
- 2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
- 3) Work effectively with others as the leader of the team and as a member of the broader hospital community
- 4) Pass on important patient information to his /her faculty in a timely manner
- 5) Respond appropriately and in a timely manner to pages, consults and requests for attention
- 6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 1, HO 2, HO 4 or HO 5:

- 1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
- 2) Demonstrate accountability to patients, society, and the medical profession
- 3) Maintain the confidentiality of patient information and provide informed consent
- 4) Understand and provide sound, ethical business practices
- 5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
- 6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 1, HO 2, HO 4 or HO 5:

- 1) Use systematic methodology for practice analysis and perform practice-based improvement.
- 2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
- 3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 1, HO 2, HO 4 or HO 5:

- 1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
- 2) Understand the interrelationships between their practice and the larger system of the center and the health care system as a whole.
- 3) Understand continuum of care issues specific to injured patients.

GOALS AND OBJECTIVES FOR BARIATRIC SERVICE (HO 4)

Medical Knowledge Objectives for HO 3, 4

1. Understand the indications for surgical treatment of obesity.
2. Understand the indications for and interpret results of laboratory and imaging studies related to preoperative and postoperative assessment of bariatric patients.
3. Acquire a basic knowledge of medical and nutritional approaches to weight loss and how they are incorporated with the care of bariatric surgical patients.
4. Learn the different kinds of bariatric surgeries and the risks and benefits specific to each procedure.
5. Learn the indications for upper gastrointestinal endoscopy including methods of evaluating the remnant

stomach of a patient who has undergone gastric bypass.

6. Understand the potential complications of upper gastrointestinal endoscopy.

Patient Care Objectives for HO 3, 4

1. Ability to perform laparoscopic partial gastrectomy and appropriate portions of roux en y gastric bypass
2. Ability to use surgical stapling devices.
3. Ability to suture laparoscopically including utilization of intracorporeal knot tying.
4. Ability to utilize ancillary data (CT scan with bariatric protocol, barium swallow, laboratory) in evaluating for postoperative complications and formulating a plan of care.
5. Ability to perform upper endoscopy in the operating room and outpatient endoscopy areas.

Interpersonal and Communication Skills Objectives for HO 1-4:

1. Create and sustain a therapeutic and ethically sound relationship with patients.
2. Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
3. Work effectively with others as the leader of the team and as a member of the broader hospital community.
4. Pass on important patient information to his /her faculty in a timely manner.
5. Respond appropriately and in a timely manner to pages, consults and requests for attention.
6. Maintain accurate and up to date medical records.

Professionalism Objectives for HO 1-4:

1. Demonstrate respect, compassion, and integrity to meet the needs of the patients and society.
2. Demonstrate accountability to patients, society, and the medical profession.
3. Maintain the confidentiality of patient information and provide informed consent.
4. Understand and provide sound, ethical business practices.
5. Demonstrate sensitivity and responsiveness to patient's culture, age, gender, religious, economic, educational differences, and disabilities.
6. Maintain a professional demeanor in difficult or sensitive patient encounters.
7. Be aware of the stereotypes regarding obesity and be able to counsel a patient on weight loss in a respectful manner.

Practice-Based Learning and Improvement Objectives for HO 1-4:

1. Use systematic methodology for practice analysis and perform practice-based improvement.
2. Be able to access current clinical practice guidelines on nutrition and be able to apply evidence based strategies to the care of obese patients.
3. Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 1-4:

1. Demonstrate the ability to effectively call on system resources to provide optimal patient care
2. Understand the interrelationships between their practice and the larger system of the health care system as a whole.
3. Understand continuum of care issues specific to bariatric surgery patients.
4. Demonstrate awareness of the obesity epidemic and the long term impact of treating obesity to all aspects of healthcare.

Below is an example of a resident evaluation:

LSU HEALTH SCIENCES CENTER - NEW ORLEANS
DEPARTMENT OF SURGERY
Evaluation Form



[Subject Name]	Evaluator
[Subject Employer]	[Evaluator Name]
[Subject Rotation]	[Evaluator Employer]
[Evaluation Dates]	

PATIENT CARE - compassionate, appropriate and effective for treatment and prevention of disease

1. Does the resident gather essential/pertinent and accurate information during history-taking?
2. Does the resident make appropriate diagnostic and therapeutic decisions based on patient information and preferences?
3. Does the resident demonstrate appropriate use of consultations and senior level residents in the management of critically ill and injured patients?
4. Does the resident perform procedures appropriate to his/her level of training on this service?

1 = Major
Deficiency



2 = Minor
Deficiency



3 = Expected
Performance



4 = Exceeds
Expectations



MEDICAL KNOWLEDGE - about established and evolving sciences and their application to patient care

1. Does the resident demonstrate an investigatory and analytic thinking approach to clinical situations?
2. Does the resident know and apply basic and clinically supportive sciences appropriate to their level of training.
3. Does the resident understand the natural history of treated and untreated vascular disease (carotid, aortic aneurysm, infrainguinal occlusive disease, DVT) and offer management alternatives for each?

1 = Major
Deficiency



2 = Minor
Deficiency



3 = Expected
Performance



4 = Exceeds
Expectations



INTERPERSONAL & COMMUNICATION SKILLS - effective information exchange and cooperative "learning"

1. Does the resident create and sustain a therapeutic and ethically sound relationship with patients?
2. Does the resident use effective listening skills and elicit and provide information using effective Communication skills?
3. Does the resident work effectively with others as a member (or leader) of a health care team?
4. Does the resident pass on important patient information to his seniors in a timely manner?
5. Does the resident respond in a timely manner to pages and requests for attention?

1 = Major
Deficiency



2 = Minor
Deficiency



3 = Expected
Performance



4 = Exceeds
Expectations



PROFESSIONALISM - commitment to professional responsibilities, ethical principles & sensitivity to diverse patient populations

1. Does the resident demonstrate respect, compassion, and integrity to meet the needs of the patients and society?
2. Does the resident demonstrate accountability to patients, society, and the medical profession?
3. Does the resident maintain the confidentiality of patient information and provide informed consent?
4. Does the resident understand and provide sound, ethical business practices?
5. Does the resident demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities?
6. Does the resident maintain a professional demeanor in difficult or sensitive patient encounters?

1 = Major
Deficiency



2 = Minor
Deficiency



3 = Expected
Performance



4 = Exceeds
Expectations



PRACTICE-BASED LEARNING & IMPROVEMENT - investigate and evaluate practice patterns and improve patient care

1. Does the resident use systematic methodology for practice analysis and perform practice-based improvement?
2. Does the resident locate, appraise, and assimilate evidence from scientific studies related to patient health problems?
3. Does the resident participate in or facilitate the learning of students and other health care professionals?

1 = Major
Deficiency



2 = Minor
Deficiency



3 = Expected
Performance



4 = Exceeds
Expectations



SYSTEMS-BASED PRACTICE - demonstrate an awareness of and responsiveness to the larger context and system of health care

1. Does the resident demonstrate the ability to effectively call on system resources to provide care that is of optimal value?
2. Does the resident understand the interrelationships between their practice and the larger system of health care?
3. Does the resident understand continuum of care issues specific to injured patients, i.e. follow-up, discharge, rehabilitation needs?

1 = Major
Deficiency



2 = Minor
Deficiency



3 = Expected
Performance



4 = Exceeds
Expectations



OVERALL

Recommendation

Promotion to next PGY level

Remediation



I have witnessed effective transitions in person and attest the essential elements as defined in the Transitions Policy was transmitted to and understood by the receiving team.

Yes



No



N/A



LSU Department of Surgery Support Staff:

Allen Alongi

Residency Coordinator
1542 Tulane Ave., Room 733
(504)-568-2729

TBD

Residency Coordinator
1542 Tulane Ave., Room 733A
(504)568-2249

Leti Borrouso

Business Manager
1542 Tulane Ave., Room 747
(504)568-4752

General Surgery Qualifying Examination - Overview

- The General Surgery Qualifying Examination (QE) is offered annually as the first of two exams required for board certification in general surgery. The exam consists of about **300** multiple-choice questions designed to evaluate a surgeon's knowledge of general surgical principles and applied science. See also the exam's [content outline](#) (pdf).
- It is a one-day exam lasting approximately **8 hours** and is held at computer-testing facilities across the U.S. The exam is administered in four 115-minute sessions, with optional 10-minute breaks after sessions one and three, and one longer 40-minute break offered between the second and third session. Once a session has concluded, you will not be able to revisit those questions.
- Results are posted approximately 4 weeks after the exam; you will be notified by email when they are available. The exam's contents are copyrighted and may not be reproduced or disclosed in any manner.

Residents are not required to meet RC-Surgery minimums at time of application; they must only meet ABS [training requirements](#). *Taking Exam After PGY-4*: See [this page](#) for details.

7-Year Limit

- Individuals who complete general surgery residency after July 1, 2012, will have no more than **7 academic years** immediately following residency to become certified (i.e., pass both the QE and CE). See Exam Opportunities below for details.

General Requirements

To be eligible for this exam, applicants must:

- **Accredited Program:** Have satisfactorily completed a residency training program in general surgery accredited by the ACGME or RCPSC. (See also [Osteopathic Trainees Policy](#))

Applicants who will not complete their residency training **by June 30** of their chief year must [notify the ABS](#). **All training must be completed by end of August** to be eligible for that year's exam.

- **Training:** Have met all ABS [training requirements](#) for graduate education in general surgery.
- **Operative Log:** Submit an operative experience report that is deemed acceptable to the ABS, not only as to volume, but as to spectrum and complexity of cases. See [training requirements](#) for specific operative experience requirements.

- **Professional Activity:** Be actively engaged in the practice of general surgery as indicated by holding full surgical privileges in this discipline at an accredited health care institution, or be currently engaged in pursuing additional graduate education in a component of general surgery or other recognized surgical specialty. An exception to this requirement is active military duty.
- **Documentation of ACLS, ATLS, FLS and FES:** Submit copies of certificates showing that certification in each of these programs was successfully achieved. *Applicants do not need to be currently certified in these programs.*
- **Other Required Documentation:** For residents who trained in multiple programs, documentation of satisfactory completion for years in prior programs must be submitted. For international medical graduates, a photocopy of an ECFMG certificate.
- **Medical License:** While possession of a medical license is **not** required to apply for the QE, candidates **must** possess a full and unrestricted U.S. or Canadian medical license to take the Certifying Exam. Applicants are required to immediately inform the ABS of any conditions or restrictions in force on any active medical license they hold.
- Adhere to the ABS [Ethics and Professionalism Policy](#).

Application Process

- Individuals who meet ABS requirements may apply for the exam through the online application process, which is posted each year in early spring (see [How to Apply](#)). Applicants in U.S. programs must use the login information mailed to programs at that time. Canadian applicants should contact the ABS office for access. After your application is approved, you will be sent instructions on how to register for this year's exam.
- Once you are registered for the exam, you will be mailed an **exam admission authorization letter** with final details and instructions on reserving a place at a [computer-testing](#) center. You must have this letter to reserve a testing center spot.
- Active duty military personnel who may encounter difficulty taking the exam due to their service should contact the ABS as soon as possible. Please see [How to Apply](#) for information about other exam accommodations.

Exam Opportunities

Current Applicants:

- Individuals who complete residency after July 1, 2012, will have no more than **7 academic years** following residency to complete the certification process (i.e., pass both the QE and CE). The 7-year period **begins immediately upon completion of residency**.
- Upon application approval, applicants will be granted up to **4 opportunities within a 4-year period** to pass the QE, providing they applied immediately after

- training. Individuals who delay in applying will lose opportunities to take and pass the QE.
- If the applicant decides not to take the exam in a given year, it is a lost opportunity. See the ABS' [exam admissibility policy](#) for further details.

Prior Policy:

- Individuals who completed residency prior to July 1, 2012, were required to apply for the QE within 3 academic years after completion of residency. Upon application approval, they were granted up to **5 opportunities within a 5-year period** to pass the QE. They were also required to take the QE at least once during the first two years following application approval.
- During the exam admissibility period, individuals who postponed or were unsuccessful will be contacted each year regarding the next exam; a new application is not necessary.
- The above limits are absolute. Individuals who exceed any of the above restrictions will lose their admissibility and must pursue a [readmissibility pathway](#) to re-enter the certification process.

General Surgery Certifying Exam

Upon successful completion of the QE, you will be admissible to the [General Surgery Certifying Exam](#), an oral exam, and may sign up for an upcoming exam site/date. Candidates should select a CE site/date as soon as possible, and no later than Sept. 1 for that academic year.

For complete requirements regarding certification in surgery, refer to the [ABS Booklet of Information - Surgery](#) (pdf).

New Innovations

New Innovations is a web based system that will be used to track schedules, conference attendance, evaluations and duty hours.

INSTRUCTIONS TO ACCESS WEB RP FROM OFF CAMPUS SITES

These are the simple procedures the attendings and residents need to follow when using WebRP.

Always use the URL www.new-innov.com to access NI.

You can log on to WebRP directly from the GME home page as well.

http://www.medschool.lsuhs.edu/medical_education/graduate/. Click on “House Officer Resources.”

If you have any questions or problems, contact the coordinators or the GME office directly:

Chris Callac, MS

Information Management Specialist
Office of Medical Education
LSU Health Sciences Center
2020 Gravier St., Room 557
New Orleans, LA 70112
(504) 568-2988
ccalla@lsuhsc.edu

DEPARTMENTAL HOUSE OFFICER MANUAL ATTESTATION

I hereby certify that I have received the mandatory 2019-2020 Department of Surgery House Officer Manual. I understand that I will be accountable for conducting duties in the workplace in accordance with the information contained in this manual. I understand that additional information is available through the LSUHSC Department of Surgery website http://www.medschool.lsuhs.edu/surgery/residency_general.aspx; LSUHSC Human Resources website <http://www.lsuhs.edu/no/administration/hrm>; LSUHSC GME website http://www.medschool.lsuhs.edu/medical_education/graduate; LSU Bylaws and Regulations, LSU System Policies, LSUHSC Policies and GME Policies

Print Name

HO Level

Signature

Date

Signature of Program Director

Date