# General Surgery Residency Program
# **2008-2009 Resident Manual**

For additional information about:

Surgery residencies in general, see the RRC program requirements online at http://www.acgme.org/acWebsite/downloads/RRC_progReq/440pr1105.pdf

Texas Tech University residencies, see the Housestaff Policies & Procedures manual online at http://www.ttuhsc.edu/som/gme/forms/HousestaffPolicies2008-2009.pdf

# INTRODUCTION

Surgical training is a unique undertaking, combining the acquisition of an enormous body of cognitive knowledge encompassing the clinical and basic sciences of surgery, the development of technical skills and, above all, the mastery of clinical judgment.

During this portion of your career when time is perhaps your most precious commodity, it is vital that you strike a balance in your life that allows you to progress toward personal, as well as professional goals.

The contents of this manual contain essentially all of the policies and content of the residency program. You should refer to this manual for answers to any procedural questions since in most cases we will adhere to established policies. If you are confronted with issues not addressed here, however, please bring them to our attention.

There will always be dedicated faculty to mentor your progress through your residency training. There will always be plenty of cases to hone your skills. There will always be adequate hospital resources to minimize your "service" demands. And, finally, there will always be good leadership for the residency program.

# I. STRUCTURE OF THE RESIDENCY PROGRAM

## A. PRINCIPLES

The Residency Program is conducted under the Requirements established by the Accreditation Council for Graduate Medical Education (ACGME), of which the Residency Review Committee (RRC) for Surgery has direct responsibility for formulating policies for the organization and conduct of the General Surgery Residency Program.

The RRC is charged with accrediting residency programs. General surgery residents graduating from accredited programs are, however, certified by a separate organization, the American Board of Surgery. Upon successful application to the Board at the completion of training, the applicant may sit for Part I (the Qualifying Examination), a written test encompassing the basic and clinical sciences of surgical practice. After passing Part I, the applicant is allowed to take Part II, the Certifying Examination, an oral test of the surgeon's ability to exercise sound judgment in various clinical situations.

A fundamental education principle of any general surgery program is to adequately prepare the resident for Board Certification. Simply "Passing the Boards" is not sufficient; however, the goal of the Texas Tech University program is to provide you with the best possible education and training for a career in General Surgery or one of its disciplines. To derive the maximal benefit from your residency requires that you actively participate in every aspect of the program, from the operating room to the classroom. *Self instruction and motivation are the primary principles of adult education.* You have been selected to this residency program primarily because the faculty believes that you can successfully fulfill the goals of the program.

## B. GOVERNANCE of the RESIDENCY PROGRAM

The following describes the overall governance of the residency program. While this might seem somewhat complicated, the goal of this structure is to ensure adequate bi-directional communication between the individual resident and the Program Director and Faculty.

The **Program Director** has primary responsibility for all aspects of the residency program. In general, the Program Director is responsible for the overall supervision of the academic responsibilities of the teaching faculty, maintenance of the academic milieu of the residency program, overall performance evaluation of each individual resident and each individual rotation and how they contribute to the program, and the preparation of documents necessary to comply with accreditation.

The Program Directoris responsible for overall evaluation of resident performance and competency. The Program Director will confirm that each rotation provides adequate resources for the residents for academic and personal needs. He will evaluate each rotation to maintain a balance of education and service.

The **Program Coordinator** will handle the administrative activities of the residency including appropriate maintenance of records, interaction with the RRC, and the development of computerized processes to enhance resident and residency evaluation.

The**Residency Committee** consists of the Program Director, Chairperson of the Department of Surgery, Program Coordinator, the chief residents, and on an ad hoc basis, the core general surgery faculty. This group will meet regularly to oversee the direction and management of the Residency Program. The Program Director will report actions of the committee at the departmental faculty meeting.

C. ROTATIONS

The RRC specifies in considerable detail what clinical experiences must be included in a general surgery residency program; the rotations in the five clinical years of our residency program conform to that "blueprint". During the first two years of training, about half of the rotations are devoted to general surgery and its principal components with additional experience in other specialties. In the third, fourth and fifth years, about two-thirds of the time is spent on general surgical services; the other rotations include components of general surgery, such as transplant, pediatric, vascular and cardiothoracic surgery.

D. Residents & Teaching Staff

## GENERAL SURGERY PROGRAM DIRECTOR

The Program Director of the General Surgery Residency will be appointed by the Head of the Department of Surgery for a period of at least six years. The Program Director will be a full-time faculty member practicing at the integrated institutions of the residency program. The Program Director will be certified by the American Board of Surgery and will be on the medical staff of one of the integrated institutions participating in the program.

The responsibilities of the Program Director include (adapted from RRC program requirements):

1. Prepare written statements about the educational goals of the program with respect to knowledge, skills, and other attributes of the residents at each level of training.
2. Prepare written statements about the expectations of the residents on each major rotation and/or other program assignments.
3. Designate appropriate and qualified surgeons to positions of teaching faculty and provide adequate supervision for the teaching faculty to guarantee that each rotation will have an adequate academic environment.
4. With the teaching faculty, select residents for appointment to the training program.
5. Develop a schedule of resident assignments to fulfill educational needs of each resident throughout the duration of the training program.
6. Monitor the educational activities of all rotations with respect to maintaining a balance between education and service obligations and assure that there is a prompt and reliable system for communication and interaction between residents and teaching faculty.
7. Implement a fair but comprehensive competency evaluation system so that each resident understands his/her progress through the training program. Identify deficiencies in resident performance and outline a plan of correction for each deficiency.
8. Ensure an adequate environment for the residents' overall needs on each rotation. This includes the appropriate availability of relaxation time and time out of the hospital. For each rotation, the Program Director must assure adequate resources for sleeping, relaxing, and studying for each resident assigned to that rotation.
9. Provide complete and accurate program information and resident operative records to the Residency Review Committee so that appropriate assessments of the training program can be made.
10. Organize an evaluation process that fairly and substantively evaluates the progress of each resident from an academic and a clinical perspective throughout the program.
    a. Develop appropriate evaluation forms to be completed at the end of each rotation by the responsible attending physicians and resident colleagues.
    b. Review the collation of each of the resident's cumulative evaluation forms on a periodic basis.
    c. Conduct bi-annual meetings of the teaching faculty to review the progress of each resident and solicit further evaluations of each resident's progress.
    d. As necessary, meet individually with residents who have identified deficiencies in order to establish a program of corrective actions.
    e. Attend the Residency Committee meetings.
11. Evaluate each of the teaching rotations for issues related to clinical responsibilities and style issues.
    a. Review the call schedules to determine compliance with RRC guidelines (80-hour work week).
    b. Review resident working hours in each of the rotations and make recommendations if it appears that the workload is excessive.
    c. Review each rotation to determine the relative balance of "service" versus "education".

d. Assure the availability of appropriate academic resources in each of the rotations so that each resident has access to appropriate materials to help in the educational process.
e. Assure that the "living needs" of each of the residents are met with appropriate resources in each hospital on each rotation.

12. Chair the Residency Committee.

## PROGRAM COORDINATOR

The Director for Administration will be responsible for many of the administrative activities of the residency office. Additionally, this individual will provide input into the overall direction of the operational aspects of the program.
Specific duties of the Director of Administration are:

1. Attend all Residency Committee meetings and discuss the administrative aspects of the program.
2. Assist the Program Director in the development of computer software for the management of rotation schedules, vacations, etc.
3. Assist the Education Director in the development of resident's vacation schedules.
4. Assist in the maintenance of the liaison between the program and the RRC.
5. Act in an advisory capacity for issues concerning the program and the school.

## FACULTY AND PHONE NUMBERS

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Faculty and Phone numbers

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| Jorge Ortiz, MD, Transplant Surgery | 210-575-8400 |
| Texas Transplant Institute-San Antonio, TX | |
| Office | |
| Robert Santoscoy, MD, Cardiothoracic Surgery | 532-3977 |
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| Office | |
| William Rast, MD Oral | 581-7800 |
| maxillofacial Surgery Office | |
| Robert Bucy, MD Oral | |
| maxillofacial Surgery | 593-5057 |
| Office | |
| Daniel Blumenfeld, MD | |
| Ophthalmology Office | 545-1484 |
| Carlos Vasquez, MD | |
| Ophthalmology Office | 591-4441 |

## 2008-2009 GENERAL SURGERY RESIDENT PAGE LIST

| PGYI | Pager Number | Cell Number | Home Number |
|---|---|---|---|
| Banerji, Soumo | 663-9244 | 713-213-0737 | |
| Castaneda, Gino | 663-9247 | 915-355-6519 | |
| Dieker, Carrie | 663-0001 | 832-878-7700 | |
| Aranibar, Mauricio | 663-0860 | 210-860-1701 | |
| Arcone, Rafael | 663-9066 | 443-226-1184 | |
| Galindo, Malini | 663-0018 | 281-684-6800 | |
| **PGY II** | | | |
| Ahmeti, Mentor | 663-9246 | 915-252-1424 | 581-3449 |
| Castro-Garcia, Jose | 663-9241 | 713-478-6724 | |
| Olivas, Victor | 663-9243 | 682-225-4664 | |
| **PGY III** | | | |
| Garza, Randy | 663-9242 | 915-861-0286 | 760-5057 |
| Howe, Jarett | 663-9238 | 915-491-4369 | 581-5375 |
| Le, Hoang | 663-9248 | 281-748-2839 | |
| **PGY IV** | | | |
| Johnson, Chad | 663-9240 | 915-760-0647 | |
| Kromah, Fatuma | 663-4936 | 915-227-2658 | |
| Thomas, Ian | 663-9237 | 602-330-6408 | |
| **PGY V** | | | |
| Ghosh, Sunanda | 663-9086 | 281-229-2127 | |
| Palladino, Humberto | 663-9085 | 915-309-5406 | |
| Payne, Eric | 663-9104 | 915-204-0224 | |

## II. EDUCATIONAL GOALS AND RESIDENT RESPONSIBILITIES

Texas Tech University Affiliated Hospitals General Surgery Residency Program includes a `preliminary track' (one or two years of training) and a `categorical track' (five years of clinical training). The program encompasses training in general surgery: its principal and additional components and related surgical specialties. The fundamental education goal of the training program is:

> "To provide a complete education in the basic and clinical sciences of general surgery, preparing the post-graduate for:
>
> - the practice of clinical general surgery, and/or
> - further specialty education and training, and/or
> - a career in academic surgical investigation and teaching."

### A. ACGME COMPETENCIES

Residents will obtain competence in the 6 areas below to the level expected of a new practitioner.

#### PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

#### MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

#### PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems

- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

**INTERPERSONAL AND COMMUNICATION SKILLS**

Residents must be able to demonstrate interpersonal and communication skills that resift in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

**PROFESSIONALISM**

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

**SYSTEMS-BASED PRACTICE**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

B. GLOBAL EDUCATION GOALS

1. The resident must acquire a fundamental knowledge base in the basic sciences applicable to general surgery.
2. The resident must acquire an extensive, sound knowledge base in the clinical science of general surgery.

3. The resident must develop, through technical training and operative experience, the competence toexecute the operative and non-operative procedures intrinsic to the practice of general surgery.
4. The resident must develop the necessary skills in clinical decision-making to become a safe and effective practitioner of general surgery.
5. The resident must demonstrate the desire and ability to care for his or her patients in a competent, responsible, compassionate and ethical manner and to serve society by always demonstrating professional integrity, intellectual honesty and social responsibility

C. SEE RESIDENT MANUAL ONLINE AT (HTTP://WWW.TTUHSC.EDU/ELPASO/SOM/SURGERY/) FOR AN OUTLINE OF GENERAL EDUCATIONAL OBJECTIVES IN THE BASIC AND CLILNICAL SCIENCES

D. RESIDENT PHYSICAN RESPONSIBILITIES

Residents in all training programs of Texas Tech University School of Medicine are required to assume the following responsibilities:

1. Develop a personal program of self study and professional growth with guidance from the teaching staff.
2. Participate fully in the education and scholarly activities of their program including the teaching and supervising of medical students and residents of a more junior level.
3. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
4. Participate in institutional committees and councils, especially those that relate to patient care review activities.
5. Participate in evaluation of the quality of education provided by the program.
6. Gain an understanding of and development within the Six Competencies of the ACGME as listed above.
7. Additional responsibilities specific to the general surgery residency program include the following:
    a. Complete medical records in an accurate and timely fashion with special reference to the dictation of operative reports.
    b. Accurately and promptly report the operative experience (case records) using the ACGME program. (This is of the greatest importance to the ultimate qualifications of the resident for Board certification and to the accreditation of the program by the Residency Review Committee.)
    c. Attend all conferences on a regular basis.
    d. Self-protection and patient protection through consistent and conscientious observation of universal precautions and other infection control measures, including immunization against hepatitis B.
    e. Participate annually in the ABSITE (American Board of Surgery In-Training Examination). Residents in clinical years four and five are required to participate in the annual oral examination (Mock Orals).

Remember: All patients are assumed to have infectious blood and bodily fluids that contain transmissible disease. In any patient contact where exposure to blood or bodily fluids is anticipated or highly likely, the following universal precaution barrier must by used:

- impervious gown
- gloves
- goggles or other approved eye protection
- booties to cover footwear

**These are Occupational Safety and Health Administration (OSHA) laws!**

## D. RESEARCH EXPERIENCE

The Department does not offer a dedicated research rotation. However, there is an active faculty clinical research effort. Residents are encouraged to participate in ongoing studies, and ideally develop projects of their own that the faculty would be pleased to support and foster. We deal with an extensive array of clinical problems that can form the basis of interesting research and publication.

Residents are strongly encouraged to author or co-author at least one publication, presentation, or published abstract during their five years of training.

## III. A. ORIENTATION TO THE CLINICAL SERVICES

"The Program Director must establish an environment that is optimal both for resident education and for patient care, while assuring that undue stress and fatigue among residents are avoided. At the same time, patients have a right to expect a healthy, alert, responsible physician dedicated to delivering effective and appropriate care."

| A Team Faculty | | B Team Faculty |
|---|---|---|
| Dougherty | | Tyroch |
| Ombaba | | McLean |
| | | Meier |

| General Surgery | | General Surgery |
|---|---|---|
| CT Vascular | | ENT |
| | | Plastic |
| | | Urology |

Service coverage is as shown above. Each faculty member covers his/her own service. Faculty members for the teams remain the same, whereas resident rotations change monthly. Potentially, all faculty could have patients in the hospital at once. Faculty who are on leave - vacation or administrative - will arrange for service coverage and inform the chief resident.

Faculty coverage of Trauma/Critical Care is rotated on a weekly basis. An upper level resident is assigned to the intensive care unit to cover trauma and to act as chief of the SICU service. An additional 1-2 residents are assigned to the SICU for patient care.

Outpatient clinics for A Team faculty are on Tuesdays; for B Team, Wednesdays. All residents, including the chief resident, are expected to attend unless specific arrangements to the contrary are made with the faculty (from whose clinic you propose to be absent).

Clinic patients or hospital patients (ED or ward) seen in consultation by a faculty member are assigned to that faculty member for that particular surgical issue or for a period of two years (whichever applies). The assigned faculty will typically provide both hospital care and post-discharge clinic follow-up. When writing hospital admission orders, house staff must indicate the admitting faculty in those orders. Similarly, discharge orders must specify outpatient clinic follow-up by the admitting faculty unless for some reason the patient has been transferred to the service of another faculty. The clinic schedule is as follows:

GENERAL SURGERY CLINIC SCHEDULE

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| ICU Resident | A Team Residents | B Team Residents | | B Team Residents |
| Dr. Tyroch (Trauma)<br>1:00 -4 p.m. | Dr. Ombaba<br>8 a.m. – 12 p.m. | Dr. Meier (Peds)<br>8 am-12:00 p.m. | | Dr. Miller (Plastics)<br>8:00 AM |
| | Dr. Dougherty<br>1:30 p.m.-5p.m. | Dr. McLean<br>1:30 p.m. - 5 p.m. | | |

BREAST CLINIC SCHEDULE

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| Saltzstein/Schabacker<br>1:30 p.m. | Saltzstein/Schabacker<br>1:30 p.m. | | | |

ENT CLINIC SCHEDULE

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| | Rhodes<br>8:00 am | | Rhodes<br>8:00 am | |
| | Rhodes<br>1:00 p.m. | | Rhodes<br>1:00 p.m. | |

PLASTIC SURGERY/MINOR SURGERY CLINIC SCHEDULE

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| | | | Miller<br>8:00 am | Miller<br>9:00 am |
| | | | Miller<br>1:00 p.m. | |

B & C. INSTITUTION-SPECIFIC EDUCATIONAL OBJECTIVES AND RESIDENT EVALUATIONS FOR EACH ROTATION

On the following pages are educational goals and objective for each resident rotation. Please become familiar with these before starting on that service and review them periodically as the rotation progresses. Following the educational goals is a copy of the evaluation sheet that will be used for the resident completing the rotation.

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON CARDIOTHORACIC SURGERY*

## *R.E. Thomason, Sierra, Providence, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE _BASE AND CRITICAL THINKING | CLINICAI; DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OP CART? | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | At the conclusion of this rotation, each resident should understand the pathogenesis, methods of diagnosis and principles of patient management of all common and many less common cardiothoracic disorders including acquired and congenital heart disease, pulmonary inadequacies, esophageal benign and malignant disease. | Become competent in:<br>I. evaluating and treating patients with CT disease, especially postoperative patients in the ICU.<br>2. The diagnosis/treatment of complications often seen post-operatively, e.g. low cardiac output, arrhythmia,<br>3. the use of inotropic drugs and the intra-aortic balloon pump.<br>4. the management of chest drainage systems | Participate in the outpatient cardiothoracic clinic. | 1. Central line and Swan-Ganz catheter placements.<br>2. Performance of the thoracotomy and median sternotomy.<br>3. Harvesting of veins for coronary artery bypasses.<br>4. 2nd assistant in major cardiac surgical procedures<br>5. Surgeon (or first assistant) in pacemaker placements.<br>6. Surgeon (or first assistant) in pulmonary procedures, e.g. wedge and lobar resections. |
| PGY IV: | See above | OBJECTIVES FOR THE ROTATION | See above | See above |
| | | Demonstrate knowledge of:<br>1. H & PE abnormalities found in common congenital and acquired CT disease,<br>2. Acquisition/interpretation/utilization of catheterization data in planning cardiac surgery<br>3. the principles of successful cardiopulmonary bypass.<br>4. the timing/selection of CT surgical interventions<br>5. the essential pre-and post-operative orders for CT surgical patients<br>6. the principles of follow-up and prognoses of CT surgical patients<br>7. patient and device selection for pacemaker implantation<br>the indications for the techniques of thoracic endoscopy | | |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON SURGICAL CRITICAL CARE MEDICINE*

## *R.E. Thomason Hospital*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| PGY I, II & III | At the conclusion of the rotation, the resident should have an understanding of the pathophysiology of the hemodynamic, pulmonary, renal, immunologic, and nutritional aspects of the management of a critically ill surgical patient. The resident should understand the use of and limitations of monitoring equipment commonly used in the SICU. The resident will have an understanding of fluid and electrolytes, renal physiology, microbiology and the use of antibiotics. | The resident will have close contact with a variety of disease processes with altered physiology in the SICU. Through day to day contact with the attending on SICU, the resident will 1) learn how to utilize ventilators to optimize pulmonary function 2) interpret data from hemodynamic monitors and utilize the appropriate fluid management, inotropes and pressors to optimize hemodynamic status 3) study altered physiologies in fluid and electrolytes and renal function to provide optimal fluid and electrolyte management to patients with impending and acute renal failure 4) interpret the results of bacteria culture and determine appropriate antibiotics usage 5) interpret results of nutritional analysis to formulate appropriate strategies for nutritional repletion 6) understand the principles of intensive neuromonitoring and manage states of decreased level of consciousness and increased intracranial pressure 7) determine the relationship between treatment of surgical disease through operation intervention and the impact of this on organ physiology | Outpatient clinic follow-up. | The resident will become facile in the insertion of central venous catheters, pulmonary artery catheters, arterial lines, jugular venous monitoring, intubation, percutaneoustracheostomy, percutaneous endoscopic gastrostomy, and tube thoracostomies. |

***EDUCATIONAL OBJECTIVES FOR ROTATIONS ON GENERAL SURGERY & TRAUMA***

***R.E. Thomason, Providence, Sierra, & Las Palmas Hospitals***

| RESIDENT | KNOWLEDGE BASF AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | For General Surgery, residents should be knowledgeable in the principles of pre-op assessment, operative intervention, and post-op care and follow-up in patients presenting with a wide variety of surgical diseases. This knowledge base should include the etiologic and pathologic basis of the disease process as well as the physiologic basis of fluid and electrolytes, wound healing, nutrition, and organ function (cardiac, pulmonary, renal, gastrointestinal and endocrine) that is important for post-op follow up. | Residents will have an understanding of the evaluation of surgical disease with attention to various diagnostic tests and modalities that are used to define the type and extent of the pathology, which will determine the need of surgical intervention. Surgical decision making will be learned along with the various phases of management skills through interaction with surgical faculty.<br><br>For trauma, the principles of resuscitation and rapid diagnosis will be emphasized in the trauma room. Rapid interpretation of clinical findings, laboratory values, and radiologic results will be stressed as important aspects of trauma management. The "team concept" of trauma care will also be emphasized on this rotation. | Residents will be expected to routinely attend the various outpatient clinics on the service in order to gain a longitudinal experience for patient care. Responsibilities will include evaluation of new patients with surgical and non-surgical disease, preoperative assessment of surgical patients; follow up of post-op General Surgery and Trauma patients, and the performance of minor out-patient procedures that are frequently done in the clinic area. | Residents will participate in the performance of surgical operations with attending supervision. The type of case and level of responsibility in each case will be determined by a level of experience of the residents. Attendings will be present in the operating room for all cases. |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON GENERAL SURGERY & TRAUMA (continued)*

## *R.E. Thomason, Providence, Sierra, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| PGY I | This resident will primarily become knowledgeable in the physiology of pre-and post-op care, including fluid and electrolytes, nutrition and wound healing. This resident will be required to successfully complete an ATLS provider course. | This resident will participate in the evaluation of less complicated problems found in surgery patients. Post-op care and the management of physiologic problems in the general surgery patients will be the primary focus of experience for this resident. For the trauma patients, this resident will participate in all of the trauma resuscitations and will be given graded responsibilities to help improve the skills needed for early resuscitation. | The responsibilities appropriate for level of training will be given at each clinic. These include history and physical examination of surgical consultations and pre-op patients. And understanding of pathophysiology and associated physical and radiologic findings will be stressed. Post-op assessment and understanding of anticipated healing and recovery will be emphasized. | Refer to Educational Objectives website for specific operative experience for PGY -I year. |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON GENERAL SURGERY & TRAUMA (continued)*

## *R.E. Thomason, Providence, Sierra, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE CONTINUITY OF CARE | OPERAI1\ L EXPERIENCE |
|---|---|---|---|---|
| PGY II - IV | This resident will be developing a knowledge base in surgical disease with concentration of disease in the endocrine system, hepatobiliary system, GI tract, pancreas, and head/neck tumors (ENT). | This resident will become familiar with the diagnostic evaluation and management of general surgery patients with a wide variety of disease processes, particularly endocrine, GI and hepatobiliary. The resident will be exposed to comprehensive but cost-effective strategies for patient evaluation and will gain experience in surgical and decision making in both the pre-op and post-op phase of care.<br><br>For trauma, this resident will be given greater responsibilities for management of resuscitation and evaluation of the trauma patient, including the critical care phase. By the end of the rotation, this resident will have the skills to be the "team leader" for trauma resuscitation. | Greater responsibilities for level of training will be given at each clinic. | Refer to Educational Objectives website for specific operative experience for PGY II - IV year |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON GENERAL SURGERY & TRAUMA (continued)*

## *R.E. Thomason, Providence, Sierra, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MAANAGEMEN"I | OUTPATIENT EXPERIENCE & CONTINUIT'Y C)1 CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| PGY V | This resident will develop a knowledge base in trauma and general surgery sufficient to teach the other residents and students on the service. Additionally, there will be much attention paid to the inculcation of a knowledge base concerning complex trauma and general surgery procedures as well as physiology of surgical complications that might be referred into a tertiary center. | With the attending, this resident will ultimately be responsible for all of the clinical decision making on the GS and Trauma services. This resident will administratively manage the service, provide an educational environment for the residents, and be prepared to make decisions about patients with complex surgical problems or complications. | The Chief resident will take on more responsibility at each clinic session and, with the attending, will ultimately determine appropriate evaluation strategies and follow-up plans for the General Surgery and Trauma patients. | Refer to Educational Objectives website for specific operative experience for PGY -V year. |

***EDUCATIONAL OBJECTIVES FOR ROTATIONS ON GENERAL SURGERY CLINICS***

***TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER - EL PASO***

| RESIDENT | KNOWLEDGE BASE AND CRITICAL T'IIINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINI JITY OF CAKE | OPERA'IVIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | At the completion of these rotations, each resident will learn the pathogenesis, diagnostic methodology and principles of surgical management of most common and some unusual disease processes falling within the scope of general surgical practice. | Develop skills in interpreting imaging studies employed in general surgery (nuclear medicine scans, radiographic contrast studies and CT, ultra-sonography and angiography of the abdomen and pelvis). | All residents are required to attend office hours weekly, in which they will evaluate and longitudinally manage - with the responsible attending surgeon - patients pre and post-hospital (or who undergo ambulatory surgical or office procedures). | Develop excellent patient skills in performing minor surgical procedures. |
| PGY I<br>PGY II | See above | OBJECTIVES FOR EACH ROTATION<br>Demonstrate the ability to interpret diagnostic studies employed in the evaluation of general surgery patients; demonstrate confidence and ability in formulating and management plans. | See above | |
| PGY IV | See above | Demonstrate expertise in performing consultations. Integrate the preoperative evaluation, intra-operative treatment and postoperative management of a variety of patients typically encountered in general surgery. Demonstrate leadership and teaching of the junior resident. | See above | |

***EDUCATIONAL OBJECTIVES FOR ROTATIONS ON GI ENDOSCOPY***

***TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER - EL PASO***

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | Develop an in-depth fund of knowledge of the more common gastrointestinal disorders likely to be encountered by the general surgeon. | Develop the ability to delineate a meaningful differential diagnosis and appropriate diagnostic plan for the efficient, effective evaluation of common gastrointestinal disorders. | Develop a working knowledge of the common gastrointestinal disorders encountered and managed in the outpatient setting. | Develop competence in performing flexible sigmoidoscopy, colonoscopy and EGD. Develop a sound knowledge of the indications and contraindications for various endoscopic procedures. |
| PGY II & III | The goal will be accomplished by the study of the literature, attendance and participation in lectures, conferences, and attending rounds, | OBJECTIVES FOR EACH ROTATION<br>The resident will perform in-patient consultations, at least one per day, which are to be reviewed with the attending gastroenterologist. | The resident will participate in the outpatient clinic (one/week) where the resident will typically see 5-7 patients. Each case will be reviewed with a gastroenterologist. | During the four week rotation the resident is expected to perform at least 10-15 flexible sigmoidoscopies, 10-15 colonoscopies, and 20 upper GI endoscopies in a supervised setting. The resident is also expected to observe and become familiar with the techniques of endoscopic retrograde cholangiopancreatography, and other diagnostic and interventional methodologies employed in GI practice (e.g. esophageal pH and manometric monitoring, PEG, etc.) |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON PEDIATRIC SURGERY*

## *R.E. Thomason, Sierra, Providence, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | Understand the pathogenesis, diagnosis and principles of surgical management of most common and some unusual disease processes falling within the scope of general and thoracic pediatric surgical practice. | The resident should possess a working knowledge of the application of various imaging modalities to the diagnosis of surgical disease in infants and children, particularly as they might differ from their application in adult patients. Proficiency in the physical examination of the uncomfortable, frightened child should be developed. | Residents must participate in the pre-and post - operative management of all pediatric surgical patients. | Residents participate as surgeon in a graded operative experience commensurate with the level of training and experience. They also participate as first assistant in more complex procedure. |
| PGY IV | See above | The resident should demonstrate effectiveness in planning the diagnostic and therapeutic management of children with severe surgical illness and in providing consultation to pediatricians. The PGY IV resident should assume management of the inpatient pediatric surgical service and direct the activities of and participate in the teaching of the PGY II resident assigned to the service. | See above | The resident should become proficient in all pediatric surgical procedures commonly part of general surgical practice. The resident will also perform more complex pediatric surgical procedures, i.e. bowel resections, neck and thoracic procedures, and abdominal tumors resections. The resident will have an understanding of the approach to TE fistulas, kidney tumor and malignancies of the neuroendocrine system. |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON TRANSPLANT SURGERY*

### *Texas Transplant Institute-San Antonio*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | Develop an understanding of the specific clinical problems encountered in recipients of organ transplant, especially of the kidney through experience participating in it's management and by review of pertinent medical literature. Become knowledgeable regarding the criteria of organ donation and social and ethical issues relating to organ supply and recipient designation and selection. | Understand the utilization of the clinical examinations, as well as diagnostic biochemical and microbiological tests and radiological intervention, in the management of the immunocompromised patient. | Develop a detailed understanding of the longitudinal care of the (potential) recipient both before and after transplant. | Gain operative experience in judgmentally and technically demanding cases, which require high levels of intellectual and manual skills. |
| PGY IV | Understand the pathophysiology and clinical manifestations of the more common diseases causing renal disease.<br><br>Understanding the timing of referral for transplant evaluation based on the natural history and clinical manifestations of those disease commonly resulting in the need for liver or kidney transplantation<br><br>Be cognizant of the various clinical problems specific to transplant patients. | OBJECTIVES FOR EACH ROTATION<br>Be familiar with the management of the following in the transplant patient: Hyperkalemia, fluid balance, diabetes, fever of unknown origin, hypertension, sepsis, wound infection, and malnutrition.<br><br>Learn the manifestations of transplant rejection.<br><br>Understand the roles of renal nuclear scans, ultrasonography, arteriography and biopsy in the diagnosis of kidney graft dysfunction. | Develop expertise in formulating a comprehensive renal transplant consultation.<br><br>Appreciate the complexities of planning and implementing related or cadaveric renal transplantations.<br><br>Become competent in the management of post-transplant renal patients. | Become thoroughly familiar with the anatomy of the retro-peritoneal iliac arterial and venous area.<br><br>Understand the technical variations between arterial and venous anastomoses.<br><br>Develop competence and speed in performing vascular anastomoses in the deep, restricted fields typically encountered in renal transplant. |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON VASCULAR SURGERY*

### *R.E. Thomason, Providence, Sierra, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| GOALS FOR ALL RESIDENTS | At the completion of this rotation, each resident should understand the pathogenesis, methods of diagnosis and principles of management of atherosclerosis, both occlusive and aneurysmal, and common disorders of the venous system. In particular, the resident must be knowledgeable in the diagnosis and management of peripheral vascular and of carotid artery disease. | The resident should posses a working knowledge of vascular laboratory diagnostic procedures, including: Ankle/brachial indices, flow Doppler, and other diagnostic methodologies commonly employed by the vascular laboratory. | Regular attendance in the out-patient vascular clinics, develop facility in the recognition, diagnosis, evaluation and treatment of common arterial and venous disorders. | During his/her rotation, each resident must complete at least 44 major vascular cases and a comparable number of additional vascular cases. |
| PGY IV | See Above | OBJECTIVES FOR EACH ROTATION<br>The resident should understand the diagnostic criteria and pathophysiologies differentiating acute and chronic arterial and venous insufficiency.<br><br>Become competent in evaluating and instituting the therapy of patients with common vascular problems.<br><br>Demonstrate the ability to interpret vascular diagnostic procedures and provide vascular consultations. Show competence in instituting management plans.<br><br>Demonstrate expertise in consultation for appropriate management of common vascular disorders. Integrate preoperative evaluation, intra-operative treatment and post-operative management of patients with a variety of vascular disorders. | Attend on a regular basis, the outpatient clinics. | Operative experience in dialysis access (-10 cases) and in placement (-20 cases) is expected, as well as experience with amputations. Achieve operative experience with dialysis access (cumulative total of -40 cases), exposure of major vessels for repair and/or reconstruction and uncomplicated arterial repair of anastomoses.<br>Acquire operative experience in major arterial reconstructive surgery, including AAA repair, bypasses for occlusive disease, carotid endarterectomy, and uncomplicated visceral arterial bypasses. |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON PLASTIC SURGERY*

### *R.E. Thomason, Providence, Sierra, & Las Palmas Hospitals*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| PGY I - V | After the completion of the rotation, the resident will know the process of normal wound healing and factors inhibiting the normal healing process. The residents should understand the pathology of skin and soft tissue diseases that require surgical intervention and will understand physiology associated with skin and myocutaneous transfers. | The resident should understand the indications for the plastic surgical management of hand, facial, and soft tissue problems requiring plastic surgical intervention. The resident will understand indications and treatment of lacerations including the principles of debridement where tissue excision is needed. The resident will be able to perform a comprehensive examination of the hand, assessing both motor and sensory components and will be able to assess the degree and extent of facial trauma. The resident will understand the principles and use its appropriate use and limitations. | The resident will participate in the preoperative evaluation of the patient requiring plastic surgical intervention. The resident will understand the goals of reconstructive and cosmetic procedures and will be able to assess the success of these procedures in the postoperative period. | The resident will provide definitive care of lacerations and wounds including those on the face, will perform and assist in selective reconstructive procedures, will perform and assist in selected cosmetic procedures, and will perform or assist in facial reconstruction after trauma wide extirpation of malignancies. |

## *EDUCATIONAL OBJECTIVES FOR ROTATIONS ON ANESTHESIOLOGY*

## *R.E. Thomason Hospital*

| RESIDENT | KNOWLEDGE BASE AND CRITICAL THINKING | CLINICAL DIAGNOSIS AND MANAGEMENT | OUTPATIENT EXPERIENCE & CONTINUITY OF CARE | OPERATIVE EXPERIENCE |
|---|---|---|---|---|
| PGY 1 | 1) Gain a more thorough understanding of depolarizing (succinylcholine) and nondepolarizing (vecuronium, rocuronium, cis-atracurium, pancuronium, etc.) muscle relaxants. Additionally, explore potential risks and benefits of each drug in different clinical settings.<br>2) Understand the indications for and dosing of a pharmacologic pressor agent (epinephrine, phenylephrine, norepinephrine, dobutamine).<br>3) Understand the alternatives for and hemodynamic consequences of inhalational anesthetic agents (isoflurane, halothane, sevoflurane and nitrous oxide).<br>4) Review ACLS protocol for cardiac rhythm disturbances. Review local anesthetic pharmacology and dosing for use as a local, subarachnoid block (spinal anesthetic) or epidural use.<br>Review regional anesthetics (spinal, epidural, Bier block, interscalene, axillary, etc.) | 1) Principles and applications of noninvasive monitoring.<br>2) Consider alternatives, risks and indications for invasive hemodynamic monitoring.<br>3) Understand the alternatives, dosing and clinical indications for various intravenous anesthetic induction agents (Sodium thiopental, propofoletomidate, ketamine, midazolam, etc.)<br>4) Become more familiar with conscious sedation techniques. Explore alternatives in intra-operative and postoperative pain management (intravenous agents, local anesthetics, NSAIDS, PCA, epidural).<br>5) Review the importance of positioning and risks of postoperative neurological deficits for the surgical patient. | NONE | 1) Improve technical skills for airway management including airway assessment and risk factors and approach for management of the difficult airway.<br>2) Learn the anesthetic machine checkout necessary prior to giving an anesthetic.<br>3) Improve technical skills for placing peripheral IV's central lines and arterial lines. |

# Texas Tech University Health Sciences Center - El Paso Surgical Residency Program

Housestaff Evaluation Form **(PGY I..V)**

Resident:

Rotation: **General Surgery**

Name of Evaluator:

Rotation Evaluation Dates:

Please evaluate the resident's competency in each of the following areas, considering his/her level of training. Use the following 6 point scale: 1 = Unsatisfactory; 4 = Average; 6 = Outstanding.

***MEDICAL KNOWLEDGE:***

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and psychosocial sciences and the application of this knowledge to patient care. (i.e., are the resident's skills in patient diagnosis

| & management commensurate with level of education) | Unsatisfactory | | | Average | | Outstanding |
|---|---|---|---|---|---|---|
| Basic medical knowledge | 1 | 2 | 3 | 4 | 5 | 6 |
| Able to synthesize & apply information | 1 | 2 | 3 | 4 | 5 | 6 |
| Able to formulate a logical differential diagnosis and develop an appropriate plan | 1 | 2 | 3 | 4 | 5 | 6 |

***PATIENT CARE:***

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

| | | | | | | |
|---|---|---|---|---|---|---|
| History and physical exam skills | 1 | 2 | 3 | 4 | 5 | 6 |
| Clinical/professional judgment (diagnostic & therapeutic) | 1 | 2 | 3 | 4 | **5** | 6 |
| Ambulatory care skills | 1 | 2 | 3 | 4 | 5 | 6 |
| Compassion & sensitivity to patients and family members | 1 | 2 | 3 | 4 | **5** | 6 |
| Familiar with expected procedures | 1 | 2 | 3 | 4 | 5 | 6 |
| Displays understanding & proficiency in use of protective habits | 1 | 2 | 3 | 4 | **5** | 6 |

***INTERPERSONAL AND COMMUNICATION SKILLS:***

Resident's must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates.

| | | | | | | |
|---|---|---|---|---|---|---|
| Humane/compassionate | 1 | 2 | 3 | 4 | 5 | 6 |
| Communicates/listens/instills confidence | 1 | 2 | 3 | 4 | 5 | 6 |
| Receptive to feedback/criticism | 1 | 2 | 3 | 4 | **5** | 6 |

***PROFESSIONALISM/ETHICS:***

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

| | | | | | | |
|---|---|---|---|---|---|---|
| Professional attitudes & behavior | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitive to diversity in patient & their needs | 1 | 2 | 3 | 4 | 5 | 6 |
| Initiative/interest in work | 1 | 2 | 3 | 4 | 5 | 6 |
| Professional appearance | 1 | 2 | 3 | 4 | **5** | 6 |

***PRACTICE-BASED LEARNING &IMPROVEMENT:***

Residents must be able to learn, investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

| | | | | | | |
|---|---|---|---|---|---|---|
| Reviews, assimilates & applies scientific evidence | 1 | 2 | 3 | 4 | 5 | 6 |
| Reading, Self-instruction, participation in conference | 1 | 2 | 3 | 4 | 5 | 6 |
| Teaches others | 1 | **2** | **3** | 4 | 5 | 6 |

***SYSTEM-BASES PRACTICE:***

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

| | | | | | | |
|---|---|---|---|---|---|---|
| Consistent test ordering & patient management | 1 | 2 | 3 | 4 | 5 | 6 |
| Promotes cost-effective patient care | 1 | 2 | **3** | 4 | 5 | 6 |
| Uses consultants properly | 1 | 2 | 3 | 4 | 5 | 6 |

***OVERALL CLINICAL COMPETENCE/PERFORMANCE OF RESIDENT***

| | Unsatisfactory | | | Average | | Outstanding |
|---|---|---|---|---|---|---|
| Please circle the number that best rates the resident | 1 | 2 | 3 | 4 | 5 | 6 |

***COMMENTS** (be specific and identify areas of strength and weakness)*

***Suggestions to improve resident clinical competency/performance***

Evaluator: Date:

Program Director: Resident:

*Please return the completed form to Norma Rincon, Program Coordinator, General Surgery Residency Program, Texas Tech University Health Sciences Center, 4800 Alberta Avenue, El Paso, Texas 79905*

*Thank you for your assistance.*
*June 2004*

## D. EVALUATION OF FACULTY

Residents are required to complete written evaluation forms of each faculty member on a yearly basis, to be distributed in June. Responses will remain confidential. All evaluations, including narrative comments will be strictly confidential. The attending will be given a typed collation of the results. It is the Chairperson's intention to provide each attending with a summary of his/her evaluations each year. When you receive these forms, please complete them in a timely fashion.

## E. EVALUATION OF THE RESIDENCY PROGRAM

The residency program including rotations will be evaluated by the residents on an annual basis This is a requirement of the RRC. Data accumulated helps guide appropriate changes to meet the needs of the residents.

RESIDENT EVALUATION OF FACULTY
Department of Surgery
Texas Tech University HSC- El Paso

YEAR: 2008-2009

Clinical Service:

SCORING: 5=Outstanding 4=Above Average 3=Average 2=Marginal 1=Poor

NAME OF FACULTY MEMBER: _____ ,MD

| | Score |
|---|---|
| 1. Serves as a suitable role model when operating, teaching (at bedside or in the clinic), and relating to patients, family, residents, and colleagues. | |
| 2. Promotes and stimulates interests and pursuits of residents and students. | |
| 3. Provides instruction in the technical aspects of surgery. | |
| 4. Provides insight into the decision making process governing the care of surgical patients including communication of pre-operative workup, co-morbid problems, contemplated procedures, and special consideration for patients admitted to the service. | |
| 5. Participates in the scholarly activities of the Residency Program (conferences, lectures, etc.) | |
| 6. Is ready available for consultation and direction of patient care. | |
| 7. Is aware of the latest information available in the surgical literature and integrates it into the clinical setting (challenges you intellectually). | |
| 8. Communicates easily and effectively with residents when providing feedback on performance (receptive to resident's ideas and viewpoints). | |

COMMENTS:

**RESIDENT PROGRAM SURVEY**
**Texas Tech University Health Sciences Center, El Paso**
**Department of Surgery**

YEAR: 2008-2009

Following is a survey of your experience in the General Surgery residency training program at Texas Tech University Health Sciences Center, El Paso. Each spring the Department Residency Committee meets to address possible changes for the upcoming year. Summaries of the survey scores will be important in assessing quality improvement issues for the residency program. **This is a very important year for the residency program in terms of accreditation. Please take a few moments to thoughtfully complete the survey and return to the "response" box above the mailboxes. The survey is completely anonymous and candid responses are appreciated.**

Please use the following scale in responding to the questions:

**5** Excellent/highly agree/meets my needs all the time/no change recommended
4 Good/agree/meets my needs most of the time/very little improvement necessary
**3** Average/somewhat agree/sometimes meets my needs/ I wish positive change would occur
2 Below average/somewhat disagree/rarely meets my needs/ Changes would significantly improve program
1 Very poor/strongly disagree/never meets my needs/program suffers as a result of this factor

A) Program Director

| | | | | | |
|---|---|---|---|---|---|
| | Provides adequate oversight to the administration of the residency | | | | |
| ii. | Obtains adequate input from the residents before making important decisions | 5 | 4 | 3 | 2 |
| iii. | Communicates all important residency issues to me | | | | |
| iv. | Is available to discuss issues with me | 5 | 4 | 3 | 2 |
| | Ts even-handed and fair in making decisions about the residency | | | | |
| vi. | Supports the residents' educational environment in my rotations | 5 | 4 | 3 | 2 |
| vii. | Positively addresses lifestyle issues (i.e. work hours, stress, working conditions, etc.) of concern to the residents | | | | |
| viii. | Establishes goals and objectives of the residency and encourages appropriate resident achievement | | | 3 | 2 |
| | Adequately addresses "problem areas" in the residency | | | | |

Comments (Required for any scores of "1")

_____
_____
_____
_____

B. Program Coordinator

Provides adequate oversight to the residency office

xi. **Understands** the organization and function of the residency program 5 4 3 2

xi, is available to handle my needs as they relate to the residency program

xiii. Deals with **residency needs** in a **timely** fashion 5 4 3 2

xiv. Communicates pertinent issues to rile appropriately

xv. Is **pleasant and represents** the **residency well** 5 4 3 2

Comments (Required for any scores of "1")

_____
_____
_____
_____
_____

C. Didactic Sessions

xvi. Adequately rovers pertinent surgical information to help prepare for a surgical practice and the Boards

xvii. The format is effective 5 4 3 2

xviii The attending involvement is appropriate

xix. **Didactic evaluation** (ABSITE, quizzes, **mini in-service)** is adequate 5 4 3 2

Comments (Required for any scores of "1")_____

_____
_____
_____
_____
_____

**D.** M & M **Conference**

xxi. The format is effective

xx.

5 4 3 2 1 The attending involvement is appropriate

Comments (Required for any scores of "1")

Adequately covers pertinent surgical information to help prepare me for a surgical practice and the Boards

_____
_____
_____

E. Trauma Grand Rounds

xxiii. Adequately covers pertinent surgical information to help prepare me for a surgical practice and the Boards

xxiv. The format is effective 5 4 3 2 1

xxv. The attending involvement is appropriate

**Comments (Required** for any scores of "1")

_____
_____
_____
_____
_____

F. Evaluation of Individual Rotating

G. Evaluation Process

xxvi. The evaluation of my performance on the clinical rotation is fair and adequately characterizes my abilities

xxvii. The rotation evaluation form is an effective and **appropriate evaluation** 5 **4** 3 **2** 1

xxviii. I receive adequate feedback from my attending during the rotations

xxix I receive adequate feed back on my performance from faculty.

xxx The rotation provides the appropriate educational needs and operative experience.
(See attachment for additional comments on **Evaluation** of Rotation)
5 4 3 2 1 5 4 3 2

Comments (Required for any scores of "1") _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Additional Comments
EVALUATION OF ROTATION
Department of Surgery
Texas Tech University HSC - El Paso

Year: 2008-2009

Name of Clinical Service: (Check Appropriate Service)

_____ ICU _____General Surgery-A

_____ General Surgery-B
_____ Transplant _____Pedi-Surgery

_____ Cardiovascular

_____ Colorectal Surgery Oncology

Program Level (PGY):

~~SCORING 5=Outstanding 4=Above Average 3=Average 2=Marginal 1=Poor~~

1. Objectives of rotation met? (See Residency Handbook for Objectives)
_____
_____

2. Adequate volume of patients?
_____
_____

3. Operative cases at level of training?
_____
_____

4. Variety of cases?
_____

5. Education/Conferences valuable compared with other services?_____
_____
_____

6. Attendings available for consultation?
_____

7. Attendings round on a regular basis (teaching provided on rounds)? _____
_____
_____

8. Call schedule/duties tolerable?
_____
_____
_____

Recommendations and comments for Attendings:
_____
_____

## SURGICAL SCIENCE CURRICULUM

### A. THURSDAY CONFERENCE

The schedule for residents' Thursday didactic conferences has been developed in advance. Resident and faculty topic assignments have likewise been made well in advance. Thus there should be no excuse for being unprepared. In general, the assigned resident(s) will lead a discussion of the topic for that week. All residents will be expected to have read the material and participate in the discussion. It is anticipated that presentations will be developed from a wide array of sources, including the current literature.

*B.* SESAP in CD-ROM format will be reviewed as part of Thursday conference.

### C. JOURNAL CLUB

Journal Club will be held approximately weekly as part of the Thursday conference. The selected articles will be copied and distributed to each resident and faculty. Occasionally these may be distributed in PDF format.

### D. GRAND ROUNDS

Trauma grand rounds and perioperative grand rounds take place monthly. Typically these are conducted by faculty or guest speakers, though sometimes with resident participation in the lecture (e.g., a joint presentation).

### E. GENERAL SURGERY MORBIDITY & MORTALITY CONFERENCE

Approximately weekly, an in-depth presentation and discussion of one or two operative cases that experienced complications will be held. The discussion will include not only the specific complication(s) for that patient(s) but complications in general that may occur with the operative procedures in question.

In a different venue, all of our surgical complications will be reviewed but in a somewhat more abbreviated form.

### F. TRAUMA MORBIDITY & MORTALITY CONFERENCE

The monthly Trauma M & M Conference covers all trauma-related deaths and complications. In addition, a monthly Multidisciplinary Trauma M & M Conference allows inter-departmental discussion of trauma-related complications.

### G. TUMOR BOARD

A Tumor Board is held monthly during which selected oncology cases are discussed. Participants include the Departments of Surgery, Radiology, and Oncology

### H. MORNING REPORT

A morning report is held daily so that admissions from the night before can be discussed as regards management and to assure continuity of care.

### I. ICU DIDACTIC MODULES

All residents are required to have completed the online Resident ICU Course (http://ricu.sccm.org/RICU Welcome.aspx) by the end of their PGY-1 year.

## J. QUARTERLY ETHICS CONFERENCE

Texas Tech/Thomason offer a quarterly noon conference on medical ethics which is mandatory for residents who are not on away rotations or tending to emergencies.

## ASSESSMENT OF THE ACADEMIC PERFORMANCE

### A. EXAMINATIONS

Multiple-choice quizzes will be administered approximately weekly on specific topics and grades will be posted in the Resident Lounge. These quizzes will be based on material presented in conference and on Sabiston's Textbook of Surgery. The ABSITE examination administered yearly also serves as a benchmark of academic performance.

### B. MOCK ORAL EXAMS

General Surgery Residency Faculty administer "mock oral exams" yearly to PGY-4 and PGY-5 residents in conjunction with the surgical faculty of Beaumont Army Hospital.

## V. RESIDENT BENEFITS

A**. Vacation** is approved for not more than 15 working days for PGY Levels I & II and not more than 20 working days for PGY-III and above, subject to residency program requirements. Residents are not allowed to take two consecutive weeks at a time. Any variance from this policy must be justified by the Program Director/Department Chair, recommended by the Regional Dean, and approved by the Dean. Except in bona fide emergencies, vacation requests must be submitted in writing at least 6 weeks in advance – for the first six months by September 1and for the remaining six months, by March 1$^{St}$. Timing and scheduling of vacation is at the discretion of the individual department. Vacation benefits do not carry forward from year to year and must be taken within the current contract agreement year. Unused vacation benefits are not paid upon termination. When leaving on vacation, residents are required to make certain that Thursday conference presentations and other such responsibilities to which they may have been previously assigned are either re-scheduled or covered by someone else.

In addition, residents may take ten total administrative days anytime in the third thru fifth year of residency training. Preliminary, PGY-I, and PGY-II residents may take five administrative days. Any additional interview/administrative leave must come out of vacation time. Chief residents and preliminary residents may request to leave the program early (June 20$^{th}$) by using vacation time and/or administrative leave, otherwise they are expected to end the program by June 25$^{th}$. Education leave (see paragraph D. below) to present papers at professional or scientific meetings, however, is not considered vacation or administrative leave and may be arranged with departmental approval.

In general, vacation may not be taken while rotating on a surgical subspecialty or non-surgical service. Except for PGY-4 residents, categorical residents will take vacation only during the months when assigned to their home clinical service. PGY-4s who take vacation during an outside rotation must inform the Department of Surgery and must also obtain approval from the director of their rotation. Due to the ABSITE examination in January, no vacation leave will be granted for residents taking call at Thomason Hospital except under extraordinary circumstances and only by approval of the Program Director. Similarly, because of the high volume of personnel turnover in June, there will be no June vacations granted except as described above in paragraph. Having failed to previously take vacation time will not be considered grounds for requesting June vacations.

a) Transitional PGY-I residents, due to their lack of a home clinical service, may take vacation on any PG rotation. When taking such vacation on a ward rotation where the resident is given direct primary responsibility for the execution of patient care (not "ward team" responsibility), reasonable limitations on vacation request (such as allocating vacation to the first or last week of a rotation, limiting vacations to 5-7 day maximum) in the interest of patient care may be negotiated or imposed. Family Medicine, Emergency Medicine, and Ob-Gyn residents will not take vacations while on surgery rotations (ICU, surgical wards, or surgical clinics).

b) The Assistant Dean for Medical Education shall monitor vacation utilization by Transitional residents. Vacation allocation for transitional residents will be distributed fairly and proportionately across clinical services based on the quantity of transitional resident rotations to each clinical service.

B**. Holiday schedule**: http://www.ttuhsc.edu/hr/documents/TTUHSCHolidaySchedule2008-2009.pdf

C. **Sick leave** entitlement may be approved for up to 12 accumulated working days per year and may be carried forward from one contract year to another. Residents will not be compensated for accumulated sick leave. A resident accrues sick leave on a pro rata basis of the percent of time worked. Sick leave with pay may be taken when sickness, injury or pregnancy prevent the resident from performing his/her duty or when a member of his/her immediate family (spouse, child, or parent) is ill and required the resident's attention. The resident must submit to the Program Director a doctor's certificate or other written statement concerning the

illness that is acceptable to the Program Director. Time taken for illness on either side of vacation requires a physician's statement; otherwise, the leave will be counted as vacation or leave without pay if all vacation leave has been exhausted. It should be noted, however, that the American Board of Surgery requires 48 weeks of attendance as a resident in each level of training in order to qualify for Board certification. For documented medical problems or maternity leave, the ABS will accept 46 weeks of surgical training in one of the first three years and 46 weeks of training in one of the last two years, for a total of 142 weeks in the first three years and 94 weeks in the last two years.

D. **Educational leave** must be approved by the resident's Program Director and an official travel form, if applicable, must be executed by the department's administrative officer. Failure to do so may jeopardize certain dependent and other benefits, which may be forfeited if the resident is not on an official leave of absence. Subject to residency program requirements, educational leave is granted with pay and not charged to vacation or administrative leave.First year residents receive an educational allowance from TTUHSC of $200.00. This may be used towards books or local meetings. Second and Third year residents are allowed one regional meeting (American College of Surgeons, Southwestern Surgical, Texas Surgical) for a maximum benefit of $500.00 or $300 for books. Fourth year residents are allowed one major national meeting or post graduate course within the 48 states. The maximum benefit is $750.00 or $400 for books. Fifth year residents are allowed one major national meeting within the 48 states or a post graduate course (e.g., Board Review) - maximum benefit of $1,250.00 or $500 for books. Educational leave, however, is unlimited (within reason) when residents are presenting papers, abstracts, or posters at recognized professional or scientific meetings, and the department will pay the allowable expenses.

E. **Drug Enforcement Administration** fees may be taken from book allowance

F. **Malpractice Coverage** for residents is $100,000 per incident and $300,000 annual aggregate while participating in TTUHSC-sponsored training. This insurance covers any activity that is a part of resident's training program but will not assume liability for activity beyond the scope of the residency program, including outside remunerative medical activity (i.e., "moonlighting"). Any resident who suspects the possibility of an incident shall immediately notify the Risk Management Office. (PLEASE REFER TO THE SELF-INSURANCE HANDBOOK CONCERNING INCIDENTS AND CLAIMS REPORTING.) Again, TTUHSC professional liability coverage is not provided for activity outside the course and scope of employment.

G. **Group Health Insurance** is provided by TTUHSC for all residents and their immediate dependents. Because of current rules and regulations, professional courtesy discounts for residents and immediate family members should not be assumed. If a resident is on approved leave, premiums will be paid according to state and federal guidelines, not to exceed 12 weeks, e.g., FMLA, parent leave, etc. Following completion of training, insurance coverage may be continued for a period of time under a COBRA policy. If a resident elects to enroll in a health plan other than the group plan, the entire cost shall be borne by the resident.

H. **Worker's Compensation** coverage is provided for all residents. Any on-the-job injury must be reported immediately to the resident's supervisor as soon as possible, and it is the supervisor's responsibility to complete the correct form and forward to the HSC Human Resources Department. Reimbursement for an on-the-job injury cannot be considered unless an appropriate report has been filed. Each resident is to follow the respective campus procedure relative to needle sticks. Any incident must be reported to the Department Safety Officer (Dan Gutierrez, Senior Clinical Administrator) who will have the appropriate forms for completion.

I. **Sleeping quarters** are provided for the "on call" resident. Meals at Thomason Hospital cafeteria will be provided for residents and be contingent upon Medical Records completion.

J. **Uniforms** (long white lab coats) are provided at the beginning of the residency and laundered at no charge. Additional uniforms will be provided with authorization of the Program Director.

K. **Cellular phone allowance** will be provided to chief residents only.

L. **Pagers** are provided by Thomason Hospital.

M. **Immunizations** are provided by TTUHSC at no cost to residents. Each resident is responsible for knowing and complying with the TTUHSC Immunization Policy which is available in the GME Office or on the TTUHSC website http:/lwww.ttuhsc.edu.

N**. Counseling Services** are provided by the institution.

O. **Financial benefits**: American College of Surgeons Candidate Membership dues will be paid for by the Department of Surgery. The Department will reimburse residents $250.00 toward obtaining Texas Licensure and will pay for the renewal of Texas Licensure. Parking at Thomason Hospital is provided for house staff.

P.**Salaries**and fringe be benefits are determined by the University as outlined under the terms of the contract with the University. (Below are the salaries for the 2008-2009 Academic year).

| | Annual Salary | Monthly Salary |
|---|---|---|
| PGY **I** | $40,622.00 | $ 3,385.17 |
| PGY II | $41,948.00 | $ 3,495.67 |
| PGY III | $43,272.00 | $ 3,606.00 |
| PGY IV | $44,596.00 | $ 3,716.33 |
| PGY V | $45,920.00 | $ 3,826.67 |

Chief residents may be eligible for a stipend that will be determined annually by the department. Adverse or disciplinary actions may result in the temporary or permanent suspension of this benefit.

Q. **Moonlighting is not permitted.** Moonlighting is defined as any activity associated with the practice of medicine, from which the resident receives compensation in cash or kind in exchange for functioning as a private physician.

R.**ACGME Duty Hours Policy.** The Department of Surgery follows the ACGME policy and regulations related to the duty hours limit.

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spend in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Hours are averaged within given rotations - not tallied so that heavy and light assignments cancel to leverage compliance - and do not include vacation time.

Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

In-house call is scheduled no more frequently than every third night, averaged over a four-week period.

Continuous on-site duty, including in-house call, do not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.

Chief residents take at-home calls (pager call).

The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

## VI. RESIDENT SUPERVISION

It is policy of the Department of Surgery, as well as of Texas Tech University, that supervision of residents in the Operating Room shall conform to Medicare regulations in all cases, not just in Medicare cases. The rules are as follows:

*In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure...*

*In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.*

Depending upon the complexity of cases, all general surgery faculty are expected to operate with all residents (at all levels of training) and thus participate actively in residents' technical instruction. Similarly, attending surgeons must supervise other aspects of each patient's care as well. This participation is important, not only in the context of patient care and administrative responsibility, but also in fulfilling the educational mission of the Department.

## RESIDENT SUPERVISION: INVASIVE PROCEDURES

The attending surgeon also has responsibility for all invasive procedures performed upon his or her patients outside the operating room. These include, but are not limited to, central line placement, pulmonary artery catheterization, arterial line placement, endotracheal intubation, etc. Most such procedures are performed either in the Intensive Care Unit or in the Emergency Department although on occasion these procedures are performed in other hospital units, (e.g., surgical wards). Junior residents who are not `privileged' to perform a given procedure must be supervised by a senior resident who is so privileged.

PGY II-V residents are privileged to perform invasive procedures after the satisfactory completion of the minimal number of cases (see below).

For residents (PGY II-V) who have not met the criterion stated above, attending evaluation and documentation of the resident's competence in the procedures is required in order for the resident to be privileged.

Junior residents may also be privileged by the documented satisfactory performance, under supervision, of the following procedures in the numbers of cases indicated:

| | |
|---|---|
| • Central line placement | Cases 5 |
| • Pulmonary artery catheterization | Cases 5 |
| • Arterial line insertion | Cases 10 |
| • Endotracheal intubation | Cases 5 |
| • Peripheral venous cut down | Cases 5 |
| • Chest tube insertion | Cases 5 |
| • Ventilator management | SICU Rotation required |

## COMMUNICATION WITH THE ATTENDING STAFF

On every service to which general surgery house-staff are assigned, one or more attending surgeons is/are always immediately available in-house or by telephone to provide supervision, guidance, and education. It is the responsibility of the resident physician to be familiar with the call schedule and how to reach the attending surgeon on call. It is the responsibility of the attending on call to ensure his or her availability at all times.

In general the attending should be consulted for the following situations:

a) The admission to the hospital of a patient for which the attending has primary responsibility
b) The completion of a consult on behalf of the attending
c) The completion of a clinic visit for a patient seen on behalf of the attending
d) A significant change of the medical condition of an attending's patient.

GENERAL SURGERY RESIDENTS' JOB DESCRIPTION

The general surgery residency program is designed to provide an opportunity for education in the principles of general surgery, which in turn, should prepare candidates to pass the American Board of Surgery Qualifying and Certifying examinations. When a resident completes the general surgical training at our institution, he/she will have the necessary skills to care for general surgical patients with knowledge of anatomy, physiology, pathology, metabolism, nutrition, wound healing, shock, resuscitation, trauma, oncology and critical care. Each resident will be well-experienced in surgery of the alimentary tract, abdomen, breast, trauma, critical care and endocrine organs. There is experience with orthopedics, neurosurgery, urology, pediatric surgery, transplantation, vascular surgery, cardiothoracic surgery, plastic surgery, gynecology and otolaryngology. These experiences will allow development of clinical knowledge, surgical judgment, and technical skills.

Surgical residency is an educational process. At the beginning, junior residents learn to gather the data. With increasing experience, the residents begin to establish and determine which data are important, and finally, through integration, establish a diagnosis and formulate a therapeutic plan. At completion, residents are expected to make diagnoses and formulate plans, which include a broad understanding of the differential diagnosis, treatment options, and potential outcomes and complications.

Resident duties include patient care and surgical education, which are under the supervision of attending faculty. The amount of responsibility increases with increasing skills, experience, and seniority. The teaching faculty and more senior residents determine the responsibilities of each resident.

The clinical responsibilities of each resident include evaluation of both hospital and clinic patients, with preoperative assessment of the patient (i.e., history, physical examination, evaluation of laboratory and radiologic examinations, etc.), making diagnoses and formulating treatment plans. The residents are required to provide complete pre-, intra- and post-operative management with knowledge of potential complications and their appropriate treatment. They also are required to obtain informed consent from patients. The surgical resident who is the primary surgeon of an operation has a primary responsibility to perform all duties encompassed in that operation.

Inpatients are cared for daily by a team of attendings, residents and medical students. The teams include residents from the chief resident level to interns. They are required to obtain pertinent histories and perform daily examinations as well as determine treatment. Daily duties may include arranging for tests, performing procedures (i.e., removal of sutures, placement or removal of central lines or chest tubes, etc.) planning for discharge and arranging disposition with help from ancillary services. Senior residents on the team oversee and coordinate the care that is carried out by the more junior residents. It is also the responsibility of the team to maintain the medical record, which includes writing orders, daily progress notes, procedure notes, operative note dictations and discharge dictations. Discharge note dictations are delegated to the more junior residents. Operative notes and procedure notes are done by the resident surgeon.

More junior residents are expected to perform complete histories and physicals on all admissions and document these in the medical record. Senior residents are expected to document their involvement. Residents also have similar responsibilities with outpatients. After internship and with advancing experience, in addition to daily care of inpatients, residents begin to evaluate consultations from the inpatient services and from the emergency department.

The resident performs operations, with supervision by the faculty and more senior residents. The most junior residents begin, under close supervision, with the most basic procedures and progress to more complicated procedures. As technical abilities improve and as knowledge increases, residents are given the opportunity to perform increasingly complicated operations. Chief residents, while still under supervision of the in-house faculty, have the opportunity to perform the most complicated cases independently, as well as the ability to teach basic operations and procedures to the more junior residents. It is responsibility of the more senior level residents to teach junior residents and students. This is done both informally in the working environment and more formally in didactic settings and in conferences.

All residents in the program are expected to attend mandatory Thursday didactic conferences. These conferences are attended by faculty as well. The residents directly involved with cases are expected to make educational presentations at conferences. Conferences consist of presentations of pertinent care information followed by discussion of differential diagnosis, current therapies, and treatment alternatives.

In addition to attending and participating in discussions at conferences, residents are expected to read independently to improve their knowledge base. This also prepares them for the American Board of Surgery in Service Training Examination each year. Reading done from current publications, surgical texts and surgical subspecialty texts is the basis of discussion at conferences, on rounds, and in the operating rooms.

Residents are encouraged to do research for publication. There is strong emphasis to complete at least one research project prior to completion of residency.

All members of the Surgery Department as a group will evaluate each resident twice a year. The residents will also evaluate the faculty annually by completion of an anonymous written form.

**PGY** I

The duties of a surgical intern include rounding with the other members of the team, assisting with operations, teaching medical students and carrying out the plans developed by the team. The interns are not expected to have primary responsibility for developing a management plan for the patients. They are expected to write orders and progress notes, examine patients and perform minor procedures. They also oversee the work that the medical students do. The procedures commonly done by the intern can include placement of central lines and chest tubes, performance of diagnostic peritoneal lavage, etc. These are done with the supervision of more senior level residents and/or faculty.

Typical operations performed by interns include simple hernia repairs, appendectomies, incision and drainage of abscesses, removal of small tumors, breast biopsies, permanent central lines and tracheostomies.

Rotations for the interns include General surgery (6 months), critical care (5 months), and anesthesia (1month).

On call, the interns are primarily responsible for responding to calls from the surgical wards regarding inpatients. They are expected to evaluate patients and administer treatment. They also have the duty of writing a history and physical on all admissions. This is done with supervision from senior residents and faculty. They must show progress throughout the year towards efficient patient care, proficient clinical skills and ability to act with limited independence.

**PGY II**

In addition to skills acquired during the PGY I year, second year residents begin to take on more responsibility for identifying the correct diagnoses and formulating treatment plans. This responsibility is graded and increases as experience and ability increase. The PGY II resident directly oversees the interns and medical students and teaches procedures such as central line placement, tube thoracostomy, and DPL.

Typical operations performed by second year residents include more complicated herniorrhaphies, breast procedures and simple alimentary tract and biliary tract operations.

Rotations for the PGY II include General Surgery (7 months), gastroenterology-endoscopy (1 month), critical care (2 months), and consult service (2 months).

On call, PGY II residents are responsible for evaluating consults from the ward and emergency room as well as evaluating surgical and trauma patients for admission. They also supervise the intern.

**PGY III**

In addition to skills acquired during the PGY II year, third year residents begin to take on additional responsibility for identifying the correct diagnoses and formulating treatment plans and are expected to have a greater understanding of surgical disease. They begin to assume more of a leadership role with the team. This responsibility is graded and increases as experience and ability increase. The PGY III resident directly oversees interns, PGY II residents and medical students.

PGY III residents assume more responsibility in the operating room by doing more complicated bowel cases,biliary tract operations, breast operations, and some vascular procedures.

The PGY III rotations include general surgery (8 months), critical care (2 months), and consult service (2 months).

On call, PGY III residents are responsible for evaluating consults from the emergency room and ward as well as evaluating surgical and trauma patients for admission. They also oversee the intern and any other more junior members of the ward team.

**PGY IV**

In addition to skills acquired during the PGY III year, fourth year residents have more responsibility for patient management. They are expected to be able to identify a problem and formulate a treatment plan along with alternative options. This responsibility is graded and increases as experience and ability increase.

PGY IV residents perform more difficult operations, including recurrent hernias, complicated bowel and biliary tract operations and thoracic/vascular procedures. They perform mastectomies and axillary dissections as well as pediatric and endocrine operations and transplantations. They will also supervise more junior residents in operations.

PGY IV rotations are somewhat flexible and typically outside of Thomason Hospital. They include transplant (1 to 2 months), colorectal/general surgery (2 months), surgical oncology (2 months) ,vascular/cardiothoracic surgery (1 to 2 months), pediatric surgery (1 month), and electives (2 to 5 months).

On call, PGY IV residents are responsible for evaluating consults from the emergency room and ward as well as evaluating surgical and trauma patients for admission.

**PGY V**

In addition to skills acquired during the PGY IV year, fifth year residents will further develop skills acquired over the first four years. This resident oversees all of the activities that occur on his/her clinical service. He/she should be a consultant/source of information for the remainder of the team. The PGY V resident oversees and teaches the residents and students. Additionally, the PGY V residents assume administrative duties including designing a study program for basic science, general surgery reading and creating resident call schedules.

PGY V residents perform the most advanced cased (e.g., biliary, hepatic, vascular, pancreatic, intestine, gastric, breast, endocrine, etc.) and serve as an assistant to junior residents on their cases. A maturation of skills is anticipated such that chief residents are capable of performing operations independently.

Chief residents rotate the entire year on general surgery and consult teams, overseeing all admissions, consultations, and operations.

FURTHER SPECIFICATION OF RESIDENCY OBJECTIVES BASED ON LEVEL OF TRAINING

CHIEF RESIDENCY (PGY V):

1. Provides supervision of the junior resident in carrying out patient care responsibilities for the patient chosen by the chief resident for care (patients with complex surgical problems).
2. Communicates the details of patient progress or complications to attending surgeon in a timely way.
3. Understands with sophistication the pathophysiology of the patient's disease processes.
4. Perfects the elements of pre-operative preparation of the surgical patient, especially in consideration of existing co-morbid factors.
5. Understands the principles of the operative procedure including pertinent anatomy and technical consideration and decision making process.
6. Develops with the attending surgeon a postoperative plan of care considering co-morbid factors, basic disease process, and conduct of the procedure.
7. Masters the interpersonal skills in dealing with patients, staff, fellow residents, and attendings.
8. Masters the surgical technique (under supervision of attendings) specific to those patients with complex surgical problems.
9. Functions as consultant to junior and senior residents as needed.
10. Functions as educator of surgical house-staff and medical students.
11. Functions as administrator of the junior and senior resident staff.

SENIOR RESIDENT OBJECTIVES (PGY II, III & IV):

1. Provide supervision of the junior resident in carrying out patient care responsibility to include:

    a. Confirm and review pertinent history and physical findings with the junior resident.
    b. Review subjective and objective evidence of patient progress or complications with the junior resident.
    c. Review pertinent laboratory and imaging data with the junior resident.
    d. Modify (as needed) patient care plan developed by the junior resident.

2. Communicate the details of the patient progress or complications to attending surgeon in a timely fashion.
3. Master with sophistication the pathophysiology of the patient's disease process.
4. Master the elements of preoperative preparation of the surgical patient, especially in consideration of existing co-morbid factors.
5. Understanding the principles of the operative procedure including pertinent anatomy and technical considerations as well as decision-making processes.
6. Develop with attending surgeon a postoperative plan of care considering co-morbid factors, basic disease process and conduct of operative procedure.
7. Supervise the junior resident in the day-to-day execution of the care plan.
8. Educate junior and senior medical students in basic surgical diseases and the conduct of pre, intra, and postoperative care of the surgical patient.
9. Refine interpersonal skills in dealing with patients, staff, fellow residents, and attendings.
10. Learn surgical techniques (under supervision of attending surgeon) specific to the rotation.
11. Become conversant with the periodical surgical literature.

JUNIOR RESIDENT OBJECTIVES (PGY I):

1. Perform comprehensive history and physical assessment and share information with senior resident/attending.
2. Use available information, in combination with the interpretation of basic laboratory and radiographic data to develop a plan for the preoperative preparation of the patient and discuss with the senior resident/attending.
3. Understand the basic pathophysiologic disease process and its surgical implications.

4. Understand the decision-making process required of the surgeon and the principles on which the decisions are based.
5. Understand the basics of the surgical procedure performed, including tubes place, drains placed, lines placed, etc.
6. Develop with the aid of senior resident and attending surgeon a postoperative plan of care and surveillance. Anticipates problems particular to this patient or disease entity.
7. Provide for the day-to-day care of the patients on his or her service - writes admission orders, organizes tasks, obtains data, etc.
8. Serve as instructor to junior and senior medical students and supervises their assigned tasks along with the senior resident.
9. Develop interpersonal skills necessary for dealing with patients, nursing staff, fellow residents, and attending staff.
10. Accomplish the course objectives stated for each rotation.
11. Learn basic surgical skills - sterile techniques, OR conduct, dressing changes, wound care, basic surgical procedures under supervision.

ALL RESIDENTS

1) Spend at least one day per week in an ambulatory setting appropriate for the rotation. This experience will focus on providing pre- and post-operative care to the patient.
2) Maintain a log of operative procedures. This will be done on an electronic database using the ACGME website, www.acgme.org. The activity on this database will be submitted *monthly without fail* to the program coordinator.
3) Maintain a list of ICU experiences in a manner acceptable to the ACGME and American Board of Surgery guidelines.
4) Maintain a log of invasive procedures that will lead to credentialing.
5) Attend all didactic and educational meetings conducted by the residency.
6) Read mail and email in timely fashion.
7) Complete evaluation forms on a monthly basis.

SPECIFIC CLINICAL RESIDENT

RESPONSIBILITIESCHIEF RESIDENT:

Generally, the chief resident is involved in the care of the most critically ill complex surgical patients. This involvement should consist of preoperative evaluation, participation in the operating room as a surgeon, and the provision of ongoing postoperative care. The chief must also arrange for the post-discharge follow-up of the patient. Any cases so selected for care by the chief becomes his/her case and he/she is responsible for maintaining attending communication as well as delegation of responsibility to junior level residents.

Administrative activities include:

1. Establishing a coverage schedule (including provision for vacations) or working with residency office staff in the preparation of the schedule.
2. Presiding over all residents activities, conferences, etc., ensuring quality of resident presentations
3. Overseeing the SICU and ED activities of surgery residents.
4. Reviewing the OR schedule prior to publication each day to make any adjustments necessary for educational needs.
5. Distributing the OR assignments for resident staff each day by 4 p.m. for the following day's schedule.

SENIOR RESIDENT:

Generally, the senior resident will have the day-to-day responsibility for organizing and running the service to which he/she is assigned. He/she is responsible for all aspects of care (preoperative evaluation, participation in the OR as surgeon or first assistant, and the providing of postoperative care and a post-discharge follow-up visit) for all patients admitted to the service.

During nights and weekends, the senior resident will provide:

I. Consultation with and oversight of junior residents covering wards, SICU and ED as needed.
2. Written surgical consultations on off-service patients when requested, followed by a discussion of the patient with the appropriate chief resident and/or surgical attending, before making recommendations for care.
3. Communication with the chief resident and/or regarding complex patient care issues and complex cases being admitted or requiring consultation.

JUNIOR RESIDENT:

Basic duties include:

1. Taking first call for problems on the service to which he/she is assigned.
2. Attending to the day-to-day needs of the patients in consultation with the senior resident or chief resident and attending.
3. Assisting in the operating room when patient care needs allow. Performing procedures in the operating room at the appropriate level for his/her skills.
4. Admission history and physical examination for patients admitted to the service.
5. The collation and correlation of laboratory data for presentation to the senior resident and attending.
6. Participating in the pre-admission workup of patients as arranged by the senior resident consistent with outlined guidelines.

## **VII. OPERATIVE** CASE LOGS
## ACGME

WWW.ACGME.ORG

Residents are expected to update their operative logs at least monthly; failure to do so may result in disciplinary actions ranging from loss of O.R. privileges to suspension.

# VIII. RESIDENT EVALUATION AND ADVANCEMENT

A.

## 1. CLINICAL EVALUATIONS

At the conclusion of each rotation, every resident is evaluated, in writing by the attending staff of that service. The evaluations, which include a number of criteria encompassing various aspects of clinical performance, are compiled and summarized quarterly. Periodically, throughout the year those summaries are reviewed with the resident by the Program Director. The resident will receive a written summary of the faculty evaluation at least twice a year.

Failure on the part of the resident to exhibit improvement in performance following counseling will constitute grounds for probation or dismissal.

The appeals process is outlined in the resident contract.

## 2. CORE CURRICULUM SCORES AND ATTENDANCE

Each resident's attendance and performance in the surgical didactics curriculum is recorded and reviewed with the resident as part of his/her biannual evaluation. These data plus the results of the American Board of Surgery In-Training Examination (ABSITE) form the basis for judging the successful progress of the resident in acquiring the cognitive skills and knowledge base requisite to a surgical career.

## 3. AMERICAN BOARD OF SURGERY IN-TRAINING EXAMINATION

Annually (usually the last Saturday in January), the American Board of Surgery administers an in-training examination (ABSITE) for all general surgical residents in accredited U.S. programs. This exam closely parallels the content and style of the ABS Qualifying (written) Examination given to graduates of General Surgery Residencies as part of "Board Certification".

All categorical and preliminary residents enrolled in our program are required to take the examination. In addition to the raw score, the resident is compared, with all other residents at her/his level of training. Key phrases from questions missed are also provided. Further information regarding the scoring of the exam can be found on the score sheet.

Since the results of the ABSITE are a reasonable predictor of a resident's passing the American Board of Surgery Qualifying (written) Examination, the Residency Committee uses these scores to assess progress in the acquisition of clinical and scientific knowledge. In this context, the ABSITE score constitutes one of a number of criteria for advancement into the next year of training.

The Program Director, after conferring with the Residency Committee, will discuss evaluation, corrective, and if necessary, disciplinary measures with residents scoring below the $30^{th}$ percentile. Continued poor performance on these exams may be cause for academic probation and/or additional disciplinary/corrective measures.

## 4. ORAL EXAMINATION

The American Board of Surgery Certifying Examination is an oral examination which primarilytests the knowledge and reasoning of the surgeon in managing clinical situations encountered in surgical practice. To assist the resident in preparing for this, the faculty of the Department of Surgery administer "mock oral" examinations. PGY IV and V residents are required to participate.The format of the exam closely approximates that of the ABS Certifying (oral)

Examination. Chief residents are also encouraged to attend a general surgery board review course to prepare for the Qualifying Examination.

B. ADVANCEMENT, OBSERVATIONAL STATUS (NOTICES OF DEFICIENCY), AND PROBATION

**DURATION OF RESIDENCY TRAINING:** The period of appointment is for one year, renewable annually for the length of the training period. Acceptance into the residency does not guarantee completion nor does it establish a definite projected time period of completion. Advancement will be determined by the resident's performance and the availability of positions for the year into which the resident will advance. The conditions of resident advancement and/or continued tenure in the program for the following year are as follows:

1. Conditions of Resident Advancement:

- Exemplary performance with advancement to the next level and notation of any areas that need further development
- Satisfactory performance with advancement and notation of deficiencies to be improved
- Marginal performance with advancement, notification of one year's probation, and specification of deficiencies to be corrected
- Marginal performance with no advancement, notification of one year's probation, and discussion of alternative career choices
- Unsatisfactory performance and dismissal from the program

2. Observational Status:Notice of Deficiency

a. Academic: One or more of the following failures may result in a Notice of Academic Deficiency:

1. ABSITE (In-Training Examination) score below the 30$^{th}$ percentile

2. Inadequate participation (more than 20% un-excused absence) in the surgical didactic curriculum (Thursday conferences)

b. Clinical: One or more of the following deficiencies:

1. Clinical evaluation consistently indicating either

a. Substandard performance, or
b. Failure to progress satisfactorily

2. Poor performance on several rotations, suggesting a lack of clinical dedication

3. Specific areas needing substantial improvement are repeatedly identified, e.g. technical skills

c. Administrative/Professional/Ethical:*Any of the following are potential grounds for Notice of Deficiency or more severe sanctions, if warranted:*

1. Failure to discharge resident responsibilities, e.g. medical records

2. Failure to comply with governance policies

3. Interpersonal conflicts/psychosocial problems/substance abuse

4. Physical, verbal or sexual harassment

5. Unprofessional conduct, including but not limited to abrogating or failing to respond to clinical responsibilities

3. Probation:may be instituted as the result of poor clinical, academic, administrative, professional, and/or ethical performance or poor testing at the discretion of the Residency Committee. Refer to Housestaff Policy 2008-2009 Policy and Procedures Manual(http://www.ttuhsc.edu/som/gme/forms/HousestaffPolicies2008-2009.pdf) for Probation and Appeals Process. A resident may be placed on probation at any time without first having been placed on observational status.

Restrictions and Requirements:Any or all of the following may be imposed in conjunction with or subsequent to a Notice of Deficiency (as detailed above)

- ❑ Structured tutoring program after an initial meeting with the Program Director/Residency Committee
- ❑ Remedial work for specific areas needing correction
- ❑ Probation for a finding of continued deficiency
- ❑ Review Course attendance.
- ❑ Suspension of CME and/or book funds and/or other privileges (i.e. stipend -- see Resident Benefits section for information on additional stipend)

*1.* The Program Director may suspend a resident, with or without pay, depending on the circumstances and at the discretion of the department.Refer to Housestaff Poli8cy and Procedures Policy (http://www.ttuhsc.edu/som/gme/forms/HousestaffPolicies2008-2009.pdf).

*2.* Non-renewal of contract may be instituted on the basis of lack of satisfactory improvement following probationary status at the discretion of the Residency Committee. Refer to Housestaff Policy 2008-2009 Policy and Procedures Manualfor Probation and Appeals Process.

3. Under Texas Medical Board Rules, Chapter 171, Section 171.6 (b), certain events involving residents, such as prolonged absences from the program, disciplinary action, suspension, or termination, are reportable to the Board (please see http://www.tmb.state.tx.us/rules/docs/Current Rules - 3-18-07.pdf)

IX. Miscellaneous Considerations Apropos Surgery Resident Responsibilities 2008-2009

Records

a. The PGY-I resident is responsible for completing a history and physical examination on all admissions. A handwritten admitting note must be on the chart on admission. A student history and physical examination does not substitute for the workup performed by the resident. For victims of multiple trauma, the admitting note must include a description of pertinent positive and negative physical finding, especially the neurologic and vascular exam. The senior trauma resident on call will complete a brief hand-written summary on admissions for all trauma patients.
b. Progress notes will be written daily by the PGY-I resident up to and including the day of discharge. The note should identify the hospital day (e.g. Hosp. day 2, SICU day 2, day 4, etc.) The senior resident should record progress notes PRN. All notes written by students and physician assistants must be countersigned by a resident.
c. The resident surgeon listed on the cover sheet is responsible for preoperative counseling of the patient and for obtaining an appropriate operative permit. A note to that effect must be recorded in the progress notes, in addition to the standard operation permit.
d. All surgical procedures, major or minor (e.g., cholecystectomy, CVP catheter insertion, venous cut down, proctoscopy, etc.) should be documented in the progress notes.
e. A preoperative note will be recorded in the progress notes prior to operation.
f. All post-operative patients will be seen within 4 hours of operation and a post-operative note will be documented in the medical record.
g. A written discharge notewill be recorded in the progress notes at discharge.
h. A provisional diagnosis should be recorded in the chart at the time the discharge order is written. The patient cannot be discharged without this provisional diagnosis.
i. All charts, including summaries, should be complete within 14 days of discharge. Charts are considered delinquent after 14 days. Discharge summaries must be completed within 3 days.
*j.* Admitting orders will be completed in full to include observation or admission status, diagnosis, attending physician, on call attending, resident(s) and service.
k. Patients transferred from one service to another or one ward to another require new orders and a transfer note. *All of the above information is required*.

Consultation

a. Requests for non-emergent surgical consultations between the hours of 8:00 am - 5:00 pm, Monday through Friday, will be telephoned into the Department of Surgery secretary at extension 5-6855 in the Medical School. Between the hours of 5:00 pm - 8:00 am weekends and holidays, consultations will be obtained by notifying the senior surgery resident on call in house (PGY II-IV only) through the hospital switchboard or the Department of Surgery answering service. Consultations must be seen on the day that they are received.

b. Attending physicians in the Department of Surgery will not accept direct consultations from other departments in the hospital. The Senior Surgical Resident will present the consult to attending surgical staff.
*c.* A copy of the consultation should be returned to Department of Surgery within 24 hours.
d. The surgical resident on call is notified on all emergency consultations.
e. Consultants:

| | |
|---|---|
| W. Miller | Plastic Surgery |
| R. Bucy | Oral maxillofacial |
| W. Rast | Oral maxillofacial |
| R. Santoscoy | Cardiothoracic/Vascular Surgery |
| M. Rhodes | ENT |
| D. Lacerte | Neurosurgery |
| F. Hanbali | Neurosurgery |
| L. Vasquez | Neurosurgery |
| D. Blumenfeld | Ophthalmology |
| C. Vasquez | Ophthalmology |

All mail, including call schedules and conference schedules, is distributed to the residents' mailboxes in room 261, located in the Department of Surgery/RAHC building.

Operating Room

i. The attending staff will be consulted on all cases considered for operation, day or night, prior to booking case.
ii. The first cases on Monday, Tuesday, Wednesday and Friday are scheduled to begin at 8:00 am and at 12:00 noon on Thursday. This means that the incision is made at 8:00 am and that it is necessary for the surgeons to be in the operating room no later than 7:40 am.
iii. Operation Reports will be dictated by the operating surgeon immediately following the procedure. The report is delinquent after 24 hours. Operating privileges will be suspended for delinquencies.

Written Prescriptions

a. New Texas State Board of Pharmacy Rules and Regulations RE Written Prescriptions: http://www.tsbp.state.tx.us/files_Word/Disp Dir1.doc

Students

a. Students will be oriented by the Clerkship Director at the beginning of the surgical rotation following this students will be oriented to the clinical service by the chief resident.
b. Cases to be worked up by the students should be assigned by the Chief Resident. They should be diversified in nature, and comprise to 3 to 5 patients per week.
c. The student's history and physical should be critically reviewed by the Chief Resident with the student and countersigned by the resident.
d. The students should accompany the resident on ward rounds as they pertain to the workups performed by the students.
**e.** Students should scrub on all patients they have worked up, and others PRN. However, the**students' presence in the OR will not take precedence over their required conferences and lectures.**
f. Students will be relieved from ward and/or operating room responsibilities to attend required conferences and lectures.

g. Students should be present 7:00 am - 5:00 pm except nights on call
h. Students will take call once a week.

Conferences - **Residents will attend all conferences.**

Clinics

a. All residents assigned to a clinic are expected to be in attendance promptly.
b. The Chief Resident assigned to the service should be consulted for each elective admission or surgical procedure scheduled from clinic.
*c.* An admission form, the brief history, and pre-op admission orders should be completed at the time of the clinic visit. *Make sure the attending staff signs the H & P so that patients are not delayed getting to the OR!*
d. See published schedule for specific clinic assignments.

Emergency Department

a. The surgical resident on call will respond to requests for consultation in the Emergency Department by telephone immediately and in person within 10-15 minutes, depending on the circumstances.
*b.* When a Level I or II trauma patient with major injuries arrives in the ED, the Trauma Team will be called automatically and will respond in person immediately. *(See Trauma Policy & Procedure Manual)*
c. No patient with a bona fide surgical emergency will be denied treatment or admission.

Resident Record of Procedures (ACGME Data Base)

a. These records will be updated on a monthly basis and submitted to Residency Coordinator to be placed in the resident's mentoring binder.

Patient Funding

a. All elective cases from the clinic should be reviewed for funding. Billing personnel attend general surgery and subspecialty clinics, and cases should be referred to them for funding review at that time.

Endoscopy

a. Only residents who have completed the GI rotation are allowed to perform GI Endoscopy.
b. All endoscopy (other than proctoscopy) must be scheduled with approval by the Attending Physician.

Pediatric Age Patients

a. In cases of suspected child abuse, the Pediatric Service Resident and Child Protective Services must be consulted.
b. Post-operative care of pediatric surgical cases is the responsibility of the surgical service, though the Pediatric Service will often co-manage.
c. Appendicitis in pediatric surgical patients under the age of 4years will be seen at the discretion of the general surgeon or referred to Pediatric Surgery.

d. All pediatric trauma patients age 12 years and younger require a pediatrics consult. *(See Trauma Policy and Procedures Manual)*

General

a. Decorum:

*iv.* A professional demeanor is expected of residents and students at all times. This includes appropriate dress, appearance, and comportment with attending staff, peers, nurses, patients, and patients' families. *A lack of professional demeanor will not be tolerated.*

v. Cases should not be discussed at the bedside in front of family members, in the hallways, in front of strangers, in the elevators, etc. Case discussions should be held in discrete venues.

b. Nursing:

1. Avoid verbal orders to nurse, if at all as possible. All verbal orders must be countersigned by the resident as soon as possible. Any member of the resident team can countersign verbal orders.
2. The Department is committed to a team approach to patient care. This involves physician, nurses, students, and ancillary personnel. Please include the nurses on your daily ward rounds, encourage their comments, and listen to what they have to say. If the support personnel feel they have a role to play and this role is appreciated by the physician, the ultimate result will be better patient care.

c. Sexual Harassment: **Such will not be tolerated** (Texas Tech University HSC OP 10.09)

d. Call Schedules

1. Call schedules are determined by the Administrative Resident and are submitted to the Program Coordinator by the 15th of each month for review by the Program Director. Please notify the Program Coordinator at least one month prior to the above date of any time needed off for exams, special conferences, etc. Should you have any questions regarding the call schedule, consult the Program Coordinator and/or the Administrative Resident. Should any revisions in the schedule be made, a revised schedule must be sent out as quickly as possible.
2. Coverage: The resident/intern on call is responsible to provide prompt coverage. If he/she must be in the clinic or operating room (such that he/she can't provide coverage), it is his/her responsibility to find alternate coverage and to inform the hospital operators of this. It is inappropriate to request or expect that others will arrange this alternate coverage.
3. Residents must check out patients for cross coverage at night.

e. Day off- TTUHSC Housestaff Policy

f. Beepers

1. Each resident is provided a pager by Thomason Hospital. The resident is responsible for his/her pager.

2. Test pages are conducted daily for the "code blue" and "trauma" pagers. When these occur, residents will respond immediately by calling the operator.

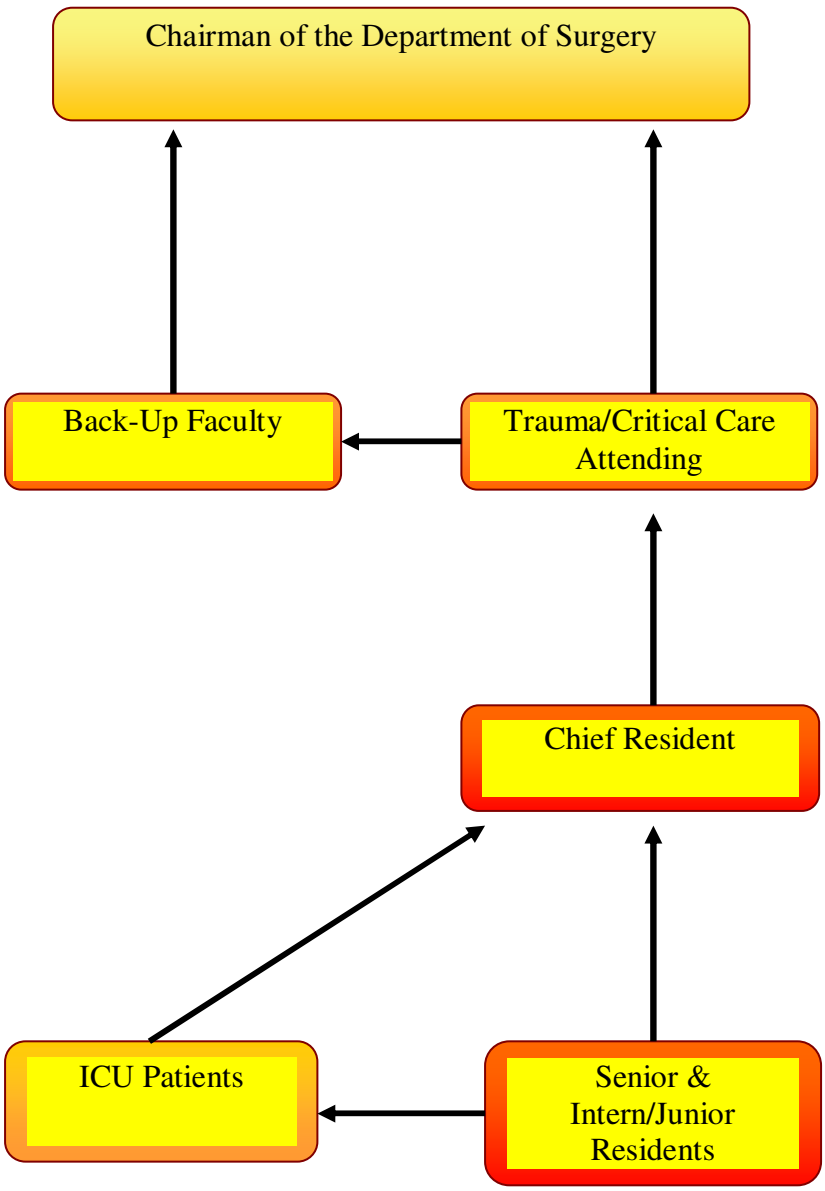
Patient Hand-off

As a result of the 80-hour work week, effective communication among residents is now more critical than ever. Post-call residents who must leave by noon should make certain that any outstanding patient issues or unfinished tasks are clearly communicated to other members of their team. Otherwise, routine patient hand-off will be accomplished on a daily basis during morning report.

Electives

There is a two month elective rotation in the PGY-IV year. Residents are responsible for the initial contacts for these electives. The resident is responsible for notifying the Program Coordinator of each rotation so that appropriate paperwork may be sent to the affiliated hospital. The Department may contribute money to offset expenses. It is to the resident's advantage to ***plan ahead*** for these.

Supervisory Lines of Responsibility
For Patients Care: ICU




- ICU team consisting of a senior resident and interns will care for all surgical patients in ICU with supervision from the critical care attending.

- Chief Residents/Critical Care faculty will oversee the senior ICU residents and have primary responsibility for their patients in the ICU.

- Whenever possible, including week-ends, chief residents will round with the ICU team.

- Any significant changes (intubations, extubations, complications, hemorrhage, ARF, etc.) in patient condition must be discussed with the chief resident/critical care faculty as appropriate.

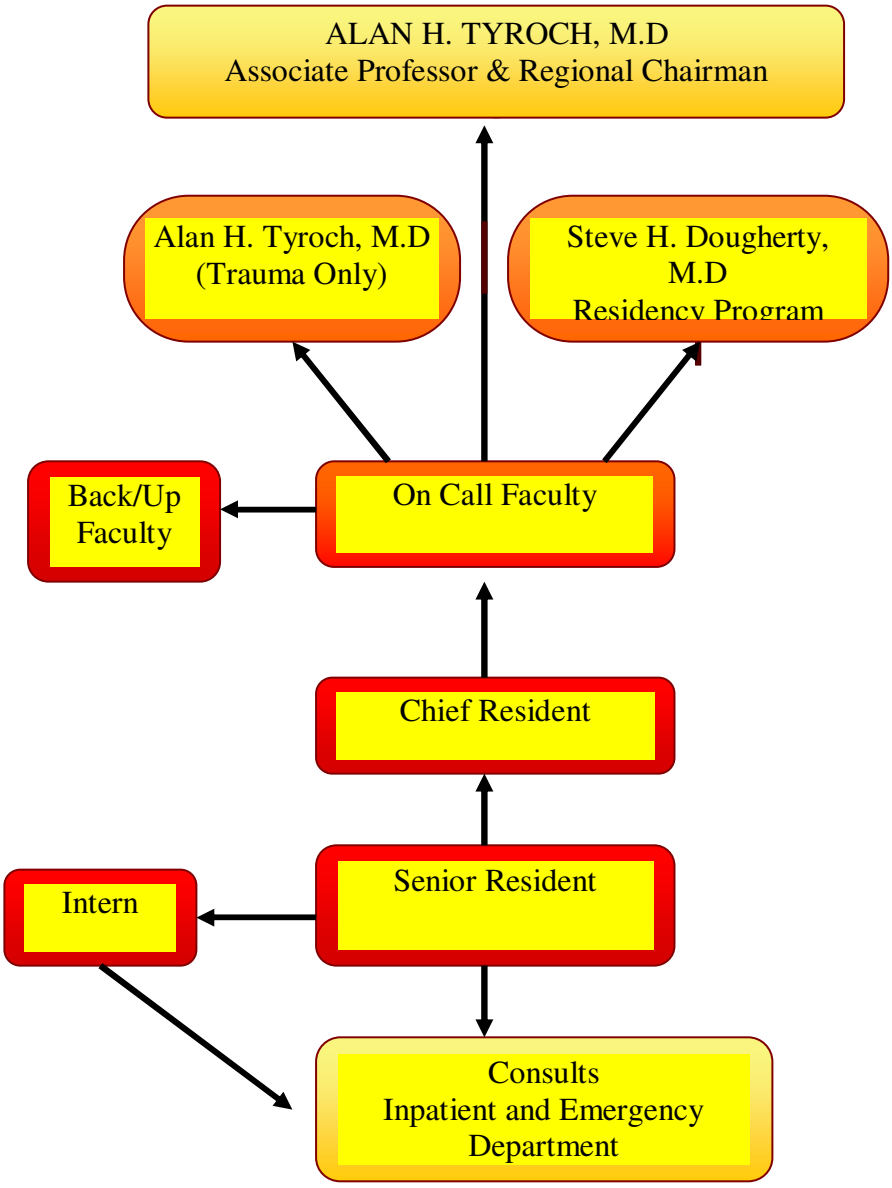
- Consults in the ICU will be seen by the senior residents and discussed with the chief resident and appropriate attending.

- Decisions to transfer patients to/from the ICU will be made with the Critical Care attending.

- Senior residents in the ICU will inform appropriate senor or chief resident about all patient transfers from the ICU.

- Information will be distributed to team members for continued patient care.

Supervisory Lines of Responsibility
For Patients Care: Consults and Admissions

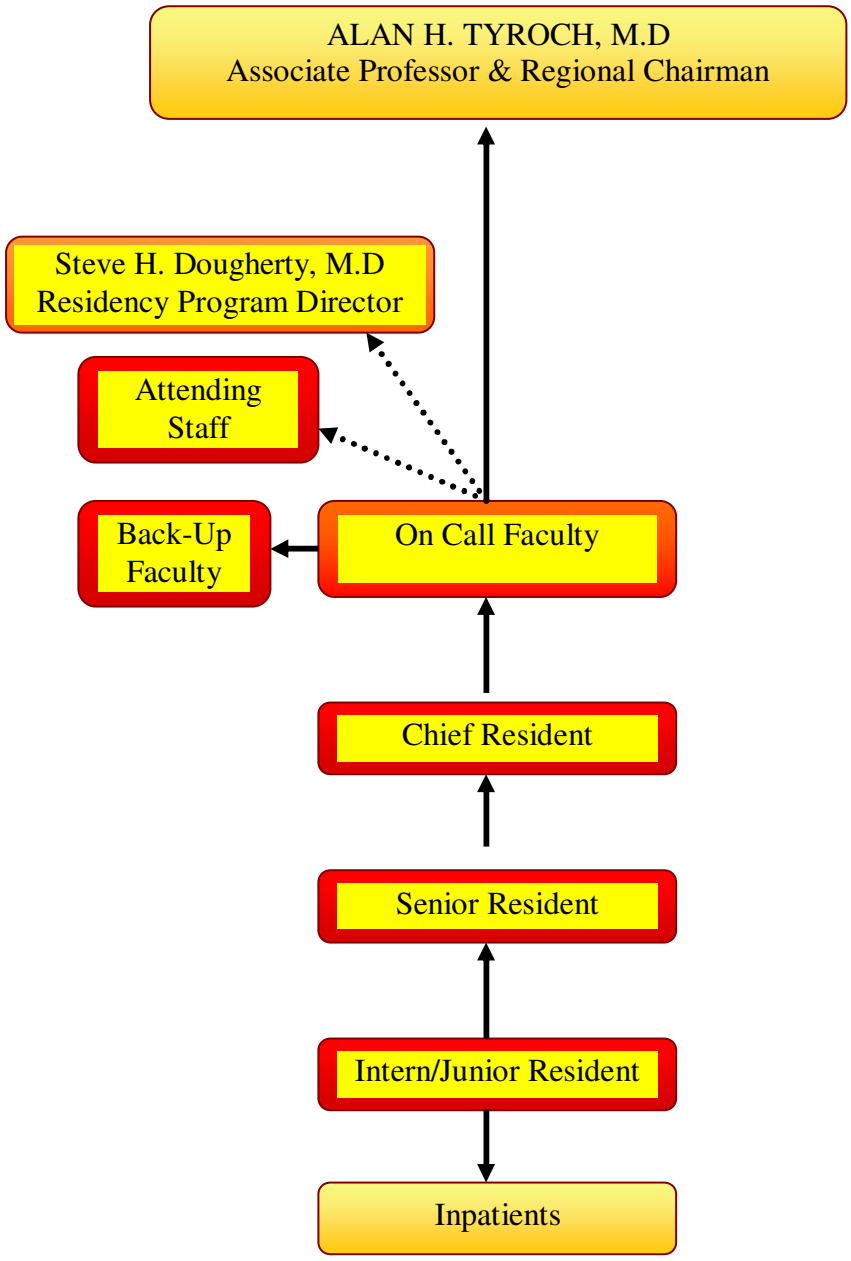



- All admissions and consults will be initially evaluated by senior (or chief) residents who will inform the chief resident about the patient.

- The residents will document a note in the medical record and discuss the case with the appropriate faculty member.

- Patients who require an operation require a pre-operative note by the resident who will perform the operation.

Supervisory Lines of Responsibility
For Patients Care: Inpatients




- Interns take primary floor call for all inpatients. They will discuss issues, questions and plans with senior resident on-call.

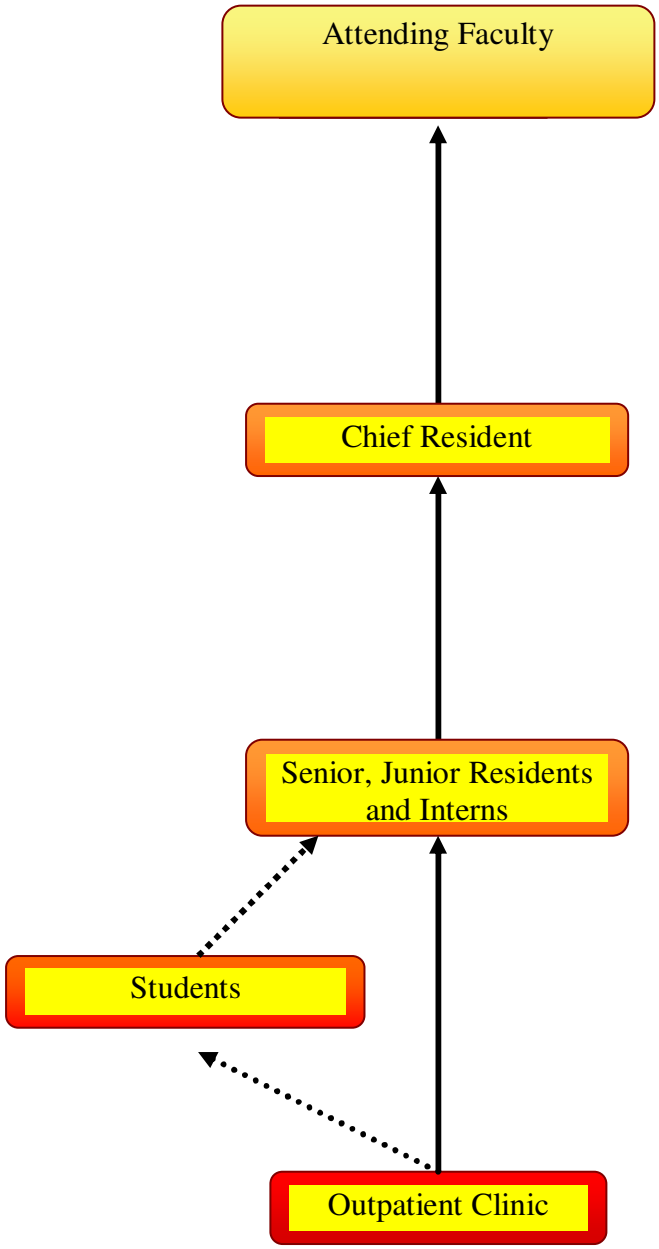
- If the senior is unavailable, then the residents will call the chief resident.

- Major changes in condition, emergent and urgent situations should be brought to the attention of the chief resident and on-call faculty attending immediately.

- Then on-call faculty will contact the patient's attending or back-up faculty as appropriate.

- Patients who require an operation require a pre-operative note by the resident who will perform the operation.

Supervisory Lines of Responsibility
For Patients Care: Outpatient Clinic




- All patients seen in clinic will be seen by faculty and residents.
- Residents will assess patients and discuss with faculty prior to disposition.
- Junior and senior residents will discuss all cases scheduled for the O.R with the chief residents.
- H & P, consents, pre-operative counseling will be completed by the resident planning to do the operation.
- Patients will be seen in the attending's clinic post-operatively and by the resident who performed the case, whenever possible.
- Patients who require operation require a pre-operative note by the resident who will perform the operation.
- Students will also see patients with the attendings as part of clinic. Residents will perform all duties for patients seen initially by students.