



TEXAS TECH UNIVERSITY  
HEALTH SCIENCES CENTER™  
Paul L. Foster School of Medicine

Department of Surgery

Resident Manual

# General Surgery Residency Program

## Resident Manual

- I Introduction
  - Structure of the Residency Program
  - A. Principles
  - B. Governance of the Residency Program
  - C. Rotations
  - D. Residents & Teaching Staff
  
- II Educational Goals and Resident Responsibilities
  - A. ACGME Competencies
  - B. Global Educational Goals
  - C. Educational Objectives
  - D. Resident Physician Responsibilities
  - E. Research Experience
  
- III.
  - A. Orientation to the Clinical Services
  - B. Educational Objectives for Each Rotation
  - C. Housestaff Resident Evaluation for Each Rotation
  - D. Resident Evaluation of Faculty
  - E. Resident Program Survey and Evaluation of Each Rotation
  
- IV. The Educational Program of the Residency
  - A. Surgical Science Curriculum
  - B. Journal Club
  - C. Mock Orals
  - D. ABSITE
  - E. SESAP
  
- V. Resident Benefits
  - A. Vacation
  - B. Holiday Schedule
  - C. Sick Leave
  - D. Educational Opportunities
  - E. Drug Enforcement Administration Fees
  - F. Malpractice Coverage
  - G. Group Health Insurance
  - H. Worker's Compensation
  - I. Sleeping Quarters
  - J. Meals
  - K. Uniforms
  - L. Cellular Phones
  - M. Pagers
  - N. Immunizations
  - O. Counseling Services
  - P. Financial benefits
  - Q. Salaries
  - R. Moonlighting

- VI. Resident
- VII. Operative Case Logs: ACGME
- VIII. Resident Evaluation and Advancement
  - A. Advancement, Notices of Deficiency and Probation
  - B. Non Renewal of contract
- IX. Specific Surgery Resident Responsibilities
- X. General Competencies
- XI. Supervisory Lines of Responsibility
  - A. Patient Care: ICU
  - B. Patient Care: Consults and Admissions
  - C. Patient Care: Inpatients
  - D. Patient Care: Outpatient Clinic

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](http://www.acgme.org/acWebsite/downloads/RRC_progReq/440pr1105.pdf)

Graduate Medical Education

<http://www.ttuhschool.edu/fostersom/gme/>

POLICIES:

[http://www.ttuhschool.edu/fostersom/gme/policies\\_procedures.aspx](http://www.ttuhschool.edu/fostersom/gme/policies_procedures.aspx)

RESIDENT CONTRACT:

[http://www.ttuhschool.edu/fostersom/gme/documents/GME\\_Contract\\_Agreement\\_2012-2013.pdf](http://www.ttuhschool.edu/fostersom/gme/documents/GME_Contract_Agreement_2012-2013.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 Director is 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.



**GENERAL SURGERY DEPARTMENT  
FACULTY DIRECTORY**

General Surgery		
Name	Title	Office
Alan H. Tyroch, MD <a href="mailto:Alan.tyroch@ttuhsc.edu">Alan.tyroch@ttuhsc.edu</a>	Chair and Professor Trauma Medical Director	915-545-6872
Steve H. Dougherty, MD <a href="mailto:Steve.dougherty@ttuhsc.edu">Steve.dougherty@ttuhsc.edu</a>	Professor Resident Program Director Clinical Medical Director	915-545-6855
Brian R. Davis, MD <a href="mailto:Br.davis@ttuhsc.edu">Br.davis@ttuhsc.edu</a>	Assistant Professor Assoc. Program Director	914-545-6855
Susan F. McLean, MD <a href="mailto:Susan.mclean@ttuhsc.edu">Susan.mclean@ttuhsc.edu</a>	Associate Professor ICU Director Assoc. Clerkship Director	915-545-6872
Angel M. Morales, MD <a href="mailto:Angel.morales@ttuhsc.edu">Angel.morales@ttuhsc.edu</a>	Assistant Professor Clerkship Director	915-545-6855
Ryan R. Freemyer, MD <a href="mailto:Ryan.freemyer@ttuhsc.edu">Ryan.freemyer@ttuhsc.edu</a>	Clinical Assistant Professor	915-545-6872
Victor Olivas, MD <a href="mailto:Victor.olivas@ttuhsc.edu">Victor.olivas@ttuhsc.edu</a>	Instructor	915-545-6855

Pediatric Surgery		Office
Donald E. Meier, MD <a href="mailto:Donald.meier@ttuhsc.edu">Donald.meier@ttuhsc.edu</a>	Professor Clinical	915-545-6855
William Spurbeck, MD <a href="mailto:William.spurbeck@ttuhsc.edu">William.spurbeck@ttuhsc.edu</a>	Assistant Professor	915-546-2656

Plastic Surgery		Office
William T. Miller, MD <a href="mailto:William.miller@ttuhsc.edu">William.miller@ttuhsc.edu</a>	Assoc. Professor Clinical	915-545-6855
Francisco Agullo, MD <a href="mailto:Frank.agullo@ttuhsc.edu">Frank.agullo@ttuhsc.edu</a>	Clinical Assistant Professor	915-545-6855
Humberto Palladino, MD <a href="mailto:Humberto.palladino@ttuhsc.edu">Humberto.palladino@ttuhsc.edu</a>	Clinical Assistant Professor	915-545-6855
Benjamin Burt, MD <a href="mailto:Benjamin.burt@ttuhsc.edu">Benjamin.burt@ttuhsc.edu</a>	Assistant Professor Director Oculoplastics	915-545-0450

ENT		Office
Miller F. Rhodes, MD <a href="mailto:Miller.rhodes@ttuhsc.edu">Miller.rhodes@ttuhsc.edu</a>	Clinical Assistant Professor	915-545-6855
Brian Reynolds, PhD.	Audiologist	915-545-6855

OMFS		Office
Trent Filler, DDS <a href="mailto:Trent.filler@ttuhsc.edu">Trent.filler@ttuhsc.edu</a>	Assistant Professor	915-545-6888

BREAST		Office
Edward Saltzstein, MD <a href="mailto:Edward.saltzstein@ttuhsc.edu">Edward.saltzstein@ttuhsc.edu</a>	Assistant Professor	915-545-6888

**GENERAL SURGERY DEPARTMENT  
RESIDENT DIRECTORY**

General Surgery		
Name	PGY-Level	Office
<i>Soumo Banerji, MD</i> <a href="mailto:s.banerji@ttuhsc.edu">s.banerji@ttuhsc.edu</a>	PGY-5 Chief Resident	915-545-6906
<i>Gino Castaneda, MD</i> <a href="mailto:Gino.castaneda@ttuhsc.edu">Gino.castaneda@ttuhsc.edu</a>	PGY-5 Chief Resident	915-545-6906
<i>Carrie Dieker, MD</i> <a href="mailto:Carrie.a.dieker@ttuhsc.edu">Carrie.a.dieker@ttuhsc.edu</a>	PGY-5 Chief Resident	915-545-6906
<i>Ziad Kronfol, MD</i> <a href="mailto:Ziad.kronfol@ttuhsc.edu">Ziad.kronfol@ttuhsc.edu</a>	PGY-4	915-545-6906
<i>Kinzie Matlock, MD</i> <a href="mailto:Kinzie.matlock@ttuhsc.edu">Kinzie.matlock@ttuhsc.edu</a>	PGY-4	915-545-6906
<i>Victor Phuoc, MD</i> <a href="mailto:Victor.phuoc.@ttuhsc.edu">Victor.phuoc.@ttuhsc.edu</a>	PGY-4	915-545-6906
<i>Luis Lee, MD</i> <a href="mailto:Luis.lee@ttuhsc.edu">Luis.lee@ttuhsc.edu</a>	PGY-3	915-545-6906
Jody Smith, MD <a href="mailto:Jody.smith@ttuhsc.edu">Jody.smith@ttuhsc.edu</a>	PGY-3	915-545-6906
	PGY-3	915-545-6906
<i>Nathaniel Ng, MD</i> <a href="mailto:Nathaniel.ng@ttuhsc.edu">Nathaniel.ng@ttuhsc.edu</a>	PGY-2	915-545-6906
<i>Henry Reinhart, MD</i> <a href="mailto:Henry.reinhart@ttuhsc.edu">Henry.reinhart@ttuhsc.edu</a>	PGY-2	915-545-6906
<i>Alex Rios-Tovar, MD</i> <a href="mailto:Alex.rios-tovar@ttuhsc.edu">Alex.rios-tovar@ttuhsc.edu</a>	PGY-2	915-545-6906
<i>Mohamed El Zaeedi, MD</i> <a href="mailto:Mohamed.el-zaeedi@ttuhsc.edu">Mohamed.el-zaeedi@ttuhsc.edu</a>	PGY-1	915-545-6906
<i>Azam.Farukhi, MD</i> <a href="mailto:Azam.farukhi@ttuhsc.edu">Azam.farukhi@ttuhsc.edu</a>	PGY-1	915-545-6906
<i>Yuichi Ishida, MD</i> <a href="mailto:Yuichi.ishida@ttuhsc.edu">Yuichi.ishida@ttuhsc.edu</a>	PGY-1	915-545-6906
<i>Rahul Rasheed, DO</i> <a href="mailto:Rahul.rasheed@ttuhsc.edu">Rahul.rasheed@ttuhsc.edu</a>	PGY-1	915-545-6906
<i>Feras Yamin, MD</i> <a href="mailto:Feras.yamin@ttuhsc.edu">Feras.yamin@ttuhsc.edu</a>	PGY-1	915-545-6906
<i>Tristan Zhang, MD</i> <a href="mailto:Tristan.zhang@ttuhsc.edu">Tristan.zhang@ttuhsc.edu</a>	PGY-1	915-545-6906

## 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 result 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 health care 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 to execute 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.ttuhschool.edu/fostersom/surgery/documents/Resident\\_Manual\\_2012-2013.pdf](http://www.ttuhschool.edu/fostersom/surgery/documents/Resident_Manual_2012-2013.pdf)

FOR AN OUTLINE OF RESIDENT EDUCATIONAL GOALS & OBJECTIVES

[http://www.ttuhschool.edu/fostersom/surgery/documents/Educational\\_Goals\\_Objectives.pdf](http://www.ttuhschool.edu/fostersom/surgery/documents/Educational_Goals_Objectives.pdf)

D. RESIDENT PHYSICIAN 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 be 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."

<u>A Team Faculty</u>	_____	<u>B Team Faculty</u>
Dougherty		Tyroch
Davis		McLean
Filler		Morales
Malave		Meier
Marcontoni		Olivas

<u>General Surgery</u>	_____	<u>General Surgery</u>
CT Vascular		ENT
		Plastics
		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
Morales (Colon & Rectal Surgery)  1 p.m – 5 p.m.	Davis 8 a.m. – 12 p.m.	Olivas 8 a.m.		
Tyroch 1:00 -4 p.m.	Dougherty 1 p.m.-5p.m.	Meier (Peds) 8 am-12:00 p.m.		
		McLean 1 p.m. - 5 p.m.		



BREAST CLINIC SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
Saltzstein/Schabacker 1:30 p.m.	Saltzstein/Schabacker 1:30 p.m.			

ENT CLINIC SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
	Rhodes 9:00 am		Rhodes 8:00 am	
			Rhodes 1:00 p.m.	

PLASTIC SURGERY/MINOR SURGERY CLINIC SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
			Miller Agullo 8 am	Miller 9:00 am
			Miller Palladino 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.

Education Goals and Objectives for the General Surgery  
Residency Program  
**THE SIX CORE COMPETENCIES IN GENERAL  
SURGERY**

[http://wip.ttuhschool.edu/fostersom/surgery/documents/Educ\\_Goals\\_Object.pdf](http://wip.ttuhschool.edu/fostersom/surgery/documents/Educ_Goals_Object.pdf)

**Texas Tech University Health Sciences Center – El Paso Surgical Residency Program**  
**Housestaff Evaluation Form (PGY I-V)**

Resident:

Rotation:

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
	1	2	3	4	5	6
Basic medical knowledge						
Able to synthesize & apply information						
Able to formulate a logical differential diagnosis and develop an appropriate plan						

**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.

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

**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.

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

**PROFESSIONALISM/ETHICS:**

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

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

**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.

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

**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.

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

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

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

*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 electronic evaluation 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 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 e-mail to complete evaluation, please complete in a timely fashion. ***When an evaluator is completing an anonymous evaluation, it will be clearly marked as an "Anonymous Evaluation."***

When reviewing anonymous evaluation reports, the following information is masked from the user and all administrators:

1. evaluator's name
2. date the evaluation was completed
3. period of the rotation

# **MyEvaluations.com**

<https://www.myevaluations.com/Logon.asp>

**ANONYMOUS/CONFIDENTIAL**

Scale Used In Responding To the Questions:

- 0 – No Interaction
- 1 – Unsatisfactory
- 2 – Marginal
- 3 – Average
- 4 – Good
- 5 – Outstanding

## E. EVALUATION OF THE RESIDENCY PROGRAM

Residents are required to complete electronic evaluation of 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.

Responses will remain confidential. *When an evaluator is completing an anonymous evaluation, it will be clearly marked as an "Anonymous Evaluation."*

When reviewing anonymous evaluation reports, the following information is masked from the user and all administrators:

1. evaluator's name
2. date the evaluation was completed
3. period of the rotation

# **MyEvaluations.com**

<https://www.myevaluations.com/Logon.asp>

**ANONYMOUS/CONFIDENTIAL**

Scale Used In Responding To the Questions:

- 0 – No Interaction
- 1 – Unsatisfactory
- 2 – Marginal
- 3 – Average
- 4 – Good
- 5 – Outstanding



**ANONYMOUS/CONFIDENTIAL**

Texas Tech University Health Sciences Center – El Paso  
GENERAL SURGERY DEPARTMENT

**RESIDENT PROGRAM SURVEY**

**Scale Used 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 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**

**5 4 3 2 1**

- |  |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Provides adequate oversight to the administration of the residency  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Obtains adequate input from the residents before making important decisions   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Communicates all important residency issues to me   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Is available to discuss issues with me  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Is even-handed and fair in making decisions about the residency   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Supports the residents' educational environment in my rotations   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Positively addresses lifestyle issues (i.e. work hours, stress, working conditions, etc.) of concern to the residents | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Establishes goals and objectives of the residency and encourages appropriate resident achievement                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Adequately addresses "problem areas" in the residency   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:

**B. PROGRAM COORDINATOR**

**5 4 3 2 1**

- |  |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Provides adequate oversight to the residency office                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Understands the organization and function of the residency program      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Is available to handle my needs as they relate to the residency program | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Deals with residency needs in a timely fashion                          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Communicates pertinent issues to me appropriately                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Is pleasant and represents the residency well                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:

**C. DIDACTIC SESSIONS****5 4 3 2 1**

- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Adequately covers pertinent surgical information to help prepare me for a surgical practice and the Boards | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. The format is effective  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. The attending involvement is appropriate   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Didactic evaluation (ABSITE, quizzes, mini in-service) is adequate.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:

**D. M & M CONFERENCE****5 4 3 2 1**

- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Adequately covers pertinent surgical information to help prepare me for a surgical practice and the Boards | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. The format is effective  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. The attending involvement is appropriate   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:

**E. TRAUMA GRAND ROUNDS****5 4 3 2 1**

- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Adequately covers pertinent surgical information to help prepare me for a surgical practice and the Boards | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. The format is effective  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. The attending involvement is appropriate   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:

**F. EVALUATION OF INDIVIDUAL ROTATING: EVALUATION PROCESS****5 4 3 2 1**

- |  |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. The evaluation of my performance on the clinical rotation is fair and adequately characterizes my abilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. The rotation evaluation form is an effective and appropriate evaluation                                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. I receive adequate feedback from my attending during the rotations  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. I receive adequate feedback on my performance from the mentor   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. The rotation provides the appropriate educational needs and operative experience.                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:

Texas Tech University Health Sciences Center – El Paso  
GENERAL SURGERY DEPARTMENT

**RESIDENT EVALUATION OF ROTATION**

**SCORING:**

5 = OUTSTANDING    4 = ABOVE AVERAGE    3 = AVERAGE    2 = MARGINAL    1 = POOR

	ICU					Anesthesia					Cardiovascular				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
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?															

	General Surgery A					Transplant					Colorectal				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
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?															

	General Surgery B					Pedi-Surgery					Surgery Oncology				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
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?															

## IV. THE EDUCATIONAL PROGRAM OF THE RESIDENCY

### 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 quarterly 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

Surgery Trauma Grand Rounds, Perioperative Grand Rounds, and Dean's 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/University Medical Center 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 William Beaumont Army Medical 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 1 and for the remaining six months, by March 1<sup>st</sup>. 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<sup>th</sup>) by using vacation time and/or administrative leave, otherwise they are expected to end the program by June 25<sup>th</sup>. 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.ttuhscc.edu/hr/documents/Holiday\\_Schedule\\_2012\\_2013.pdf](http://www.ttuhscc.edu/hr/documents/Holiday_Schedule_2012_2013.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 University Medical Center 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 phones** allowance will be provided to chief residents only.

**L. Pagers** are provided by University Medical Center.

**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://www.ttuhs.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 University Medical Center is provided for house staff.

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

	<u>ANNUAL</u>	<u>MONTHLY</u>
PGY 1	\$45,037.00	\$3,753.08
PGY 2	\$46,508.00	\$3,875.66
PGY 3	\$47,975.00	\$3,997.91
PGY 4	\$49,443.00	\$4,120.25
PGY 5	\$50,911.00	\$4,242.58

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

## 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 (1 month).

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 cases (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 placed, 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](http://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 RESPONSIBILITIES

##### CHIEF 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](http://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<sup>th</sup> 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 primarily tests 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<sup>th</sup> 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 and Procedures Manual <http://www.ttuhschool.edu/fostersom/gme/policies.aspx> 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 Policy and Procedures Policy <http://www.ttuhschool.edu/fostersom/gme/policies.aspx>
  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 and Procedures Manual for 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

### 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 findings, 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 note will 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 M.	Cardiothoracic/Vascular Surgery
Rhodes	ENT
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/HSC 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](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 4 years 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 15<sup>th</sup> 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 cannot 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 University Medical Center. 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.

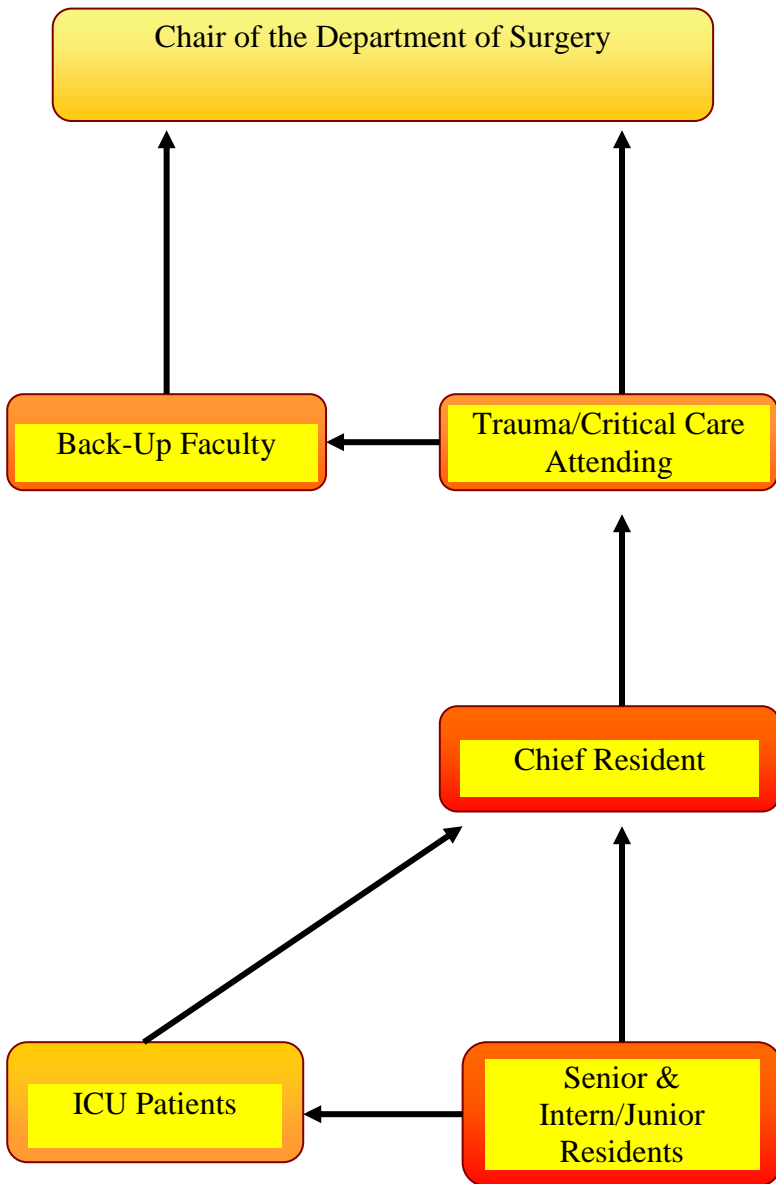
#### Patient Hand-off

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 weekends, 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.

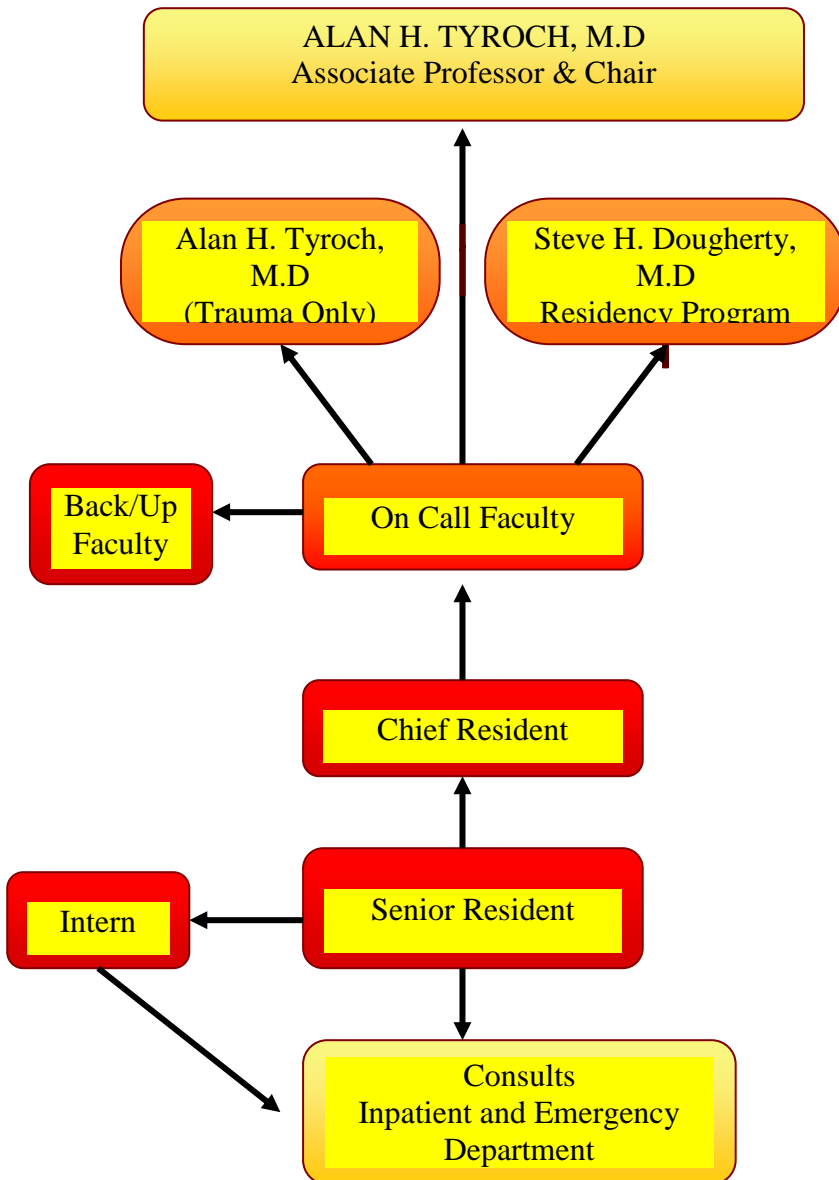
- Consults in the ICU will be seen by the senior residents and discussed with the chief resident and appropriate attending.

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

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

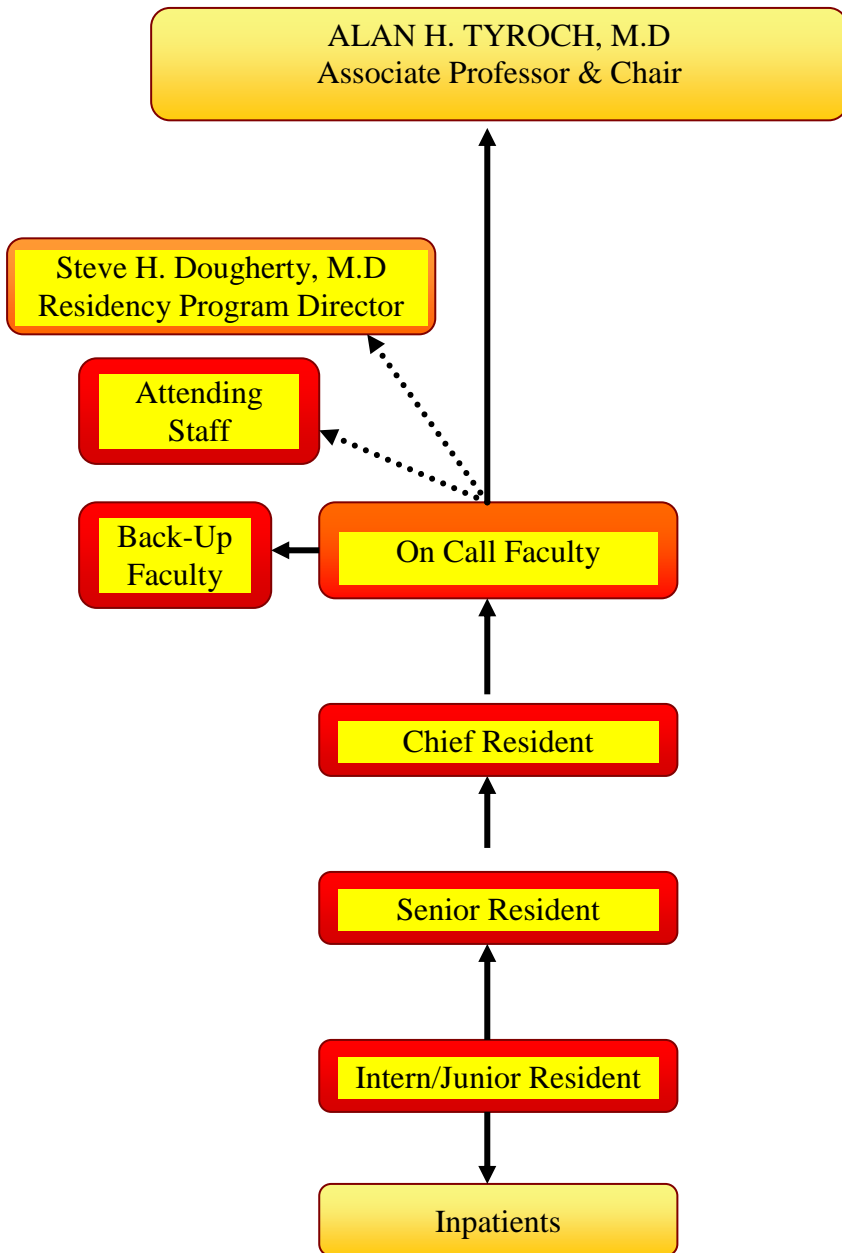
- Information will be distributed to team members for continued patient care.

Supervisory Lines of Responsibility  
For Patients Care: Consults and Admissions



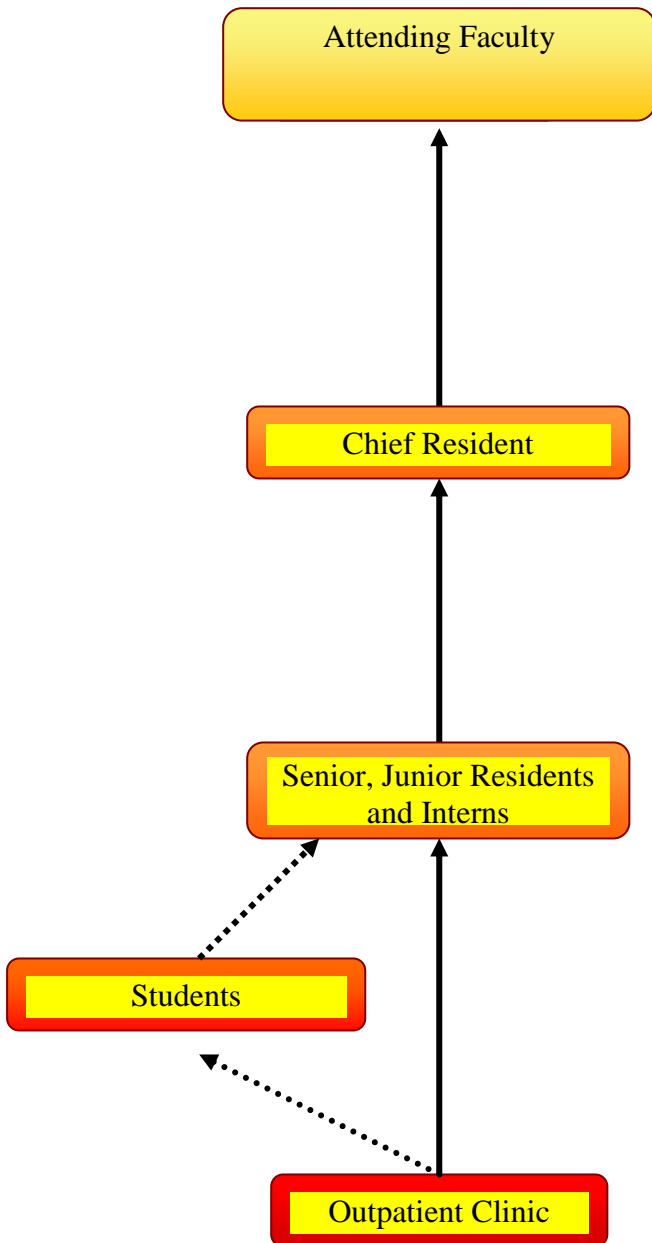
- All admissions and consults will be initially evaluated by senior (or chief) residents who will inform the chief resident about the patient.
- The residents will document a note in the medical record and discuss the case with the appropriate faculty member.
- Patients who require an operation require 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.