



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
EL PASO

Paul L. Foster School of Medicine
Department of Surgery

GENERAL SURGERY RESIDENCY

PROGRAM HANDBOOK

2021-2022



Revision date: February 10, 2022

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Vision/Mission Statement and General Information

VISION STATEMENT:

Nationally recognized and regionally trusted; advancing surgical science and technique. Bringing tomorrow's surgical care to today.

MISSION STATEMENT:

To deliver the most compassionate, highest quality and scientifically proven surgical care to the El Paso region and to advance the field of surgery through research and education of future surgeons and physicians.

The philosophy in the department of surgery is to provide the highest level of service and care to our community as physicians committed to exceptional education and mentoring of the next generation of surgeons. In line with the Texas Tech University Health Sciences Center El Paso (TTUHSC EP) mission statement, the department of surgery's residents are expected to strive to improve the lives of this community. This borderland area has unique health care needs which require knowledge of health care issues currently affecting the community. For example, health disparities are a major issue in the United States. According to the Centers for Disease Control and Prevention, "Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations." These disparities may be the result of poverty, access to care, etc. In order to combat these disparities, the department promotes "best practices" in surgery.

TTUHSC EP has served the El Paso, Texas and Juarez, Mexico communities as an approved ACGME resident training site for over thirty years. From the inception of Thomason Hospital through the transition to University Medical Center of El Paso, this institution has prided itself on training exemplary surgeons throughout the community as well as graduates that have pursued excellent subspecialty training.

Dr. Edward Saltzstein was the chairman through 2002 followed by the current tenure of Alan H. Tyroch, M.D. who became the founding chairman of Surgery at the TTUHSC EP, Paul L. Foster School of Medicine in 2009.

University Medical Center of El Paso first became a Trauma Level 1 certified center in 2005 and serves as the regional trauma center for West Texas and Southern New Mexico. Significant admissions also occur from our sister city Juarez, Mexico. The modernized ICU care is considered the best in the city with 30 private ICU beds including both separate pediatric and cardiac critical care units. The expansion of the emergency department serves as the highest volume provider of outpatient urgent, emergency and trauma care in our region.

Dedication to student didactics has proven rewarding for residents and faculty who experience an exceptional quality of interaction with many students who matriculate into surgical residencies throughout the country. In 2010, the addition to the surgical education includes a simulation laboratory with laparoscopic towers.

Scholarly activity such as research is a large contributing factor within the academic resident development. This supports residents with post-residency endeavors such as fellowship specialty training or private practice. Dr. Tyroch has championed the National Trauma Practitioner Databank for studies on adrenal insufficiency and seatbelt sign outcomes. Dr. McLean has proven to be an academic leader in the field of abdominal compartment syndrome and abdominal wall closure, and Dr. Davis has accompanied several residents to national conferences for poster presentations.

Surgical oncology has been a strong component of training in elective general surgery. Hepatobiliary cases is a strong focus of Dr. Davis with a multidisciplinary approach with surgeon directed ERCP therapy followed by surgical resection of pancreatic, biliary and hepatic tumors.

For additional information about:

Surgery residencies in general, see the RRC program requirements online at:
<https://www.acgme.org/specialties/surgery/program-requirements-and-faqs-and-applications/>

Graduate Medical Education:

<http://elpaso.ttuhs.edu/som/gme/>

Policies:

https://elpaso.ttuhs.edu/som/gme/policies_procedures.aspx

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Resident Block Schedule 2021-2022

Texas Tech University Health Sciences Center - General Surgery Residency Program

BLOCK DIAGRAM

	1	2	3	4	5	6	7	8	9	10	11	12
PGY-5 Block												
Institution	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1
Rotation Name	Team A	Consults	Team B	Team A	Consults	Team B	Team A	Consults	Team B	Team A	Team B	Consults
% Outpatient	30	10	30	30	10	30	30	10	30	30	10	10
% Research	5	5	5	5	5	5	5	5	5	5	5	5
PGY-4 Block												
Institution	Site 8	Site 8	Site 5,8	Sites 5,8	Site 6	Site 6	Site 3,8	Site 1,7	Site 1,7	Site 8	Site 1	Site 1
Rotation Name	Surg Onc	Surg Onc	Colorectal	Colorectal	CardioTho	Transplant	Pediatric Surgery	Vascular	Vascular	Bariatric	Colorectal/Endoscopy	Team A or B
% Outpatient	20	20	20	20	10	10	10	30	10	10	10	30
% Research	5	5	5	5	5	5	1	5	5	5	5	5
PGY-3 Block												
Institution	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1
Rotation Name	Team A	ICU	Team B	Team A	Night Float	Team B	Team A	ICU	Night Float	Consults	Consults	Team B
% Outpatient	30	0	30	30	0	30	30	0	0	0	0	30
% Research	5	5	5	5	5	5	5	5	5	5	5	5
PGY-2 Block												
Institution	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1
Rotation Name	Team A	ICU	Team B	Team A	Night Float	Team B	Team A	ICU	Night Float	Consults	Consults	Team B
% Outpatient	40	20	20	20	0	20	30	20	0	0	0	0
% Research	5	5	5	5	5	5	5	5	5	5	5	5
PGY-1 Block												
Institution	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1
Rotation Name	ICU	Team A	Team B	ICU	Night Float	ICU	Team A	ICU	Night Float	Team A	Team A	Team B
% Outpatient	0	40	40	0	0	0	40	0	0	40	40	40
% Research	5	5	5	5	5	5	5	5	5	5	5	5

Rotation Name	Site	Possible Electives	Site
Breast	1	Bariatric Surgery	8
CardioThoracic	6	Pediatric Surgery	3,8
Colorectal/Endoscopy	1	Plastic Surgery	1
Colorectal	5,8		
Consults	1		
GenSurg Team A or B	1		
GI Endoscopy	1		
ICU	1		
Night Float	1		
Oncology	4		
Pediatric Surgery	3,8		
Surgical Oncology	8		
Transplant	6		
Vascular	1,7		

Vacation Allocation:

- Residents will take vacation only during the months when assigned to their home clinical service (excludes PGY-4s).
- PGY-4's who take vacation during an outside rotation must obtain approval from the director of their current rotation and inform the residency program director.
- No vacation will be granted during Block 1 and 12, due to high volume of resident turnover in June/July, special circumstances will be reviewed and considered by the Program Director.
- No vacation will be granted during block 7, due to ABSITE, special circumstances will be considered and reviewed by the Program Director.

Revision Date: 2022 Feb 08

Site	Institution	Clarifications:
1	University Medical Center of El Paso (UMC EP)	General Surg Team A - all of general surgery, oncology, and plastic surgery cases. General Surg Team B - Trauma, endocrine, and colorectal Chief resident takes consults during their consult month while the teams round on patients, then the chief will be discharged and round on patients at the end of the day. Pediatric Surgery is both a required and elective rotation.
2	Texas Tech University Health Sciences Center	
3	El Paso Children's Hospital	
4	El Paso Day Surgery	
5	Foundations Surgical Hospital	
6	University of Texas Southwestern Medical Center	
7	Midland Memorial Hospital	
8	Hospitals of Providence (THOP) - Memorial	

Program Director and Associate Program Director Roles

Program Director

The program director is appointed by the chair of surgery for a period of at least six years and by ACGME requirements be at least five years in practice since completing residency or fellowship. The program director will be a full-time faculty member practicing at the integrated institutions of the residency program. The program director must also 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 the official Goals and Objectives documentation of the program with respect to knowledge, skills, and other attributes of the residents at each level of training.
2. 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.
3. With the teaching faculty, select residents for appointment to the training program.
4. Develop a schedule of resident assignments to fulfill educational needs of each resident throughout the duration of the training program.
5. 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.
6. Implement a fair but comprehensive competency evaluation system to include MILESTONE evaluations 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.
7. 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.
8. 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.
9. 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 Clinical Competency Committee meetings.
10. 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.

ASSOCIATE PROGRAM DIRECTOR(S)

The associate program director(s) are put in place to parcel creative diversity in leadership to the program director (PD). Additionally, they will provide input into the overall direction of the operational aspects of the program. Specific duties include:

1. Form part of the Clinical Competency Committee (CCC) and/or the Program Evaluation Committee (PEC).
2. Assist in the maintenance of the liaison between the program and the RRC.
3. Act in an advisory capacity for issues concerning the program and the school.
4. Knowledge of personnel and human resources issues.
5. Act as a liaison with regards to employment, discipline, and healthcare to the residents.

Structure of the Residency Program

A. Resident Physician Responsibilities

Residents in all training programs at TTUHSC EP 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 ACGME. Competencies can be accessed: [ACGME Competencies](#).
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 didactic 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!

B. 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.

C. 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 **Associate Program Directors** are assigned to simulation training development of the didactic curriculum of the residency. The associate program directors serve as members of the Clinical Competency Committee that advises the program director on the MILESTONE evaluation system and the progression of residents toward competency. The associate director for simulation directs simulation training curricula and advocates for improved simulation resources throughout the year. The associate director for didactics works with the chief residents to develop a structured didactic curriculum to include routine testing in preparation for the ABSITE exam as well as integration of the Decker curriculum into resident education.

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 program coordinator will manage and coordinate the applicant resident interview season, documentation of evaluations, management and credentialing all away rotations, and be able to provide reports, summaries, and reviews of all training program activities.

The **Clinical Competency Committee (CCC)** consists of the associate and/or assistant program directors, core faculty members, and the program coordinator. This group is chaired by the associate program director who directs measurements of MILESTONE evaluations. This group meets monthly regularly to oversee the direction and management of the Residency Program. The Clinical Competency Committee also serves as the grievance committee for any resident issues that require resolution. Anonymous grievances or suggestions to improve the program will be reviewed by the CCC whether by suggestion box or by web portal submission on a monthly basis. The CCC also meets to determine resident probationary status and remediation requirements in all resident disciplinary matters.

The **Annual Program Evaluation Committee (PEC)** is composed of members of the clinical competency committee to include chief residents and one representative from each PGY level and meets on a monthly basis to evaluate the educational goals and objectives of the program. The Annual Program Evaluation Committee approves annual submitted reports and conducts the self-study for the Next Accreditation System. This committee reports directly to the chair as to plans for residency expansion and new rotation or objectives for education.

The **Resident Selection Committee** is composed of all faculty engaged in resident interviews. This committee meets briefly after all applicant interview dates to rank candidates and meets in February prior to rank list submission to determine resident selection and ranking. All rankings are made

democratically at the final meeting for submission to the National Residency Matching Program web portal.

D. Research

The Department does not offer a dedicated research rotation however; there is protected research time during weekly resident conference for research activity. We deal with an extensive array of clinical problems that can form the basis of interesting research and publication. The research coordinator is available to facilitate all research projects. The faculty support resident participation in basic and/or clinical research with ongoing or new research studies.

Residents are strongly encouraged to author or co-author at least one publication, presentation, or published abstract during their five years of training. The department financially supports external presentations. Residents are required to present their research during the bi-annual department research evaluation day, which allows the resident to receive constructive feedback from faculty. Top three resident presentations will receive an award. There are two research related presentation to encourage resident research interests, mentorship from faculty and promotes research dialogue. Committee involvement in relation to quality improvement presentations can supplant required research presentations. Research presentations are evaluated and used to measure systems-based practice and problem based learning competencies for milestone evaluations.

Structure of the Educational Program

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. There should be no excuse for being unprepared. In general, assigned faculty will lecture from high yield topics from the Decker educational platform. 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. Journal Club

Journal Club will be held monthly as part of the Thursday conference. Selected articles will be distributed in PDF format. Residents will lead discussions while faculty mediate.

C. Grand Rounds

Surgery Trauma 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).

D. General Surgery Morbidity & Mortality Conference

Approximately twice a month, 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.

E. 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.

F. Tumor Board

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

G. 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.

H. Intern Modules

All incoming residents are required to have completed the Entering Resident Readiness Assessment during onboarding. The Fundamentals of Surgery is assigned beforehand when the interns first match with the program to prepare for this assessment.

J. Assessment of the Academic Performance

Examinations:

Multiple-choice quizzes based on the Decker platform curriculum will be administered approximately weekly on specific topics and grades will be reviewed during resident conference. The ABSITE examination administered yearly also serves as a benchmark of academic performance.

Mock Oral Exams:

General Surgery Residency Faculty administer "mock oral exams" quarterly to PGY 3-5 residents with PGY 1- 2 shadowing if there is no other educational activity planned. Mock oral faculty fill out a grading rubric from each resident and give them feedback. Afterwards, faculty meet to discuss resident progress. Mock oral topics are based on the Decker lectures assigned 6-8 weeks before the mock oral date.

Resident Benefits

A. Vacation

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 by July 31st for review and approval for the current academic year. 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 20th) by using vacation time and/or administrative leave, otherwise they are expected to end the program by June 25th. 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 trauma, SICU, or night float service. Except for PGY-4 residents, categorical residents will take vacation only during the months when assigned general surgery service to Gen Surg Team A or Team B. 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 University Medical Center 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) 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.

Holiday schedule:

<https://el Paso.ttuhsc.edu/hr/ documents/TTUHSC EP FY22 Holiday Schedule.pdf>

<https://el Paso.ttuhsc.edu/the-scope/excellence/2021-2022-holiday-schedule.aspx>

B. 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 prevents 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. The American Board of Surgery (ABS) requires 48 weeks of full-time clinical activity in each of the five years of residency, regardless of the amount of operative experience obtained. The remaining four weeks of the year are considered non-clinical time that may be used for any purpose, such as vacation, conferences, interviews, etc. The ABS acknowledges the need to take at least six (6) weeks away from training for certain significant life events. Effective as of the 2021-2022 academic year and thereafter, as allowed by their programs, residents may take documented leave to care for a new child, whether for the birth, the adoption, or placement of a child in foster care; to care for a seriously ill family member (partner, child, or parent); to grieve the loss of a family member (partner, child, or parent); or to recover from the resident's own serious illness. Residents may take an additional four (4) weeks off during the first three (3) years of residency, for a total of 140 weeks required, and an additional four (4) weeks off during the last two (2) years of residency, for a total of 92 weeks required. This allows for six (6) weeks of leave for significant life events while preserving two (2) additional weeks for vacation or other uses, as approved by the residency program. Residents are expected to complete a minimum of 48 weeks of Chief Resident rotations. Note: This is an ABS policy only and should not be confused with family leave as permitted by the Family and Medical Leave Act (FMLA). No approval is needed for this option if taken as outlined. The 48 weeks may be averaged over the first 3 years of residency, for a total of 144 weeks required in the first 3 years, and over the last 2 years, for a total of 96 weeks required in the last 2 years. Thus, non-clinical time may be reduced in one year to allow for additional non-clinical time in another year.

C. 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 EP of \$400.00. 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 \$500.00 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 \$500.00 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 \$600 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.

D. Drug Enforcement Administration fees may be taken from book allowance.

E. Malpractice Coverage

For residents is \$100,000 per incident and \$300,000 annual aggregate while participating in TTUHSC-EP 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.

F. Group Health Insurance

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.

G. 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 (Calvin Shanks, Sr. Director) who will have the appropriate forms for completion.

Website: <https://el Paso.ttuhs c.edu/safety/admin.aspx>

H. Sleeping Quarters

Provided for the "on call" resident. Meals at University Medical Center of El Paso cafeteria will be provided for residents and be contingent upon Medical Records completion.

I. Uniforms

White lab coats are provided at the beginning of the residency and laundered at no charge. Replacement uniforms will be provided during the third year if needed it.

J. Pagers

Provided by The University Medical Center of El Paso. If pager is lost, resident is responsible for replacement fees.

K. Immunizations

Provided by TTUHSC EP at no cost to residents. Each resident is responsible for knowing and complying with the TTUHSC EP Immunization Policy which is available in the GME Office.

L. Counseling Services

Provided by the institution through the Resident Assistance Program (RAP). Crisis Line: 915-779-1800. Website: <https://elpaso.ttuhsu.edu/som/gme/secure/rap.aspx>

M. 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 The University Medical Center of El Paso is provided for house staff.

N. 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).

2021-2022 ALBERTA CAMPUS RESIDENT AND FELLOW SALARIES

	PGY-1 Salary	PGY-2 Salary	PGY-3 Salary	PGY-4 Salary	PGY-5 Salary	PGY-6 Salary
Annual Salary	\$54,299.32	\$56,072.14	\$57,840.43	\$59,611.10	\$61,380.52	\$63,098.91
Monthly Salary	\$4,524.94	\$4,672.68	\$4,820.04	\$4,967.59	\$5,115.04	\$5,258.24

O. Moonlighting

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.

Duty Hour Policy

The Department of Surgery follows the ACGME policy and regulations related to the duty hour's 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.

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

Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Adequate time for rest and personal activities must be provided. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Title	DUTY HOURS	Policy Number	1
		Version Number	3
		Effective Date	04/2015
		Original Approval	03/2015

Purpose:

This policy is to sustain The University Medical Center of El Paso patient care compliance by surgical resident trainees. This policy is intended to educate surgical residents on system-based practices and professionalism.

Procedure:

1. Duty hours
 - a. Monthly hours must be entered on a weekly basis through MyEvaluations.
 - i. The associate director (AD) for the academic division provides the program director with the resident's weekly hours.

Consequences:

1. First warning
 - a. Email notification to surgical resident and program director.
2. Second warning
 - a. Schedule a meeting with the Clinical Competency Committee.

CERTIFICATION: This policy was approved by the Clinical Competency Committee.

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 4 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.

Resident Supervision Policy

It is policy of the Department of Surgery, as well as of TTUHSC EP, 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.

Description of Levels of Supervision

The program director shall provide explicit written descriptions of lines of responsibility for the care of patients, which shall be made clear to all members of the teaching teams. Residents shall be given a clear means of identifying supervising physicians who share responsibility for patient care on each rotation. In outlining the lines of responsibility, the program director will use the following classifications of supervision:

1. **Direct Supervision**: the supervising physician is physically present with the resident and patient.
2. **Indirect Supervision**:
with Direct Supervision immediately available: the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
3. **Oversight**: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision shall be structured to provide residents with progressively increasing responsibility commensurate with their level of education, ability, and attainment of milestones. The program director in conjunction with the program's faculty members shall make determinations on advancement of house officers to positions of higher responsibility and readiness for a supervisory role in patient care and conditional independence through assessment of competencies based on specific criteria (guided by national standards-based criteria when available). Faculty members functioning as supervising physicians should assign portions of care to residents based on the needs of the patient and the skills of the resident. Based on these same criteria and in recognition of their progress toward independence, senior residents or fellows should serve in a supervisory role of junior residents.

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.

Supervision in the Operating Room

Attending faculty should be present in the operating room for all critical portions of the surgery and should be in the peri-operative area for the entire duration of the surgery. The attending surgeon should scrub and gown for the critical portions of the operation to educate and instruct the residents in surgical technique.

Trauma Call Supervision

Per trauma center rules the faculty should be present within 15 minutes of the arrival of all level 1 traumas. The attending should remain in the emergency department until the level 1 patients have been resuscitated and films are completed to include computed tomography. The on-call staff should be notified of all level 2 and 3 traumas within 30 minutes (see trauma guidelines). The trauma staff will see level 2 traumas with resident within 60 minutes of consult. The trauma staff also physically rounds with the trauma resident either immediately before or after morning report. The chief resident will communicate directly with the faculty concerning all level 1 activations and indicate when immediate supervision is indicated.

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/her availability at all

times.

Circumstances and events in which all residents must communicate with appropriate supervising faculty members/attending physicians:

- Emergency admission
- Consultation for urgent condition
- Transfer of patient to a higher level of care
- Code Blue Team activation
- Change in DNR status
- Patient or family dissatisfaction
- Patient requesting discharge AMA
- Patient death

Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If the attending does not respond promptly, the resident should ask the chief resident to assist in contacting the attending. The Rapid Response Team (RRT) should be utilized freely in urgent situations.

Supervision of Residents in the Clinical Environment

Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed American Board of Medical Specialties (ABMS) board-certified surgeons. In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS board certified critical care physicians. Residents and faculty members should inform patients of their respective roles in each patient’s care. The supervising physician may be the attending, depending on the clinical scenario and the PGY of the resident.

During daytime working hours (0700-1700 Monday-Friday) each service has faculty and chief residents in the hospital and in each outpatient facility immediately available to provide direct supervision as needed. At night and on the weekends, there is a faculty member and a senior or chief resident available by phone at all times. In-house trauma surgical attendings are available for direct supervision 24 hours a day. At all times, at least 1 junior (PGY-1) and/or 2 senior residents (PGY-2 through PGY-4) are also available for direct supervision on the in-house EGS and trauma services.

Direct Supervision for PGY-1 Residents

Interns (PGY-1 residents) are supervised either directly or indirectly with direct supervision immediately available. There is no situation where an intern will be participating in clinical care where there is not this level of supervision available. Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or manage a particular clinical scenario and include more senior residents (PGY-2 residents and above who have met competency for the particular

task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined relationship outlined in the supervision policy may directly supervise PGY-1 residents.

Defined Tasks for PGY-1 Residents

PGY-1 surgical residents are given a procedural checklist at the beginning of the year for central venous insertion, arterial cannulation, tube thoracostomy, tracheostomy change, and bronchoscopy. PGY-1 residents must have a supervising resident (PGY-3 or above with appropriate competency themselves) observe them performing the procedures, while providing minimum direction, and attest to their competency to perform the procedure with indirect supervision.

Indirect supervision is allowed for the following (in consultation as needed with supervising residents and attendings):

1. Patient Management Competencies

- a) evaluation and management of a patient admitted to hospital, including taking an initial history and conducting a physical examination, formulation of a plan of therapy, and determining necessary orders for therapy and tests.
- b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests.
- c) evaluation and management of post-operative patients, including the conduct of monitoring and ordering medications, testing, and other treatments.
- d) transfer of patients between hospital units or hospitals.
- e) discharge of patients from the hospital.
- f) interpretation of laboratory results.

2. Procedural Competencies

- a) performance of basic venous access procedures, including establishing intravenous access (after competency has been established).
- b) placement and removal of nasogastric tubes and Foley catheters (after competency has been established).
- c) arterial puncture for blood gases (after competency has been established).

Senior Resident Responsibilities (PGY 2-4)

It is the responsibility of the senior resident to assist and supervise the junior residents. Senior residents are expected to directly supervise junior residents for the aforementioned procedural competencies until the junior resident has demonstrated that they are able to successfully and safely execute the procedural task. Senior residents will also perform each of the patient management competencies and procedural competencies above when their role on the team requires it, and in cases where a junior resident is not available. They will assume graduated levels of responsibility, as deemed appropriate by the attending

surgeon.

Chief Resident Responsibilities (PGY-5)

Chief residents are expected to provide leadership throughout the residency. If questions or problems arise with a particular assignment, resident, or schedule, then this matter should be addressed with one of the Administrative Chief Residents. If a satisfactory resolution cannot be achieved, then the issue can be referred to the Residency Program Director. The GME administrative office may serve to resolve administrative disputes, grievances, or problems that cannot be managed by the Department of Surgery Academic Division. Chief residents are responsible for delegating tasks and responsibilities equitably among team members, with appropriate attention to the level of skill of the resident. Ultimately, they are responsible for ensuring timely and appropriate patient care by all members of the team, including following up on daily inpatient labs/imaging, and ensuring that the plan of care determined on rounds is carried out. Chief residents will ensure that junior residents adhere to work hour rules, are in clinic ½ day per week, and attend all required teaching conferences. They will communicate directly with attending surgeons regarding patients in their care, and will respond to outpatient calls as determined by their clinical service assignment. They are to be role models of professionalism and exemplary patient care.

For all residents:

It is every resident's responsibility to know the limits of the scope of authority and the circumstances under which the resident is permitted to act with conditional independence.

The chain of command applies to both clinical and administrative issues. Decisions regarding patient care should be reviewed with upper level residents. In general, residents should consult the team member directly above them. Final decisions regarding management should be discussed with the senior team member, who will discuss the plan with the fellow and/or attending. Urgent patient care issues should be discussed immediately with the fellow and/or attending (see above). Consultation should be used freely within the chain of command, as this is optimal for learning, teaching, and patient care.

The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure. It is expected that a resident shall inform the faculty member or upper level resident when he/she does not feel capable of performing a bedside procedure. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again. The procedure should be aborted and alternate plans discussed with the attending when the risk of the

procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.

Faculty Responsibilities

The designation of faculty dictates these physicians are responsible for teaching, evaluating and supervising the residents; therefore, they have the privilege of having resident physicians assist them with patient care. The Program Director (or his/her designee) will structure faculty supervision assignments of enough duration so that individual faculty members can assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility for patient care interactions and procedures, both in and out of the operating room.

The faculty member will routinely review the Resident's documentation in the medical record, attesting clinical documentation with the faculty's own assessment. Further, they will ensure compliance with institutional requirements such as updating problems lists, performing medication reconciliation, and maintenance of accurate and timely medical record-keeping. Faculty members will serve as role models of professionalism, providing exemplary patient care and demonstrating excellent communication skills.

The faculty supervisor(s) assigned for each rotation or clinical experience (inpatient or outpatient) shall provide to the Program Director a written evaluation of each trainee's performance during the period that the resident or clinical fellow was under his or her supervision. Supervisors will also provide residents with constructive feedback in real-time as appropriate.

Resident 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 pediatric surgery, transplantation, vascular surgery, cardiothoracic surgery, and plastic surgery. 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 attending's, 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 and review them with faculty. 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-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 conduct research that will lead to a publication especially those seeking fellowship training.

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.

Orientation to Clinical Services

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

A Team Faculty

Davis
Andrade
Castro
Nemir
Diamond
Konstantinidis

B Team Faculty

Tyroch
McLean
Rios Tovar
G. Ng
Fikfak
N. Ng
Alkhalili
Aidinian

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. Two upper level residents (one TTUHSC EP and one WBAMC) are assigned to the intensive care unit to cover trauma and to act as chief of the two SICU services. An additional 1-2 residents are assigned to the SICU for patient care and divided between the teams to provide care. Additionally 1 SICU fellow is assigned to each of the two services.

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:

Surgery Clinic Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
AM		Fikfak (CRS)	Davis (GS)	Konstantinidis (Surg Onc)	
PM	G Ng/ Tyroch (GS)	Andrade (GS)	McLean (GS)	RiosTovar(GS) N Ng (CRS)	

Breast Clinic Schedule (no resident coverage)

	Monday	Tuesday	Wednesday	Thursday	Friday
AM		Andrade		Castro (PRS)	
PM				Nemir (PRS)	

Plastic Surgery/Minor Surgery Clinic Schedule (no resident coverage)

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Nemir				Castro
PM	Nemir				Castro

Program Evaluations

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/>

Evaluation of the Program

Residents are required to complete electronic evaluation of the residency program including rotations, 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/>

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.

Resident Evaluation Policy

Monthly feedback will be recorded on the automated web portal My Evaluations that will be completed by faculty following each rotation and service assignment. The My Evaluations portal addresses the six core competencies and makes space for specific comments.

Bi-annual evaluations will occur in December and June of each year where the faculty will review the resident case logs, resident clinical performance, milestone evaluation indications, career counseling, research mentoring and performance according to the six core-competencies.

Evaluation Policy to Protect Confidentiality and Professionalism:

- a) All remediation discussions will be held with the clinical competency committee (CCC).
- b) Senior residents and faculty can submit a written evaluation to the core competency committee requesting resident discipline or remediation.
- c) There is clear communication that chief residents and senior residents will not administer remediation or discipline to other residents.
- d) Feedback during morbidity and mortality conferences will be limited to medical decision making and will not involve lapses in professionalism or interpersonal communication.

Intra-Departmental Grievance Policy

- a) There is a formal anonymous suggestion box that is hung at the entry-way to the department.
- b) Formal complaints or grievances can also be submitted to the core competency committee.
- c) A suggestion box has been placed by the resident lounge for submission of problems or suggestions. Only the program coordinator has access to the suggestion box and is checked on a weekly basis.
- d) The CCC will review suggestions and problems to develop an action plan on a monthly basis.

Operative Case Logs

Residents are expected to update their operative logs at least weekly; failure to do so may result in disciplinary actions ranging from loss of O.R. privileges to suspension. Case logs must be logged at www.acgme.org.

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 | | | | | |
| 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 5 4 3 2 1
- 2. The format is effective 5 4 3 2 1
- 3. The attending involvement is appropriate 5 4 3 2 1
- 4. Didactic evaluation (ABSITE, quizzes, mini in-service) is adequate 5 4 3 2 1

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 5 4 3 2 1
- 2. The format is effective 5 4 3 2 1
- 3. The attending involvement is appropriate 5 4 3 2 1

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 5 4 3 2 1
- 2. The format is effective 5 4 3 2 1
- 3. The attending involvement is appropriate 5 4 3 2 1

COMMENTS:

F. EVALUATION OF INDIVIDUAL ROTATING:

5 4 3 2 1

EVALUATION PROCESS

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

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					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					Pedi-Surgery					Surgery Oncolog				
	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?															

Resident Advancement, Observational Status, and Probation

Core Curriculum Score 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.

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 30th percentile. Continued poor performance on these exams may be cause for academic probation and/or additional disciplinary/corrective measures. Learning contracts and performance improvement plans will be used to keep track and document progress.

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 will administer "mock oral" examinations. PGY 3-5 residents are required to participate quarterly unless on vacation, outside rotation, or post call from on night float. 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.

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

- Academic: One or more of the following failures may result in a notice of academic deficiency:
 - ABSITE (In-Training Examination) score below the 30th percentile.
 - Inadequate participation (more than 20% un-excused absence) in the surgical didactic curriculum (Thursday conferences).
- Clinical: One or more of the following deficiencies:
 - Clinical evaluation consistently indicating either
 - Substandard performance, or failure to progress satisfactorily
 - Poor performance on several rotations, suggesting a lack of clinical dedication
 - Specific areas needing substantial improvement are repeatedly identified, e.g. technical skills
- Administrative/Professional/Ethical: Any of the following are potential grounds for notice of deficiency or more severe sanctions, if warranted:
 - Failure to discharge resident responsibilities, e.g. medical records
 - Failure to comply with governance policies
 - Interpersonal conflicts/psychosocial problems/substance abuse
 - Physical, verbal or sexual harassment

Unprofessional conduct, including but not limited to abrogating or failing to respond to clinical responsibilities Performance Improvement Plans (PIP) will be issued if there is need to address and track progress. These plans are issued and assessed for satisfactory progress by the CCC. Failure to meet the objectives of the Performance Improvement Plan will result in the resident being issued a Performance Deficiency Alert Review.

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: https://el Paso.ttuhsc.edu/som/gme/policies_procedures.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.

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: https://el Paso.ttuhsc.edu/som/gme/policies_procedures.aspx.

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.

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. Additional Information: <http://www.tmb.state.tx.us/idl/36978563-5411-C9E2-616B-9A13943C6202>

Resident Responsibilities

Records

The residents are responsible for completing a history and physical examination on all admissions. A student history and physical examination does not substitute for the workup performed by the resident. For victims of multiple trauma, the admitting note must include a description of pertinent positive and negative physical finding, especially the neurologic and vascular exam.

Progress notes will be written daily by the 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.

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.

All surgical procedures, major or minor (e.g., cholecystectomy, CVP catheter insertion, proctoscopy, etc.) should be documented in the progress notes.

A preoperative note will be recorded in the progress notes prior to operation.

All post-operative patients will be seen within 4 hours of operation and a post-operative note will be documented in the medical record.

A written discharge note will be recorded in the progress notes at discharge.

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.

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.

Admitting orders will be completed in full to include observation or admission status, diagnosis, attending physician, on call attending, resident(s) and service.

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

All surgical consults are to be placed through the UMC operator.

The ACS/Trauma Consult resident will be paged through the operator for all surgical consults to include: general surgery, trauma, colorectal, plastics, vascular, surgical oncology, endocrine surgery, and cardiothoracic surgery.

Consults will then be presented to the appropriate attending on call for each specialty.

An admission history and physical or a consultation note should be placed in the chart in a timely manner. Latest, is the end of shift.

All mail, including call schedules and conference schedules, is distributed to the residents' mailboxes in room 104, located in the Department of Surgery Administration, Academic Education Center, 1st Floor.

Operating Room

The attending staff will be consulted on all cases considered for operation, day or night, prior to booking case.

The first cases on Monday, Tuesday, Wednesday and Friday are scheduled to begin at 7:00am and at 1:00pm on Thursday.

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

New Texas State Board of Pharmacy Rules and Regulations RE Written Prescriptions:

<http://www.pharmacy.texas.gov/rules/>

Students

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.

Cases to be worked up by the students should be assigned by the Chief Resident. They should be diversified in nature, and comprise 3 to 5 patients per week.

The students should accompany the resident on ward rounds as they pertain to the workups performed by the students.

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.

Students will be relieved from ward and/or operating room responsibilities to attend required conferences and lectures.

- Students should be present 7:00 am - 5:00 pm except nights on call

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

Clinic

All residents assigned to a clinic are expected to be in attendance promptly.

The chief resident assigned to the service should be consulted for each elective admission or surgical procedure scheduled from clinic.

An admission form, the brief history, and pre-op admission orders should be completed at the time of the clinic visit.

See published schedule for specific clinic assignments.

Emergency Department

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.

When a Level I trauma patient with major injuries arrives in the ED, the Trauma Team will be called automatically and will respond in person immediately. Level II and III trauma patients will be seen by the trauma resident within 10 minutes of being consulted (or within 10 minutes of patient arrival if a trauma transfer). (See Trauma Guidelines: <https://el Paso.ttuhs c.edu/som/surgery/Fellowship/resources.aspx>).

No patient with a bona fide surgical emergency will be denied treatment or admission.

Resident Record of Procedures (ACGME Data Base)

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

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.

Pediatric Age Patients

In cases of suspected child abuse, the Pediatric Service Resident and Child Protective Services must be consulted.

Post-operative care of pediatric surgical cases is the responsibility of the surgical service, though the Pediatric Service will often co-manage.

Appendicitis in pediatric surgical patients under the age of 4 years old will be seen at the discretion of the general surgeon or referred to Pediatric Surgery.

All pediatric trauma patients age 12 years and younger require a pediatrics consult. (See Trauma

Guidelines: <https://el Paso.ttuhs c.edu/som/surgery/Fellowship/resources.aspx>).

General

Decorum:

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.***

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.

Nursing

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.

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.

Sexual Harassment: **Such will not be tolerated** (Texas Tech University HSC OP 10.09). We encourage persons to know their rights. Sexual harassment is a violation of university policy (OP 70.14 found at <http://www.ttuhsu.edu/HSC/OP/>) and the Code of Student Conduct. It is also prohibited under Title VII of the Civil Rights Act of 1964, as amended, and Title IX of the Educational Amendments of 1972. All people have a right to an education and work environment that is free of bias, intimidation, or hostility. Educational programs and training sessions on the subject of sexual harassment are available to students, faculty, and staff.

The university provides counseling services that may be used by persons who believe they have been sexually harassed. Students may seek counseling through the Student Assistance Program, while faculty members and other employees may use the Employee Assistance Program.

All students will receive training at matriculation through the Campus Clarity on-line module. Students are required to sign a statement that verifies completion of this training. Signed completion statements will be recorded in the student's file in the Office of Student Affairs.

Contact: Linda Ellis, M.D.
TTUHSC El Paso Title IX Coordinator
PLFSOM Office of Student Affairs
Medical Education Building 3320-A
5001 El Paso Drive
El Paso, Texas 79905
Office: 915.215.5439
Email: linda.s.ellis@ttuhsc.edu

Scheduling

Call Schedules

Call schedules are determined by the Administrative Chief Resident and are submitted to the Program Coordinator by the 15th of each month for review by the PD.

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.

Residents must check out patients for cross coverage at night.

Day off- TTUHSC Housestaff Policy

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.

Beepers

Each resident is provided a pager by University Medical Center. The resident is responsible for his/her pager. 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.

Transitions When Fatigued Policy: Managing Fatigue

In compliance with the ACGME work-hour regulations the PGY II-V level residents can only be on call for 24-hour periods. They are allowed 4 hours following any 24 hour period to complete any checkout or continue care of critically ill patients. Residents will not be allowed to enter the operating room following 24-hours on call.

Fatigue management is addressed by:

- 1) Cab fare reimbursement for residents too fatigued to drive.
- 2) Interns and junior residents are instructed to checkout to chief residents during day shifts if fatigue or illness prevents completion of service duties.

- 3) Residents facing extreme fatigue during night-shift are encouraged to notify on-call faculty and home-call chief residents so that appropriate coverage can be arranged.
- 4) Call rooms will be made available for naps during call periods to reduce and manage fatigue.
- 5) As per ACGME 80 hour work rules all residents should be dismissed to go home by 10AM the day following call with no pressures to complete further checkout or follow-up duties.

Transition of Care Policy

- 1) Transition of care occurs at morning report (630 AM) and afternoon report (530 PM).
- 2) Residents assigned to 24-hour shifts of call will sign-out during morning report to discuss all admissions in the ICU conference room with delivery of a patient list to the attending faculty who will verify examination of the patients and discuss therapeutic planning and follow-up.
- 3) Afternoon transition of care occurs in the ICU work-room and is supervised by the chief residents to include the on-call night senior resident and intern, and Trauma Advanced Practice Providers. A resident per team should attend to communicate patient problem lists and conduct appropriate hand-offs.
- 4) ICU transition of care occurs starting at 4 PM. The senior resident/fellow from each team are expected to walk through the unit together with the rotating ED resident/Surgery intern who will be covering the ICU overnight. Morning hand off occurs at 5 AM in a similar fashion.
- 5) Sign-out handoffs will include patient lists with checklists to include day admissions and tasks to be completed to include discharge summaries and discharge planning documentation.

Educational Goals and Objectives

The Accreditation Council for Graduate Medical Education (ACGME), including the Residency Review Committee (RRC) for surgery has adopted a set of general competencies for all physicians who complete higher training programs in an effort to create measurable outcomes and improve standardization of the training process. In the future, all chief residents will be assessed as competent in these areas prior to certification for completion of residency training and examination for certification by the American Board of Surgery.

The Six Core Competencies

- 1. Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Surgical residents must demonstrate manual dexterity appropriate for training level and be able to develop and execute patient care plans.
- 2. Medical Knowledge** about established and evolving biomedical, clinical, and cognitive (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Surgical residents are expected to critically evaluate and demonstrate knowledge of pertinent scientific information.
- 3. Practice-Based Learning and Improvement** involves investigation and evaluation of patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Surgical residents are expected to critique personal practice outcomes and demonstrate recognition of the importance of life-long learning in surgical practice.
- 4. Interpersonal and Communication Skills** that result in effective information exchange and learning with patients, their families, and other health professionals. Surgical residents are expected to communicate effectively with other health care professionals, counsel and educate patients and families and effectively document practice activities.
- 5. Professionalism** is manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Surgical residents are expected to maintain high standards of ethical behavior, demonstrate a commitment to continuity of patient care, and demonstrate sensitivity to age, gender and culture of patients and other health care professionals.
- 6. Systems Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and systems of health care and the ability to effectively call on system resources to provide care that is of optimal value. Surgical residents are expected practice high quality, cost effective patient care, demonstrate knowledge of risk-benefit analysis,

and demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

Major Educational Goals

The major educational goal of the general surgery residency training program is to produce a board-certified surgeon capable of independently practicing general surgery of the highest quality. On completion of the program, the surgeon should possess general knowledge, clinical judgment, technical skills and personality attributes to establish rapport with patients and families for the practice of general surgery; and be assessed as competent in the areas outlined under the ACGME's six core competencies.

The six core competencies will be acquired over 5 years of training by obtaining new knowledge through clinical experience, reading current literature through web-based media, attending conferences as well as preparing reports for presentation and publication. Knowledge of the clinical course of disease will be understood through management of surgical patients in the clinics, hospital wards, emergency department and ICU. Technical skills to perform operations will be acquired through observation, simulation, and performance of a variety of surgical procedures over the training period. Intra-operative decision-making will be modeled by faculty in pre-operative checklists, intra-operative Socratic teaching as well as in post-operative debriefings. Decision making will also cover problem based learning and improvement during morbidity and mortality conferences.

The resident will record each operation performed or assisted with, in keeping with practice based learning, in the ACGME case log system. This operative log will be reviewed as part of the resident's ongoing evaluation process. Communication skills will be developed by case presentations and resident prepared conferences where practice based learning and improvement will disclose scenarios of special import, exceptional decision making and cases of morbidity or mortality. The professional ability to interact appropriately with referring physicians and consultants as well as nursing staff will be acquired through 360 evaluations throughout the training period.

Milestones

The Milestones are designed only for use in evaluation of residents in the context of their participation in ACGME-accredited residency programs. The Milestones provide a framework for the assessment of the development of the resident in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

This document presents the Milestones, which programs use in a semi-annual review of resident performance, and then report to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME Competencies organized in a developmental framework. The narrative descriptions are targets for resident performance throughout their educational program.

Milestones are arranged into levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert resident in the specialty or subspecialty. For each reporting period, the Clinical Competency Committee will review the completed evaluations to select the milestone levels that best describe each learner's current performance, abilities, and attributes for each sub competency.

These levels do not correspond with post-graduate year of education. Depending on previous experience, a junior resident may achieve higher levels early in his/her educational program just as a senior resident may be at a lower level later in his/her educational program. There is no predetermined timing for a resident to attain any particular level. Residents may also regress in achievement of their milestones. This may happen for many reasons, such as over scoring in a previous review, a disjointed experience in a particular procedure, or a significant act by the resident.

Selection of a level implies the resident substantially demonstrates the milestones in that level, as well as those in lower levels.

A general interpretation of levels for general surgery is below:

Level 1: The resident demonstrates milestones expected of an incoming resident.

Level 2: The resident is advancing and demonstrates additional milestones.

Level 3: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.

Level 4: The resident has advanced so that he or she now substantially demonstrates the

milestones targeted for residency. This level is designed as the graduation target.

Level 5: The resident has advanced beyond performance targets set for residency, and is demonstrating “aspirational” goals that might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

Additional Notes

Level 4 is designed as a graduation goal but does not represent a graduation requirement. Making decisions about readiness for graduation and unsupervised practice is the purview of the program director. Furthermore, Milestones 2.0 include revisions and changes that preclude using Milestones as a sole assessment in high-stakes decisions (i.e., determination of eligibility for certification or credentialing). Level 5 is designed to represent an expert resident whose achievements in a sub competency are greater than the expectation. Milestones are primarily designed for formative, developmental purposes to support continuous quality improvement for individual learners, education programs, and the specialty. The ACGME and its partners will continue to evaluate and perform research on the Milestones to assess their impact and value. Examples are provided for some milestones within this document. Please note: the examples are not the required element or outcome; they are provided as a way to share the intent of the element.

Some milestone descriptions include statements about performing independently. These activities must occur in conformity to ACGME supervision guidelines as described in the Program Requirements, as well as to institutional and program policies. For example, a resident who performs a procedure independently must, at a minimum, be supervised through oversight.

A Supplemental Guide is also available to provide the intent of each sub competency, examples for each level, assessment methods or tools, and other available resources. The Supplemental Guide, like examples contained within the Milestones, is designed only to assist the program director and Clinical Competency Committee, and is not meant to demonstrate any required element or outcome. Additional resources are available in the [Milestones](#) section of the ACGME website. Follow the links under “What We Do” at www.acgme.org.

Department of Surgery Milestone Project

PGY-1 Milestones

1. The resident obtains a score of 30 percentile or higher on the ABSITE exam. Failure to score a 30 percentile or higher will result in being put on a learning contract.

Assessment: ABSITE performance

Competencies: Medical Knowledge; Practice Based Learning and Improvement

2. The resident has 80% attendance at Surgery Conferences and obtains an average of 80% correct on the weekly Decker quizzes.

Assessment: Attendance and Quiz records

Competencies: Medical Knowledge; Professionalism

3. The resident has a conference attendance record of 80% at grand rounds and M&M, and all scheduled skills activities.

Assessment: Attendance

Competencies: Professionalism; Practice Based Learning and Improvement

4. The resident demonstrates competence with the following patient care skills at a level which allows for indirect supervision. The resident must also complete the ACS Entering Resident Readiness Assessment (ACS ERRRA) and the Fundamentals of Surgery modules.

- Evaluation and management of post-operative complications including:
 - Hypo and hypertension
 - Oliguria and Anuria
 - Cardiac arrhythmias
 - Hypoxia and respiratory distress
 - Change in mental status

5. Initial consults and ER consults evaluation and management of patients in the urgent or emergent setting, including urgent

6. Evaluation and management of critically ill patient with ICU conditions.

7. Obtain a preoperative history and informed consent, and adequately prepare a patient for surgery.

Assessment: Direct observation and evaluation by a supervising physician (Chief resident or Attending). Certification of observed competence in hand documented notebooks for procedures to include central lines and chest tubes.

8. The resident demonstrates competence with the following procedures at a level which allows for indirect supervision:

- Repair of incisions and wounds
- Excision of simple skin lesions
- Abscess drainage and debridement

Assessment: Direct observation and evaluation by a supervising physician (Chief resident or Attending). Certification of observed competence in a new innovations evaluation form or by signing off in a log-book. Each resident must be observed at least three times for each category.

Competencies: Patient care; Practice based learning and improvement; Technical Skills.

9. The resident demonstrates the ability to perform bedside procedures with minimal assistance.

These procedures include:

- Central line and arterial lines
- Chest tube placement

Assessment: Direct observation by a faculty member or chief resident with completion of a log-book operative and procedure assessment.

Competencies: Patient care; Technical Skills.

10. The resident demonstrates the ability to perform level appropriate operative procedures with minimal to moderate assistance.

These procedures include:

- Inguinal hernia
- Laparoscopic appendectomy
- WLE of skin cancer
- I&D of perirectal abscess
- Breast biopsy

Assessment: Direct observation by a faculty member or chief resident with operative and procedure assessment.

Competencies: Patient care; Technical Skills.

11. The resident demonstrates good interpersonal and teamwork skills.

Assessment: Direct evaluation in MyEvaluations by Nurses, Midlevel providers, Program assistants and coordinators, medical students and chief residents.

Competencies: Interpersonal communications, Professionalism, System based practice.

12. The resident has fewer than 10 delinquent operative notes or discharge summaries for the entire year.

Assessment: Tracking using Cerner and UMC QI department.

Competencies: Professionalism; Systems Based Practice.

13. The resident has met or exceeded expectation on 75% of the evaluations in MyEvaluations for all 6 ACGME competencies.

Assessment: MyEvaluations

Direct observation by a faculty member in the performance of procedures and operations with documentation using a MyEvaluations instrument. Each resident will be evaluated 2 times every 6 months performing a mix of procedural and operative tasks.

Competencies: All

PGY-2 Milestones

1. The resident obtains a score of 30 percentile or higher on the ABSITE exam. Failure to score a 30 percentile or higher will result in being put on a learning contract.

Assessment: ABSITE performance.

Competencies: Medical Knowledge; Practice based learning and Improvement.

2. Attendance of at least 85% of the lectures and skills lab sessions.

Assessment: Attendance

Competencies: Medical Knowledge; Professionalism

3. Attendance of at least 80% at M&M and Grand Rounds.

Assessment: Attendance

Competencies: Professionalism, Practice Based Learning and Improvement.

4. Successful completion of USMLE Step 3 before the end of the PGY-2 year.

Assessment: Tracking of Step 3 performance.

Competencies: Professionalism; Medical Knowledge, Communication.

5. Resident demonstrates progressive accomplishment with procedural and operative skills.

6. The resident will demonstrate appropriate medical documentation skills and perform his or her documentation in a timely fashion with no more than 5 delinquent operative reports, discharge summaries or consults.

Assessment: Audit of delinquency reports from The University Medical Center of El Paso.

Competencies: Professionalism; System Based Practice.

7. The resident will function as an effective teacher of medical students and junior residents.

Assessment: Teaching evaluations.

Competencies: Interpersonal communications; Systems Based Practice.

8. Resident will function as an effective team member in the surgical care team and the health care system overall.

Assessment: Direct evaluation in MyEvaluations by Nurses, Midlevel providers, Program assistants and coordinators, medical students and EM Faculty.

Competencies: Interpersonal communications, Professionalism, System based practice.

9. Demonstrate mastery of effective patient care handoffs both in terms of “signing out” and “signing in”.

Assessment: Direct evaluation in MyEvaluations by chief residents or attending physicians.

Competencies: Patient care; Interpersonal Communications; Systems Based Practice.

10. The resident has met or exceeded expectation on 75% of the evaluations in MyEvaluations for all 6 ACGME competencies.

Assessment: MyEvaluations portal.

Competencies: All

PGY-3 Milestones

1. The resident obtains a score of 30 percentile or higher on the ABSITE exam. Failure to score a 30 percentile or higher will result in being put on a learning contract.

Assessment: ABSITE performance.

Competencies: Medical Knowledge; Practice based learning and Improvement.

2. Resident will have an attendance of at least 80% at M&M and Grand Rounds.

Assessment: Attendance.

Competencies: Professionalism, Practice Based Learning and Improvement.

3. The PGY-2 resident has built on their patient care skills and is able to perform the initial assessment and management of critically ill patients with minimal assistance.

Assessment: Direct observation by a faculty member in the evaluation and management of patients with documentation using a MyEvaluations instrument. Each resident will be evaluated 4 times every 6 months performing a mix of patient management tasks selected from the following list:

- Resuscitation of a critically injured trauma patient
- Assessment and management of emergency general surgery and vascular consultations
- Evaluation and management of a critically ill ICU patient

Competencies: Patient care; Medical Knowledge; Systems Based Practice; Interpersonal, Communication.

4. Resident demonstrates progressive accomplishment with procedural and operative skills.

At the PGY-3 level the basket of cases residents are to be assessed on will include: Lap cholecystectomy, open or laparoscopic ventral hernia repair, Laparoscopic appendectomy, open right colectomy, small bowel resection and anastomosis.

5. The resident will demonstrate appropriate medical documentation skills and perform his or her documentation in a timely fashion with no more than 5 delinquent operative reports, discharge summaries or consults.

Assessment: Audit of delinquency reports from University Medical Center

Competencies: Professionalism; System Based Practice.

6. The resident will function as an effective teacher of medical students and junior residents.

Assessment: Teaching evaluations.

Competencies: Interpersonal communications; Systems Based Practice.

7. Resident will function as an effective team leader in the surgical care team and the health care system overall serving as floor and ICU service leader.

Assessment: Direct evaluation in MyEvaluations by Nurses, Midlevel providers, Program assistants and coordinators, medical students and Emergency Medicine Faculty.

Competencies: Interpersonal communications, Professionalism, System based practice.

8. Resident will demonstrate the ability to effectively run a patient care service, providing high quality care to his or her patients and effectively utilizing and teaching the junior residents on the service. This will include effective communication of patient care plans and identification of patients who deviate from standard care pathways.

Assessment: Evaluation of the residents' performance as the chief on Trauma.

Competencies: Patient care, System Based Practice, Interpersonal Communication.

9. By the end of the PGY-3 year residents will have successfully passed the FLS curricula.

Assessment: Course completion certificates

Competencies: Professionalism, Patient Care

10. Demonstrate mastery of effective patient care handoffs both in terms of "signing out" and "signing in".

Assessment: Direct evaluation in MyEvaluations by chief residents or attending physicians.

Competencies: Patient care; Interpersonal Communications; Systems Based Practice.

11. The resident has met or exceeded expectation on 75% of the evaluations in new innovations for all 6 ACGME competencies.

Assessment: MyEvaluations portal.

Competencies: All

PGY-4 Milestones

1. The resident obtains a score of 30 percentile or higher on the ABSITE exam. Failure to score a 30 percentile or higher will result in being put on a learning contract.

Assessment: ABSITE scores.

Competencies: Medical Knowledge.

2. Resident must pass at least 2 of 3 rooms in each session of the mock oral examinations.

Assessment: Mock Oral performance.

Competencies: Medical Knowledge, Patient Care.

3. Resident will demonstrate the ability to independently evaluate and formulate a management plan for an elective surgery consult.

Assessment: PGY-4 residents will be assigned two evaluation consults on each rotation that they are expected to evaluate consults, and will be evaluated by one of their supervising faculty using a MyEvaluations evaluation instrument. It will be the resident's responsibility to insure that this occurs. Also a global assess of the residents effectiveness as a consultant will be considered in their end of rotation evaluation.

Competencies: Patient Care, Medical Knowledge, Communication, System Based Practice

4. The resident will demonstrate the ability to perform effectively in the operating room during the performance of a specific set of level appropriate operations. Operative skill will be assessed 4 times every 6 months.

At the PGY-4 year the basket of cases for assessment will include: splenectomy, vascular access placement, Femoral popliteal bypass, Mastectomy and/or axillary LN dissection, left colectomy, thyroidectomy.

Assessment: The resident will be assessed using MyEvaluations form completed by the faculty member involved in the assessment case.

Competencies: Medical Knowledge, Patient care.

5. Resident will demonstrate the ability to effectively work up and plan patient management for patients with peripheral vascular disease.

Assessment: Evaluation by supervision of faculty.

Competencies: Patient care.

6. The resident will log in a timely fashion, all procedures and operative cases in the ACGME case log system. At the conclusion of their PGY-4 year, the resident will be expected to meet defined category minimums for thoracic, pediatric and colonoscopy cases. At the completion of their PGY-4 year, the resident will have meet the defined category minimums for skin and soft tissue, vascular, operative and non-operative trauma.

Assessment: Reviewed monthly at the CCC meeting and reviewed at the time of semiannual review.

Competencies: Professionalism, Practice based learning and improvement.

7. The resident will attend 80% of Grand rounds, Surgery 401 and M&M conferences.

Assessment: Attendance.

Competencies: Professionalism, Practice based Learning.

8. The resident will have identified the topic of their scholarly project by the end of the PGY-3 year and will be expected to have a rough draft of a manuscript or an accepted abstract at a national or regional meeting by the end of the PGY-4 year.

Assessment: Completion of the project.

Competencies: Practice Based learning and Improvement, Medical Knowledge.

9. By the completion of the PGY 4 year each resident will have been actively involved in at least one quality improvement project that concluded with a meaningful change in a departmental patient care process.

Assessment: Direct reporting of the project

Competencies: Practice based learning and improvement, System based practice.

10. The resident has met or exceeded expectation on 75% of the evaluations in new innovations for all 6 ACGME competencies.

Assessment: MyEvaluations Portal

Competencies: All

PGY-5 (Chief) Milestones

Medical Knowledge

The resident obtains a score of 30 percentile or higher on the ABSITE exam. Failure to score a 30 percentile or higher will result in being put on a learning contract. Chief residents will pass all rooms by the final session of the mock oral examinations.

Patient Care

The chief resident will develop the necessary technical dexterity to successfully and independently (under supervision) perform the following operations: Laparoscopic/Open Colectomy, Laparoscopic Nissen Fundoplication, Hepaticojejunostomy, Open Gastrojejunostomy.

The chief resident will develop the necessary technical dexterity to successfully and independently (under supervision) perform and take a junior resident through: Laparoscopic/Open Inguinal Hernia Repair^[1]Laparoscopic Cholecystectomy, Laparoscopic/Open Appendectomy, Ostomy formation, Melanoma Excision, Lymph Node Biopsy, and any additional cases.

Chief residents will demonstrate that they can complete all the above cases in a given amount of time specified by the attending supervising the case.

Professionalism

Chief residents will log all of their procedures and cases in the ACGME Operative Log on daily basis. This will be spot checked and officially validated during semi-annual resident review. Chief residents will attend 80% of all Departmental Conferences.

Chief residents will receive overall favorable assessment (average scores indicating competence) of their interpersonal and communication skills from extenders, nursing, and ancillary staff. Chief resident leadership/teamwork skills will receive overall favorable assessment (average scores indicating strong leadership skills and excellent teamwork) by junior residents.

Interpersonal and Communication Skills

Chief residents will exhibit excellent teamwork and team management skills defined as communicating patient care plans, identifying patients that fall of care pathways, and challenging the attending plan with evidence of a better management plan. Chief residents should receive overall favorable assessment (average scores indicating competence) of their interpersonal and communication skills from extenders, nursing, and ancillary staff.

Practice-based Learning and Improvement

Chief residents will log all minimum numbers of cases in the ACGME Op Log in all defined categories by the time of the first semi-annual resident review. Chief residents will have prepared an abstract for submission to a professional journal or conference and /or presented their scholarly activity before the second semi-annual resident review period.

Systems-based Practice

Supervising attendings on every service should sign off on the efficient management of the service by the chief resident reflected on timely discharges, OR cancellations. The Chief residents will be evaluated by the Junior Residents through MyEvaluations.

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 year of training there are four months devoted to intensive care unit daytime coverage in compliance with the 16-hour work-day rule and 80 hour work week, including approximately two months as night float and the remainder on surgical services devoted to elective surgical care. The second and third years are the senior resident years which are responsible for directing care in the intensive care unit, serving as the admitting doctor for trauma and general surgery, and serving as consult resident. In the fourth year, 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. The fifth year is devoted to chief resident status to include leadership roles in serving as teaching assistant and developing the didactic curriculum and schedules for the other resident classes.

Robotic Surgery Curriculum

The following outlines the pathway for potential surgical residents/who wish to develop knowledge and skills for da Vinci minimally invasive surgery. Commitment to this curriculum will lead to successful completion and issuance of a robotic surgery certificate. This will make you eligible to request clinical hospital privileges using the da Vinci platform for robotic assisted surgery.

Participating Mentors:

Alonso Andrade, M.D.
Associate Program Director
Director for Surgical Simulation

Proctor for Intuitive Surgical:
Brian R. Davis, M.D., FACS, FASGE
Residency Program Director

Director of Surgical Research:
Alejandro Rios Tovar, M.D.

Da Vinci Clinical Specialist:
Robert Palmer
Robert.palmer@intusurg.com
585-329-7356

Roles of Surgical Residents in Robotic Training

PGY-1-2 – Phase I - Intro to da Vinci Surgery Community (1-2 hours) – Completion of Web-Based Modules.

PGY-2 Phase II – Preparation & System Training (2 instructor + 8 docking hours)-Completion of up to 5 docking bedside assists.

PGY-3 – Phase III – Simulation Training (40 Drills), participation in Tier I cases/console surgeon (cholecystectomy, hernias).

PGY-4 – Phase IV – Console surgeon with private practice surgeons.

PGY-5 Independent case completion as console surgeon under direct supervision by faculty of up to 2 Tier 1 cases required for credentialing.

Overview – Da Vinci Resident Training

Curriculum –consistent with Da Vinci credentialing practices to allow transition to private practice with privileges.

PGY 1 – Phase I (1-2 hours)

- Intro to da Vinci on-line community
- Register at www.davincisurgerycommunity.com
- Look around “Training” tab under “Residents & Fellows” and “Surgeons”
- Access procedure videos
- Print out score or save print screen (control & print screen button)

PGY 1 – Phase II

- Preparation & System training 2+8 hours
- Da Vinci Si system on-line training 2-3 hours
- Complete both resident/fellow & surgeon Si Modules
 - 1) first assist essentials
 - 2) cable management
 - 3) sterile field troubleshooting
 - 4) system overview
 - 5) OR set-up & systems connections
 - 6) vision system
 - 7) draping
 - 8) docking
 - 9) safety features

- 10) surgeon console
- 11) DaVinci OR staff assessment
- 12) Print certificate-bring to program director
- Completion of 5 bedside first assistant cases at Tier I or Tier II to include: access, port placement, docking and robotic arm positioning.

PGY 3 – Phase II Preparation & system: training 2+8 hours

- 1) On-site training with OR DaVinci specialist
- 2) Surgical component overview 1 hour
- 3) System manipulation, surgeon console overview (dual console), OR set up, emergency procedures
- 4) Port placement philosophy 1 hour
- 5) Patient positioning, side-cart placement, system arm position, ancillary trocar placement
- 6) Docking, Endowrist instrument overview 2 hours
- 7) Stage 1-camera arm positioning
- 8) Stage 2-instrument arm positioning & port placement, patient cart
- 9) Stage 3-docking camera & instrument arms
- 10) Stage 4-check system set up
- 11) Stage 5-endowrist instrument insertion & removal
- 12) Surgeon & dual console set-up
- 13) Emergency procedures
- 14) Surgical skills practicum & evaluation (simulation or training pods)
 - Manipulation
 - Dissection
 - Transection
 - Suturing
- 15) PGY 3 – Phase III Simulation Training
 - Surgeon login information
 - Complete 40 training modules
 - Score 90% or greater/each module
 - Record 2 scores

PGY 4-5 – Phase IV Clinical training

Console surgeon 20 cases

20 Tier I procedures minimum

Residents to log cases

PGY-5 –Phase V Progression to Independent Console Surgeon

After completion of 10 console surgeon cases as an assist role the PGY-5 independent console surgeon will need to complete 20 independent procedures start to finish prior to obtaining certification for practice at graduation. All independent console cases will be supervised directly by a surgeon credentialed in robotic surgery. The first 10 procedures as independent surgeon will occur at a Tier I level with progression to Tier II based on the resident's completion of this level and skills.

Tier I-general surgery robotic procedures

- Inguinal hernia
- Cholecystectomy
- Colonic mobilization (splenic flexure-assisted LAR)
- Ventral or umbilical hernia

Tier II-advanced robotic surgery

- Gastric electrical stimulator plus pyloroplasty
- Nissen fundoplication
- Para-esophageal hernia repair
- Colectomy with internal anastomosis
- Distal pancreatectomy w/ or w/o splenectomy
- Bile duct exploration

Resident Evaluation File

Phase I-video assessment quizzes.

Document enrollment in Da Vinci community.

Phase II-on-line training certificate, hands-on system training port placement philosophy, docking & surgical skills practicum evaluation.

Phase III-simulation training 40 modules with 90% or better.

Phase IV-, console surgeon 10 proctored cases.

Phase V- Completion of 10 independent Tier I cases.

The Letter signed by Robotic Council-Proctor, Program, Director and Clinical Intuitive Representative.

Laparoscopy Curriculum

PGY-1

Objectives of first assisting laparoscopic procedures, completion of laparoscopic appendectomy and cholecystectomy for elective symptomatic cholelithiasis.

PGY-2

Objectives for completion of laparoscopic cholecystectomy for acute cholecystitis and laparoscopic umbilical hernia repair.

PGY-3

Objectives to complete laparoscopic inguinal hernia repair and mobilization of colon for laparoscopic colectomy.

PGY-4

Community experience with laparoscopic colectomy with objectives of first assistance of Nissen fundoplication with hiatal hernia repair and laparoscopic colectomy.

PGY-5

Objective to meet to independent performance of Nissen fundoplication and laparoscopic colectomy as complex laparoscopic cases.

Simulation Curriculum

Strategy: The strategy for the simulation curriculum is to utilize technology and training to create safer surgery through deliberate practice. Deliberate practice and preparation allow graduation of skills and procedures to a lower level providing improved exposure and competency training. There will be protected time of two hours for each resident to utilize faculty teaching and the automated simulators. Group simulation sessions will also occur during protected fifth Thursday.

PGY-1: Required completion of the Simbionix Lap Mentor Gallbladder modules, participation in the introduction to Fundamental Use of Safe Energy, Introduction to Laparoscopy Modules, Cadaver based introduction to emergency procedures.

PGY-2: Required completion of the Simbionix Lap Mentor Umbilical Hernia Modules, Introduction to Flexible Endoscopy (using modules on GI mentor), Bowel anastomosis simulations, Stapled anastomosis simulations.

PGY-3: Required completion of all Fundamentals of Laparoscopic Surgery Modules on the Simbionix Lap Mentor, Bowel anastomosis simulations, stapled anastomosis simulations, completion of FLS certification by the end of PGY-3 year. There will also be completion of the 40 robotic simulator modules with a score of 90% or better.

PGY-4: Required preparation on Simbionix GI Mentor for Fundamentals of Endoscopic Surgery. Certification, completion of vascular anastomosis simulations and bowel anastomosis simulations.

PGY-5: Required completion of Fundamentals of Endoscopic Surgery Curriculum.

Flexible Endoscopy Curriculum (American Board of Surgery)

PGY 1 Level

The majority of the early stages of this curriculum are dedicated to didactic materials so as to provide a basic understanding of GI diseases and the anatomy of the GI tract as perceived by flexible endoscopic techniques. The hands-on portion involves simulation-based training using computer-generated simulation, or a clinical tutorial experience geared toward the novice resident. Further clinical exposure to flexible endoscopy will occur after this initial introduction to basic scope mechanics and the rotation with the colorectal service in the latter part of the fourth year.

Introduction: Simulation or clinical tutorial exposure with an emphasis on basic scope manipulation including one-handed wheel deflection, control of suction, irrigation, and insufflation, and passage of instruments through the working channel.

Equipment: GI Mentor by 3D Systems

Basic understanding of flexible endoscope function didactics

1. Characteristics of endoscopes
 - a. Fiberoptic components
 - b. Videoendoscopic components
 - c. Image capture
 - d. Channels
 - e. Tip control
2. Equipment setup
 - a. Cart
 - b. Umbilical cable
 - c. Equipment setup steps
 - d. Equipment testing
3. Troubleshooting
4. Equipment care
 - a. Maintenance
 - b. Cleaning

General Educational Goals and Objectives for Residents Rotating on All Services

The following goals and objectives are presented in the format of the ACGME's six core competencies and should be considered additive to the goals and objectives of individual rotations.

PGY-1 Level

A. Medical Knowledge

1. Learn in-depth the fundamentals of basic science as they apply to the clinical practice of surgery.
 - a. The resident will learn to prepare for and attend the Thursday morning didactics structures around the Decker platform, and Decker online textbook. The resident will analyze all assigned topics from using either Decker or other web-based media. The resident will demonstrate proficiency by testing on questions in the Decker and TrueLearn platforms.
 - b. The resident will demonstrate cognitive proficiency in assessment of medical knowledge by taking the Decker quizzes tests and the annual ABSITE.
 - c. The resident will communicate in discussion during presentation of lectures from the Decker curriculum.
 - d. The resident will participate in weekly quizzes based on the Decker reading in preparation for the yearly ABSITE exam.
2. The resident will attend the following mandatory conferences.

Multi-Department Morbidity and Mortality	Trauma Morbidity and Mortality
Multi-Disciplinary Tumor Board	General Surgery Morbidity and Mortality
Trauma Grand Rounds	Mock Orals

B. Patient Care

1. The resident will assume care of all patients on the hospital ward and be responsible for admission/discharge of all patients on the hospital wards and day surgery units. The resident should assume care of all patients on the hospital wards and intensive care units.
2. The resident will perform a complete and accurate history and physical examination on every new admission to the service.
3. The resident will demonstrate proficiency in invasive procedures on ward and ICU patients, with appropriate supervision from faculty or a PGY-5 resident. The resident will obtain sign-off of all invasive procedures to demonstrate adequate supervision.
4. The resident will demonstrate planning for appropriate diagnostic and imaging tests on ward patients.
5. The resident should insure proper disposition and follow-up of all patients discharged from the hospital.

C. Interpersonal and Communication Skills.

1. The resident will demonstrate clear, accurate, and succinct patient information to faculty and senior residents regarding newly admitted patients.

2. The resident will consult the senior resident and faculty on all progress of all patients and will alert the senior resident and faculty of new problems on the service.
3. The resident will demonstrate clear, accurate, and respectful communication with nurses and other hospital employees.
4. The resident will perform clear, accurate, and respectful communication with referring and consulting physicians, including residents.
5. The resident will perform clear, accurate, and respectful communication with patients and appropriate members of their families about identified disease processes, the expected courses, operative findings and operative procedures.
6. The resident will maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.
7. The resident will participate in all morning report and evening sign-out sessions to relay patient information in a timely manner to communicate changes in patient condition and unfinished tasks.
8. The resident will demonstrate proficiency in obtaining consent that explains appropriate course of therapy including potential complications sensitive to patient education level and language barriers for consent.
9. The resident will ensure that all student ward notes are accurate, reflect a proper plan, and are countersigned by a physician each day.
10. The resident will demonstrate participation in the night-float system as scheduled monthly and demonstrate proficiency in checkout and task completion between shifts.

D. Practice-Based Learning and Improvement

1. The resident will write an accurate, detailed preoperative assessment note on all patients for which he/she serves as the surgeon of record.
2. The resident will perform self-assessment by entering all procedures and operative cases in which he /she is the surgeon of record into the ACGME database within 24 hours of completing the procedure.
3. Resident will submit SIMPL evaluation to attending and review feedback received.
4. The resident will participate in discussions at morbidity and mortality conferences for cases in which they were involved with critical portions of the care.
5. The resident will dictate accurate discharge summaries of all patients under their care within 24 hours of discharge from the hospital.

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services, and pharmacy.
2. The resident will be able to determine and convey to appropriate individuals the instruments and other materials necessary for all procedures.
3. The resident will justify diagnostic tests (including laboratory studies) ordered and document when needed.

4. The resident will perform appropriate discharges utilizing social services and home health services to ensure timely care of the patient.

F. Professionalism

1. The resident will demonstrate honesty with all individuals at all times in conveying patient care issues.
2. The resident will plan to place the needs of the patient above all the needs or desires of him/herself.
3. The resident will demonstrate high ethical behavior in all professional activities.
4. The resident will demonstrate compliance with all required training designated by the Texas Tech Department of Compliance and University Medical Center of El Paso.
5. The resident will demonstrate a commitment to the continuity of patient care through carrying out professional responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead (e.g. checkout procedures).
6. The resident will understand the institutional policy on duty hours and remain compliant with all duty hour regulations.
7. The resident will be professionally attired at all times while engaged in patient care.
8. The resident will be professionally groomed at all times when engaged in patient care.
9. The resident will demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.
10. The resident will demonstrate respectful treatment of patients, families, and all members of the health care team.
11. The resident will participate in events in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident will notify the appropriate supervisor if he or she will be unable to be present.

PGY-2 Level

A. Medical Knowledge

1. Learn in-depth the fundamentals of basic science as they apply to the clinical practice of surgery.
 - a. The resident will prepare for and attend the Thursday morning didactics structures. The resident will read all assigned topics from the curriculum using either TrueLearn, Decker or other web-based media. The resident will take the tests in the Decker platform curriculum.
 - b. The resident will participate in scheduled delivery and presentation of lectures from as assigned by faculty during Thursday morning didactics conferences.
 - c. The resident will prepare and deliver morbidity and mortality presentations for trauma morbidity and mortality and general surgery morbidity and mortality conferences.
 - d. The resident will analyze articles to provide summaries of outcomes following trauma and general surgery morbidities and mortalities.
 - e. The resident will participate in weekly quizzes based on the Decker reading in preparation for the yearly ABSITE exam.

2. The resident will attend the following mandatory conferences.

Multi-Department Morbidity and Mortality	Trauma Morbidity and Mortality
General Surgery Morbidity and Mortality	Trauma Grand Rounds
Multi-Disciplinary Tumor Board	Mock Orals

3. Develop technical skills appropriate to level of training.

The resident will attend simulation skills training sessions each fifth Thursday and will obtain written signoff in performance of laparoscopic skills stations appropriate for his or her level of training. The skills will include intermediate laparoscopic skills (rope pass and bean drop) and an orientation to upper GI endoscopy and lower GI endoscopy. Those residents post-call on simulation center days can schedule make-up sessions at time appropriate intervals.

B. Patient Care

1. The resident will demonstrate care for all patients in the critical care units and hospital wards as well as responsibility for the evaluation and disposition of all consults generated by the emergency department or other hospital service.
2. The resident will perform a complete and accurate history and physical examination on every new admission to the critical care unit and from the emergency department.
3. The resident will make daily assessments plans on every patient in the intensive care unit and every inpatient consult, and have full knowledge of all medical problems and progress of such patients.
4. The resident will assist interns in completion of procedures and perform all invasive procedures on patients in the critical care units.
5. The resident will perform service based organization, including daily care plans for patients on the hospital ward and outpatient units.
6. The resident will demonstrate delegation of responsibilities to interns and medical students.

C. Interpersonal and Communication Skills

1. The resident will be apply clear, accurate, and succinct presentation of patient information to critical care faculty regarding newly admitted patients.
2. The resident will demonstrate notification of the senior resident and faculty of all progress of all critical care unit patients and will alert the senior resident of new problems on the service.
3. The resident will apply clear, accurate, and respectful communication with nurses and other hospital employees in the critical care and intensive care units.
4. The resident should clearly, accurately, and respectfully communicate with referring and consulting physicians, including residents and students.
5. The resident should clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes (including complications), the expected courses, operative findings and operative procedures.
6. The resident should maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.

7. The resident should be able to clearly and accurately teach medical students about the procedures performed on this rotation.
8. The resident will determine that all ICU student notes are accurate, reflect a proper plan, and are countersigned by a physician each day.
9. The resident will gain competence in communicating with family members to deliver prognosis and describe patient care plans as well as obtaining advanced directives especially in critically ill patients.

D. Practice-Based Learning and Improvement

1. The resident will write an accurate, detailed and legible preoperative assessment note on all patients for which he/she serves as the surgeon of record.
2. The resident will enter all procedures and operative cases in which he /she is the surgeon of record into the ACGME database within 24 hours of completing the procedure.
3. The resident must dictate an accurate and descriptive narration of the operative procedure in which he/she is the primary surgeon within 24 hours.
4. The resident will prepare presentations of complications from the emergency department or critical care unit for discussions at Trauma morbidity and mortality conferences for cases in which they were involved.
5. The resident will analyze the literature and perform self-assessment of complications in the intensive care unit.
6. The resident will demonstrate formation of an evidence- base plan for patient treatment in daily progress notes in the critical care unit and on floor patients.

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, pastoral care, discharge planning, physical therapy, occupational therapy, speech therapy, nutrition services, and pharmacy.
2. The resident will be able to summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures in the intensive care unit.
3. The resident will be able to determine and convey to appropriate individuals the instruments and other materials necessary for all procedures in the operating room and intensive care unit.
4. The resident will be able to justify all diagnostic tests (including laboratory studies) ordered.
5. The resident will demonstrate coordination of care in the intensive care unit to include daily rounds, discharge planning with rehabilitation hospitals, and coordination with organ donation services.

E. Professionalism

1. The resident will demonstrate honesty with all individuals at all times in conveying issues of patient care in the intensive care unit and surgical floor.
2. The resident will perform completion of the needs of the patient above all the needs or desires of him/herself.
3. The resident will demonstrate high ethical behavior in all professional activities.

4. The resident will perform compliance with all required training designated by the Texas Tech Department of Compliance and University Medical Center.
5. The resident will demonstrate commitment to the continuity of patient care through carrying out professional responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead (e.g. checkout procedures).
6. The resident will understand the institutional policy on duty hours and remain compliant with all duty hour regulations. Residents will enter the number of hours spent in the hospital into the departmental datasheet within four days of duty.
7. The resident will be professionally attired at all times while engaged in patient care.
8. The resident will be professionally groomed at all times when engaged in patient care.
9. The resident will demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.
10. The resident will at all times treat patients, families, and all members of the health care team with respect.
11. The resident will demonstrate proficiency and compassion in delivering critical difficult information to families, communicating with critically ill patients, and placing do not resuscitate orders.
12. The resident will participate reliably in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident will notify the appropriate supervisor if he or she will be unable to be present.

PGY-3

A. Medical Knowledge

1. Learn in-depth the fundamentals of clinical science and decision making as they apply to the practice of surgery.
 - a. The resident will prepare for and attend the Thursday morning didactics structures. The resident will read all assigned topics from the curriculum using either Decker or TrueLearn. The resident will take the tests in the Decker platform curriculum.
 - b. The resident will participate in scheduled delivery and presentation of lectures from as assigned by faculty during Thursday morning didactics conferences.
 - c. The resident will prepare and deliver morbidity and mortality presentations for trauma and general surgery morbidity and mortality conferences.
 - d. The resident will analyze articles to provide discussions of clinical patient care for mortality and morbidity presentations focusing on decision making and clinical judgment.
 - e. The resident will participate in weekly quizzes based on the Decker reading in preparation for the yearly ABSITE exam.
2. The resident will attend the following mandatory conferences.

Multi-Department Morbidity and Mortality	Trauma Morbidity and Mortality
General Surgery Morbidity and Mortality	Trauma Grand Rounds
Multi-Disciplinary Tumor Board	Mock Orals

3. Develop technical skills appropriate to level of training.

The resident will attend simulation skills training sessions each month on Thursday afternoon from 1-4 PM and will obtain written signoff in performance laparoscopic skills stations appropriate for his or her level of training. Those residents post call on simulation center days can schedule make-up sessions at time appropriate intervals. The resident will demonstrate proficiency in advanced laparoscopic skills including laparoscopic intra-corporeal suturing and laparoscopic intestinal anastomosis.

B. Patient Care

1. The resident will assume care of all patients on the hospital ward, emergency department and intensive care unit; and be responsible for admission/discharge of all patients on the hospital wards, ICU, emergency department and day surgery units.
2. The resident will perform a complete and accurate history and physical examination on every new admission to the service.
3. The resident will assess and plan care strategies on every ward patient on the service and will have full knowledge of all medical problems and progress of all ward and ICU patients.
4. The resident will perform invasive procedures on ward and ICU patients and assist junior residents in these procedures providing education and supervision.
5. The resident will perform arrangements for appropriate diagnostic and imaging tests on ward and ICU patients.
6. The resident will ensure proper disposition and follow-up of all patients discharged from the hospital.
7. The resident will perform service as the senior resident responsible for the service with accurate communication with chief residents and faculty including delegation of responsibilities to junior residents.

C. Interpersonal and Communication Skills

1. The resident will demonstrate clear, accurate, and succinct communication of patient information to faculty and chief residents regarding newly admitted patients.
2. The resident will communicate with the chief resident and faculty resident to create awareness of progress of all patients and will alert the faculty of new problems on the service.
3. The resident will demonstrate clear, accurate, and respectful communication with nurses and other hospital employees.
4. The resident will demonstrate clear, accurate, and respectful communication with referring and consulting physicians, residents and students.
5. The resident should clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes (including complications), the expected courses, operative findings and operative procedures.
6. The resident should maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.

7. The resident should be able to clearly and accurately teach medical students about the procedures performed.
8. The resident will ensure that all student ward notes are accurate, reflect a proper plan, and are countersigned by a physician each day.
9. The resident will gain competence in communicating with family members to deliver prognosis and describe patient care plans as well as obtaining advanced directives.
10. The resident will gain competence in leadership with delegation of responsibility to junior residents and enforcement of discipline to ensure effective management of the service.

D. Practice-Based Learning and Improvement

1. The resident will write an accurate, detailed and legible preoperative assessment note on all patients for which he/she serves as the surgeon of record.
2. The resident will enter all procedures and operative cases in which he /she is the surgeon of record into the ACGME database within 24 hours of completing the procedure.
3. The resident will demonstrate dictation of an accurate and descriptive narration of the operative procedure in which he/she is the primary surgeon within 24 hours.
4. The resident will participate in discussions at morbidity and mortality conferences for cases in which they were involved with critical portions of the care.
5. The resident will deliver morbidity and mortality presentations for cases in which they were involved in critical portions of the care.
6. The resident will analyze the literature for written discussions following morbidity and mortality presentations to demonstrate clinical decision making and judgment.

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services, and pharmacy.
2. The resident will be able to summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures on the surgical floors, intensive care unit and emergency department.
3. The resident will be able to determine and convey to appropriate individuals the instruments and other materials necessary for all procedures in the emergency department, surgical floors and intensive care unit.
4. The resident will be able to justify all diagnostic tests (including laboratory studies) ordered and document when needed.
5. The resident will delegate responsibilities to junior residents and make appropriate use of ancillary services including physician extenders.
6. The resident will demonstrate proficiency in leadership roles as senior resident on the surgical services and in the intensive care unit.

F. Professionalism

1. The resident will demonstrate honesty with all individuals at all times in conveying patient care issues.

2. The resident will practice placing needs of the patient above needs or desires of him/herself.
3. The resident will demonstrate high ethical behavior in all professional activities.
4. The resident will demonstrate compliance with all required training designated by the Texas Tech Department of Compliance and University Medical Center.
5. The resident will demonstrate a commitment to the continuity of patient care through carrying out professional responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead (e.g. checkout procedures).
6. The resident will understand the institutional policy on duty hours and remain compliant with all duty hour regulations. Residents will enter the number of hours spent in the hospital into the departmental datasheet within four days of duty.
7. The resident will be professionally attired at all times while engaged in patient care.
8. The resident will be professionally groomed at all times when engaged in patient care.
9. The resident will demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.
10. The resident will demonstrate respect for patients, families, and all members of the health care team.
11. The resident will participate in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident will notify the appropriate supervisor if he or she will be unable to be present.
12. The resident will demonstrate effective leadership skills in delegating authority to junior residents and ensuring completion of service tasks.
13. The resident will perform disciplinary actions to motivate and correct junior residents in a compassionate and effective manner.
14. The resident will direct medical student assignments to patients and surgeries, resolving conflicts and providing mentorship and educational opportunities.

PGY-4

A. Medical Knowledge

1. Learn in-depth the fundamentals of judgment and clinical science as they apply to the practice of surgery.
 - a. The resident will prepare for and attend the Thursday morning didactics structures. The resident will read all assigned topics from the curriculum using either TrueLearn, Decker or other web-based media. The resident will take the tests in the Decker platform curriculum.
 - b. The resident will participate in scheduled delivery and presentation of lectures as assigned by faculty during Thursday morning didactics conferences.
 - c. The resident will participate in weekly quizzes based on the Decker reading in preparation for the yearly ABSITE exam.
2. The resident will attend the following mandatory conferences.

Multi-Department Morbidity and Mortality

Trauma Morbidity and Mortality

General Surgery Morbidity and Mortality

Trauma Grand Rounds

3. Develop technical skills appropriate to level of training.

The resident will attend simulation skills training sessions each month on Thursday afternoon from 1-4 PM and will obtain written signoff in performance of laparoscopic skills stations appropriate for his or her level of training. Those residents post-call on simulation center days can schedule make-up sessions at time appropriate intervals. Residents on away or out of town rotations will schedule make-up simulation sessions to attain appropriate skill levels. The resident will demonstrate proficiency in laparoscopic intra-corporeal suturing skills, laparoscopic intestinal anastomosis skills, and laparoscopic Nissen fundoplication model skills.

B. Patient Care

1. The resident will assume care of all patients on the hospital ward and be responsible for admission/discharge of all patients on the hospital wards ICU, and day surgery units at community hospitals for all external clinical rotations.
2. The resident will perform a complete and accurate history and physical examination on every new admission to the community surgeon's service.
3. The resident will perform daily assessments and plans on every patient on the community surgeon's service and will have full knowledge of all medical problems and progress of all patients.
4. The resident will arrange for appropriate diagnostic and imaging tests on patients.

C. Interpersonal and Communication Skills

1. The resident will demonstrate clear, accurate, and succinct patient presentations to community surgeons regarding newly admitted patients.
2. The resident will inform the community surgeons of progress of patients and will alert the surgeon of new problems on the service.
3. The resident will communicate clearly, accurately, and respectfully with nurses and other hospital employees at community hospitals.
4. The resident will communicate clearly, accurately, and respectfully with referring and consulting physicians.
5. The resident will communicate clearly, accurately, and respectfully with patients and appropriate members of their families about identified disease processes (including complications), the expected courses, operative findings and operative procedures.
6. The resident will maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.

D. Practice-Based Learning and Improvement

1. The resident will enter all procedures and operative cases in which he /she is the surgeon of record into the ACGME database within 24 hours of completing the procedure.
2. The resident will dictate an accurate and descriptive narration of the operative procedure in which he/she is the primary surgeon within 24 hours.

3. The resident will participate in morbidity and mortality conferences at community hospitals where they will present patients in conjunction with community surgeons.

E. Systems-Based Practice

1. The resident will demonstrate utilization of ancillary services including social services, discharge planning, physical therapy, nutrition services, and pharmacy and physician extenders in community hospitals.
2. The resident will summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures in community hospitals.
3. The resident will determine and convey to appropriate individuals the instruments and other materials necessary for all procedures at community hospitals.
4. The resident will justify all diagnostic tests (including laboratory studies) ordered and document when needed at community hospitals.
5. The resident will demonstrate an understanding of procedural coding and insurance issues associated with private practice.

F. Professionalism

1. The resident will demonstrate honesty with all individuals at all times in conveying patient care issues.
2. The resident will place the needs of the patient above all the needs or desires of him/herself.
3. The resident will maintain high ethical behavior in all professional activities.
4. The resident will understand the institutional policy on duty hours and remain compliant with all duty hour regulations.
5. The resident will be professionally attired at all times while engaged in patient care.
6. The resident will be professionally groomed at all times when engaged in patient care.
7. The resident will demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.
8. The resident will demonstrate respect for patients, families, and all members of the health care team.
9. The resident will participate reliably in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident will notify the appropriate supervisor if he or she will be unable to be present.
10. The resident will maintain a professional relationship with surgeons at community hospitals respecting the private-practice environment and the private surgeon's authority to deliver prognoses and discuss treatment plans.

PGY-5 Chief Year

A. Medical Knowledge

1. Learn in-depth the fundamentals of judgment and clinical science as they apply to the practice of surgery.
 - a. The resident will assist in the preparation of the curriculum for the Thursday morning didactics.

- b. The resident will read all assigned topics from the Decker curriculum using either Decker or other TrueLearn. The resident should take the tests in the Decker curriculum.
- c. The resident will participate in scheduled delivery and presentation of lectures from as assigned by faculty during Thursday morning didactics conferences.
- d. The resident will prepare and deliver morbidity and mortality presentations for trauma and general surgery morbidity and mortality conferences.
- e. The resident will analyze articles to provide discussions of clinical patient care for mortality and morbidity presentations focusing on decision making and clinical judgment.
- f. The resident will participate in weekly quizzes based on the Decker reading in preparation for the yearly ABSITE exam.
- g. The resident should prepare for and participate in the Mock Orals conference.
- h. The resident will participate in assessment of medical knowledge by taking the semi-monthly Surgical Core Curriculum tests and the annual ABSITE.

2. The resident will attend the following mandatory conferences.

Multi-Department Morbidity and Mortality	Trauma Morbidity and Mortality
General Surgery Morbidity and Mortality	Trauma Grand Rounds
Multi-Disciplinary Tumor Board	Mock Orals

3. Develop technical skills appropriate to level of training.

The resident will attend simulation skills training sessions each fifth Thursday and will obtain written signoff in performance of laparoscopic skills stations appropriate for his or her level of training. Those residents post-call on simulation center days can schedule make-up sessions at time appropriate intervals.

The resident will demonstrate proficiency in laparoscopic intra-corporeal suturing, laparoscopic intestinal anastomosis skills, and a laparoscopic common bile duct exploration model.

B. Patient Care

- 1. The resident will assume care of all patients on the hospital wards emergency department and intensive care units and be responsible for admission/discharge of all patients.
- 2. The resident will perform rounds on service patients daily to supervise assessments and plans on every patient on the service and will have full knowledge of all medical problems and progress of all patients.
- 3. The resident will perform proper disposition and follow-up of all patients discharged from the hospital.
- 4. The resident will perform in the capacity of faculty during trauma evaluations caring for all trauma and emergency department patients in the absence of direct supervision.
- 5. The resident will perform supervision all intern/ PGY-1 residents in the completion of bedside procedures on the wards and intensive care units.

C. Interpersonal and Communication Skills

- 1. The resident will demonstrate clear, accurate, and succinct communication to present patient information to faculty regarding newly admitted patients.

2. The resident will keep the faculty aware of all progress of all patients and will alert the faculty of new problems on the service.
3. The resident will demonstrate clear, accurate, and respectful communication with nurses and other hospital employees.
4. The resident will demonstrate clear, accurate, and respectful communication with referring and consulting physicians, including residents.
4. The resident will clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes (including complications), the expected courses, operative findings and operative procedures.
5. The resident will maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.
6. The resident will teach medical students about the procedures performed on this rotation.
7. The resident will develop leadership skills in discipline and delegation in working with junior residents in a supervisory role.
8. The resident will perform in a supervisory role with junior and senior residents in administering delegation of authority and discipline as well as determining remediation.

D. Practice-Based Learning and Improvement

1. The resident must enter all procedures and operative cases in which he /she is the surgeon of record into the ACGME database within 24 hours of completing the procedure.
2. The resident must dictate an accurate and descriptive narration of the operative procedure in which he/she is the primary surgeon within 24 hours.
3. The resident will determine which cases will be presented for the general surgery morbidity and mortality conference in keeping with quality improvement initiatives for the elective surgery services.
4. The resident will participate in discussions at morbidity and mortality conferences for cases in which they were involved with critical portions of the care.
5. The resident will prepare general surgery morbidity and mortality presentations to discuss clinical decision making, quality improvement and outcome measures.

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services, and pharmacy and physician extenders.
2. The resident will summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures.
3. The resident will determine and convey to appropriate individuals the instruments and other materials necessary for all procedures in the intensive care unit, operating room and emergency department.
4. The resident will justify all diagnostic tests (including laboratory studies) ordered and document when needed.

5. The resident will direct the morning report and evening checkout rounds assuring accurate and efficient exchange of patient information to on-call and night float residents and faculty.

F. Professionalism

1. The resident will demonstrate honesty with all individuals at all times in conveying issues of patient care.
2. The resident will place the needs of the patient above all the needs or desires of him/herself.
3. The resident will maintain high ethical behavior in all professional activities.
4. The resident will demonstrate compliance with all required training designated by the Texas Tech Department of Compliance and University Medical Center.
5. The resident will demonstrate a commitment to the continuity of patient care through carrying out professional responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead (e.g. checkout procedures).
6. The resident will understand the institutional policy on duty hours and remain compliant with all duty hour regulations.
7. The resident will be professionally attired at all times while engaged in patient care.
8. The resident will be professionally groomed at all times when engaged in patient care.
9. The resident will demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.
10. The resident will demonstrate respect for patients, families, and all members of the health care team.
11. The resident will participate reliably in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident will notify the appropriate supervisor if he or she will be unable to be present.
12. The resident will demonstrate leadership skills in delegating authority, administering discipline and determining remediation for junior and senior residents.
13. The resident will perform as a clinical instructor during faculty absence in the emergency department for trauma and in the supervision of junior residents.
14. The resident will demonstrate compassion and understanding in supervising tasks and responsibilities for junior residents and medical students.

Goals and Objectives for all Services

General Surgery – Team A and B

PGY-1

A. Medical Knowledge

1. The resident will learn in-depth the fundamentals of basic science as they apply to patients with elective surgical problems. Examples include elements of wound healing, pathophysiology of cholelithiasis, and surgical anatomy of hernias.
2. The resident will be able to discuss the evaluation and treatment of gallbladder disease.
3. The resident will understand the principles and rationale for ambulatory management of surgical patients. This will include the preoperative assessment, preoperative management and post-operative care of patients. Examples include assessment of patient risk, selection of patients for outpatient versus inpatient surgery, and principles of postoperative pain management and wound care. The resident will understand the pathophysiology of appendicitis.
4. The resident will establish and account on the DaVinci online community and complete online training modules commensurate with an introduction to robotic surgery.

B. Patient Care

1. The resident will perform a complete history and physical examination in patients with common surgical problems.
2. The resident will demonstrate an understanding of the principles of surgical decision-making, with particular reference to the appropriateness of treating problems in an ambulatory setting.
3. The resident will efficiently utilize and interpret diagnostic laboratory testing. Examples of appropriate tests include serum chemistries, hematological profiles, and coagulation tests.
4. The resident will efficiently utilize and interpret diagnostic radiological tests. Examples of studies include gallbladder ultrasonography and gastrointestinal studies.
6. The resident will be able to assess patients on the ward when called for cross-coverage. Examples include evaluation of patients with fever, oliguria, hypotension, respiratory insufficiency, and intractable pain.
7. The resident, under appropriate supervision, will perform basic surgical procedures such as: Open lymph node biopsy (cervical, axillary, groin), excision of small subcutaneous masses, and open and laparoscopic appendectomy
8. The resident will first assist at the bedside in robotic surgery cases to learn access, docking and arm positioning.

C. Interpersonal and Communication Skills

1. The resident will create sound relationships and working partnerships with patients and families.
2. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments, recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
3. The resident will work effectively with all members of the health care team.
4. The resident will perform an accurate and complete history and physical examination.

5. The resident will exhibit effective listening skills and respond well to constructive feedback.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.

2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.

3. The resident will manage data efficiently and record documentation will be timely, concise, and understandable

4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making.

5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.

6. The resident will use all such electronic resources to educate and teach others (including their patients).

7. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.

2. The resident will become familiar with the proper and efficient utilization of surgical intervention.

3. The resident will participate as an integral member of the surgery resident team.

4. The resident will actively partner with health care managers and care providers to assess, coordinate, and improve the health care provided to patients.

5. The resident will begin to understand how patients' insurance status and financial resources affect health care.

6. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.

7. The resident will understand the basic principles of a multidisciplinary approach to the treatment of cancer and general surgery patients in particular and patients in general.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.

3. The resident will recognize and respect patients' rights, confidentiality, and privacy.

4. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language;

5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.

6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.

PGY-2

A. Medical Knowledge

1. The resident will learn pertinent scientific information applicable to preoperative and postoperative conditions.
2. The resident will learn detailed surgical anatomy applicable to procedures. Examples include anatomy of lymphatic's (neck, groin, and axilla); anatomy of the structures of the porta hepatic and structures within the triangle of Calot; and anomalous biliary anatomy.
3. The resident will have an in-depth understanding of the various options available for hernia repair and be able to discuss the preoperative variables important in selection of the most appropriate type of repair. Examples include pre-peritoneal repair, laparoscopic repair, and open mesh vs. tissue repairs.
4. The resident will be able to demonstrate an understanding of the principles of surgical decision-making.

B. Patient Care

1. The resident will obtain detailed operative consent and participate in "time out" procedures prior to operations.
2. The resident will be able to identify instruments and supplies that will be necessary for operative procedures on which he or she will serve as surgeon of record.
4. The resident will, under appropriate supervision, perform surgical procedures such as:
Open and needle-localization breast biopsy
Laparoscopic cholecystectomy Incisional hernia repair
Sentinel node biopsy Recurrent inguinal hernia repair
5. The resident will first assist at the bedside in robotic procedures to learn port access, arm docking and proper robotic arm position.

C. Interpersonal and Communication Skills

1. The resident will manage data efficiently and record documentation.
2. The resident will create and sustain ethically sound relationships with patients.
3. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments.
4. The resident will recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management;
5. The resident will work as a team leader and work effectively with all members of the health care team.
6. The resident will perform an accurate and complete history and physical examination.
7. The resident will educate the interns (PGY-1) and medical students.
8. The resident will demonstrate exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.

2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.
3. The resident will manage data efficiently and record documentation will be timely, concise, and understandable (interpretable).
4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making.
5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
6. The resident will use electronic resources to educate and teach others (including their patients, interns, and medical students).
7. The resident will participate in morbidity and mortality conference discussions for general surgery cases where they were involved in the care.
8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will participate as an integral member of the surgery resident team.
4. The resident will actively partner with health care managers and care providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will learn how to coordinate disability status, enrollment in Medicaid and financial resources to affect health care.
6. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
7. The resident will understand the basic principles of a multidisciplinary approach to the treatment of cancer and general surgery in particular and patients in general.
8. The resident will learn to become a team leader and take responsibility for intern and medical student education.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care;
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided;
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.

6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
8. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

PGY-3

A. Medical Knowledge

1. The resident will understand the pathophysiology, presentation, and treatment of acute surgical illness. Examples include peritonitis, acute bowel ischemia, small and large bowel obstruction, esophageal perforation, gastric ulcers, duodenal ulcers, and ascending cholangitis.
2. The resident will be able to differentiate acute and subacute clinical conditions in the spectrum of disease. Examples include biliary tract disease, duodenal ulcer disease, and diverticulitis.
3. The resident will be able to recognize and treat comorbid conditions in the patient with acute surgical illness.
4. The resident will be able to discuss management options for patients with acute surgical illness. Examples include medical management of complications bowel disease, use of percutaneous cholecystectomy, and creation of colostomy vs. primary anastomosis to treat colon perforation.
5. The resident will complete all robotic surgery simulation modules with a score of 90% or better in preparation to assist and perform surgery behind the robotic console.

B. Patient Care

1. The resident will assume supervisory responsibility for the overall care of patients on the service, including personally examining every new admission, knowing the daily progress and new complications of every patient, and making discharge plans.
2. The resident will demonstrate an understanding of the principles of surgical decision-making, including making therapeutic plans for every patient and determining timing of operative intervention.
3. The resident will serve as the senior resident and team leader delegating responsibility for task completion and patient follow up to junior residents.
4. The resident will, under appropriate supervision, perform intermediate surgical procedures such as:
Laparoscopic cholecystectomy for acute cholecystitis
Colectomy Enterectomy/enterolysis
5. The resident will begin to sit behind the robotic console and perform portions of Tier I surgeries to include robotic cholecystectomy and robotic mobilization of the colon for segmental resection.

C. Interpersonal and Communications Skills

1. The resident will be able to clearly, accurately, and succinctly present pertinent information to faculty regarding newly admitted patients.
2. The resident will keep the faculty aware of all progress of all critical care unit patients and will

alert the respective faculty of new problems on the service.

3. The resident will clearly, accurately, respectfully, and professionally communicate with referring and consulting physicians, physician assistants, nurse practitioners, and other residents.

4. The resident will clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes, complications, the expected courses, operative procedures, and operative findings.

5. The resident will maintain clear, concise, accurate, and timely medical records including but not limited to history and physical examination documentation, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries;

6. The resident will be able to clearly and accurately teach medical students and junior residents about the procedures performed.

7. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.

8. The resident will communicate as team leader and delegate responsibility to work effectively with all members of the health care team.

9. The resident will exhibit effective listening skills and perform well under constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will write an accurate, detailed and legible preoperative assessment on all patients for which he/she serves as surgeon of record.

2. The resident will enter all procedures and operative cases in which he/she is the surgeon of record into the ACGME case log system within 24 hours of completing the procedure or operation.

3. The resident will dictate an accurate and descriptive narration of the operative procedure in which s/he is the primary surgeon within 24 hours.

4. The resident will prepare presentation cases at the bi-monthly morbidity and mortality conference.

5. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.

6. The resident will learn to develop clinical questions, search the literature effectively and use evidence-based criteria to determine the value of information for decision making;

7. The resident will learn to utilize the computer and web-based resources to make patient care decisions.

8. The resident will use all such electronic resources to educate and teach others (including their patients).

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services, pharmacy, and physician extenders.

2. The resident will be able to summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures;

3. The resident will be able to justify all diagnostic tests (including laboratory studies) ordered.
4. The resident will make appropriate and timely referrals.
5. The resident will become familiar with the proper and efficient utilization of surgical intervention.
6. The resident will participate as team leader of an integral member of the academic surgery resident team responsible for educating junior surgical residents and students.
7. The resident will actively partner with health care managers and care providers to assess, coordinate and improve the health care provided to patients.
8. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
9. The resident will understand the basic principles of a multidisciplinary approach to the treatment of cancer and general surgery patients in particular and patients in general.

F. Professionalism

1. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided
2. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
3. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
4. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
5. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
6. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
7. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

PGY-4 (1 month)

A. Medical Knowledge

1. The resident will be able to correctly explain the operative approaches for acute surgical conditions of the abdominal cavity and retroperitoneal organs.
2. The resident will be able to accurately explain the physiologic rationale for vagotomy, pyloroplasty, gastric resection and reconstructive techniques for ulcer disease, and stoma formation.
3. The resident will be able to correctly explain the indications and contraindications for diagnostic and therapeutic endoscopy in the acute setting.
4. The resident will be able to discuss the management alternatives for common bile duct stones.

B. Patient Care

1. The resident will assume the overall responsibility for all patients on the service after the graduating chiefs exit service, including supervision of the residents assuming direct care responsibilities.
2. The resident will serve as teaching assistant for PGY 1-3 residents as they perform operations appropriate to their level.
3. The resident will attend weekly outpatient clinics.
4. Under appropriate supervision, the chief resident should perform advanced operative procedures such as:

Subtotal Gastrectomy	Total Gastrectomy
Pancreatectomy	Hepaticojejunostomy
Thyroidectomy	Parathyroidectomy
5. The resident is expected to have completed portions of robotic cases allowing them to complete entire sequences of tier 1 cases to include cholecystectomy.

C. Interpersonal and Communication Skills

1. The resident will be able to clearly, accurately, and succinctly present pertinent information to faculty regarding newly admitted patients and present complete therapeutic plans.
2. The resident will keep the faculty aware of all progress of all critical care unit patients and will alert the respective faculty of new problems on the service as well as assist in managing patients.
3. The resident will clearly, accurately, and respectfully communicate with nurses, peers, ancillary staff and all hospital employees and direct activities of junior residents.
4. The resident will clearly, accurately, respectfully, and professionally communicate with referring and consulting physicians, physician assistants, nurse practitioners, and other residents. They will direct junior residents in a respectful fashion.
5. The resident will clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes, complications, the expected courses, operative procedures, and operative findings. They will communicate prognoses and see patients in follow-up in clinic.
6. The resident will maintain clear, concise, accurate, and timely medical records including but not limited to history and physical examination documentation, consultation notes, progress notes, written and verbal orders, and operative notes.
7. The resident will be able to clearly and accurately teach medical students and junior residents about the procedures performed.
8. The resident will create and sustain ethically sound relationships with patients.
9. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
10. The resident will assist in delegation of service responsibilities as well as disciplining junior residents.
11. The resident will identify any gaps or errors in communication during checkout proceedings and report them to faculty for quality improvement review.

D. Practice-Based Learning and Improvement

1. The resident will enter all procedures and operative cases in which he/she is the surgeon of record into the ACGME case log system within 24 hours of completing the procedure or operation;
2. The resident will dictate an accurate and descriptive narration of the operative procedure in which s/he is the primary surgeon within 24 hours.
3. The resident will present cases at the bimonthly general surgery Morbidity and Mortality Conference.
4. The resident will assist junior residents in identification and presentation of complications.
5. The resident will learn to develop clinical questions, search the literature effectively and use evidence-based criteria to determine the value of information for decision-making.
6. The resident will learn to utilize the computer and web-based resources to make patient care decisions.
7. The resident will use all such electronic resources to educate and teach others (including their patients, students and junior residents).
8. The resident will assist in formation of the didactic curriculum and in review of the weekly quizzes to assist junior resident in obtaining knowledge and clinical judgment.
9. The resident will assist in quality improvement by identifying gaps or errors in communication during checkout proceedings and report them to faculty for quality improvement review.

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services, pharmacy, and physician extenders.
2. The resident will be able to summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures.
3. The resident will be able to justify all diagnostic tests (including laboratory studies) ordered.
4. The resident will become familiar with the proper and efficient utilization of surgical intervention.
5. The resident will participate as an integral leader of the surgery resident team.
6. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
7. The resident will understand the basic principles of a multidisciplinary approach to the treatment of cancer and elective general surgery in particular and patients in general.
8. The resident will learn to serve as an instructor and educator within the academic educational setting responsible for delegation of authority and discipline of junior residents.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will recognize and respect patients' rights, confidentiality, and privacy.
3. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.

4. The resident will demonstrate sensitivity to and awareness of the impact of the patient’s culture, values, age, gender, and disabilities.
5. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
6. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
7. The resident will serve as a role model for junior residents and medical students in the conduct of professional and ethical behavior.

PGY-5

A. Medical Knowledge

1. The chief resident will be able to correctly explain the operative approaches for acute surgical conditions of the abdominal cavity and retroperitoneal organs.
2. The chief resident will be able to accurately explain the physiologic rationale for vagotomy, pyloroplasty, gastric resection and reconstructive techniques for ulcer disease, and stoma formation.
3. The chief resident will be able to correctly explain the indications and contraindications for diagnostic and therapeutic endoscopy in the acute setting.
4. The chief resident will be able to discuss the management alternatives for common bile duct stones.

B. Patient Care

1. The chief resident will assume the overall responsibility for all patients on the service, including supervision of the residents assuming direct care responsibilities.
2. The chief resident will serve as teaching assistant for PGY 1-3 residents as they perform operations appropriate to their level.
3. The chief resident will attend weekly outpatient clinics.
4. Under appropriate supervision, the chief resident should perform advanced operative procedures such as:

Subtotal Gastrectomy	Total Gastrectomy
Pancreatectomy	Hepaticojejunostomy
Thyroidectomy	Parathyroidectomy
5. Chief residents will complete Tier 1 robotic procedures under direct faculty supervision as console surgeons and complete portions of Tier II robotic surgeries for a total of 20.

C. Interpersonal and Communication Skills

1. The resident will be able to clearly, accurately, and succinctly present pertinent information to faculty regarding newly admitted patients and present complete therapeutic plans.
2. The resident will keep the faculty aware of all progress of all critical care unit patients and will alert the respective faculty of new problems on the service as well as assist in managing patients.
3. The resident will clearly, accurately, and respectfully communicate with nurses, peers, ancillary staff and all hospital employees and direct activities of junior residents.
4. The resident will clearly, accurately, respectfully, and professionally communicate with referring and consulting physicians, physician assistants, nurse practitioners, and other residents. They will

direct junior residents in a respectful fashion.

5. The resident will clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes, complications, the expected courses, operative procedures, and operative findings. They will communicate prognoses and see patients in follow-up in clinic.

6. The resident will maintain clear, concise, accurate, and timely medical records including but not limited to history and physical examination documentation, consultation notes, progress notes, written and verbal orders, and operative notes.

7. The resident will be able to clearly and accurately teach medical students and junior residents about the procedures performed when qualified (credentialed) to do so by hospital and program policy.

8. The resident will create and sustain ethically sound relationships with patients.

9. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.

10. The resident will serve as a clinical instructor during trauma resuscitations effectively communicating with anesthesia and other services during trauma resuscitations.

11. The resident will assist in delegation of service responsibilities as well as disciplining junior residents.

12. The resident will identify any gaps or errors in communication during checkout proceedings and report them to faculty for quality improvement review.

D. Practice-Based Learning and Improvement

1. The resident will enter all procedures and operative cases in which he/she is the surgeon of record into the ACGME case log system within 24 hours of completing the procedure or operation;

2. The resident will dictate an accurate and descriptive narration of the operative procedure in which s/he is the primary surgeon within 24 hours.

3. The resident will present cases at the bimonthly general surgery Morbidity and Mortality Conference.

4. The resident will assist junior residents in identification and presentation of complications.

5. The resident will learn to develop clinical questions, search the literature effectively and use evidence-based criteria to determine the value of information for decision-making.

6. The resident will learn to utilize the computer and web-based resources to make patient care decisions.

7. The resident will use all such electronic resources to educate and teach others (including their patients, students and junior residents).

8. The resident will assist in formation of the didactic curriculum and in review of the weekly quizzes to assist junior resident in obtaining knowledge and clinical judgment.

9. The resident will assist in quality improvement by identifying gaps or errors in communication during checkout proceedings and report them to faculty for quality improvement review.

E. Systems-Based Practice

1. The resident will be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services, pharmacy, and physician extenders.
2. The resident will be able to summarize the financial costs, the risks and benefits of the proposed diagnostic studies and therapeutic procedures.
3. The resident will be able to justify all diagnostic tests (including laboratory studies) ordered.
4. The resident will become familiar with the proper and efficient utilization of surgical intervention.
5. The resident will participate as an integral leader of the surgery resident team.
6. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
7. The resident will understand the basic principles of a multidisciplinary approach to the treatment of cancer and elective general surgery in particular and patients in general.
8. The resident will learn to serve as an instructor and educator within the educational setting responsible for delegation of authority and discipline of junior residents.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will recognize and respect patients' rights, confidentiality, and privacy.
3. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
4. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
5. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
6. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
7. The resident will serve as a role model for junior residents and medical students in the conduct of professional and ethical behavior.

Trauma and Acute Care Surgery

PGY-1

A. Medical Knowledge

1. The resident should understand the principles of Advanced Trauma Life Support.
2. The resident should be able to identify different forms of shock associated with the injured patient. Examples include hemorrhagic, neurogenic, cardiogenic and septic shock.

- f. effective and positive communication with ICU nurses and ancillary ICU personnel.
- 5. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
- 6. The resident will work effectively with all members of the health care team.
- 7. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

- 1. The resident will recognize the indications for surgical intervention.
- 2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.
- 3. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
- 4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making.
- 5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
- 6. The resident will know when to call for assistance.

E. Systems-Based Practice

- 1. The resident will make appropriate and timely referrals.
- 2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
- 3. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
- 4. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
- 5. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma and patients.

F. Professionalism

- 1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
- 2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
- 3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
- 4. The resident will discuss patients and their care with appropriate staff, attending, and fellow residents in private areas or in a private manner and with respectful language.
- 5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
- 6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.

PGY-2

A. Medical Knowledge

1. The resident should learn the principles of triage and be able to demonstrate appropriate triage of injured patients based on number of patients, severity of injury and available resources.
2. The resident should review the principles of ATLS and be able to perform a rapid primary survey of the trauma patient, followed by an in depth secondary survey to detect all injuries.
3. The resident should be able to prioritize injuries in the multiply injured trauma patient.
4. The resident should understand the principles of resuscitation of the injured patient, including airway management, fluid administration, blood transfusion, and hemodynamic support.
5. The resident should be able to outline the signs and symptoms as well as the etiology of respiratory failure in the injured patient.
6. The resident should understand the indications for, and the complications of blood component therapy. Examples include PRBC's, FFP, platelets and cryoprecipitate.
7. The resident should understand indications/institution of the massive transfusion protocol.
8. The resident should understand the factors associated with non-surgical bleeding in the injured patient. Examples include hypothermia, dilutional, and consumptive coagulopathy.

B. Patient Care

1. The resident should institute the trauma resuscitation protocol in trauma patients presenting to the emergency department.
2. The resident should assume responsibility for care of all patients in the emergency department, including initial assessment, identification of all injuries, creation of a therapeutic plan based on priority of injuries, initial resuscitation, and determination of admission to the hospital ward or to the ICU.
3. Under appropriate supervision, the resident should perform basic procedures such as:
Surgical airway
Focused abdominal ultrasound for trauma Initial trauma resuscitation laparotomy

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator.
 - b. dealing with the families of critically injured or ill patients.
 - c. ethics of do-not-resuscitate orders.
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient.

- e. guidance and counseling of families towards and through difficult decisions.
 - f. effective and positive communication with ICU nurses and ancillary ICU personnel.
5. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management;
 6. The resident will work effectively with all members of the health care team.
 7. The resident will serve as coordinating senior resident for trauma floor patients coordinating effective communication and patient care with nurses, faculty, and discharge planners.
 8. The resident will serve as admitting trauma doctor communicating effectively with staff in the emergency department including emergency medicine faculty, residents, and nurses.
 9. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.
3. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making in treating patients in the intensive care unit and emergency department.
5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions about antibiotic treatment of pneumonias and treatment of deep venous thrombosis.
6. The resident will use all such electronic resources to educate and teach others (including patients, intern residents and medical students).
7. The resident will organize presentations for trauma morbidity and mortality conferences to discuss complications in which they were involved including deep venous thrombosis, ventilator associated pneumonias and mortalities.
8. The resident will understand quality measures and work to reduce quality measure lapses in trauma ward patients.
9. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will participate as an integral team leader of the academic surgery resident team during trauma ward rounds and in organizing the care of trauma patients.
4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will understand the basic principles of a multidisciplinary approach to the treatment

of trauma patients in particular and patients in general.

6. The resident will learn to organize and facilitate effective transfer from the trauma ward to rehabilitation hospitals.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.

3. The resident will recognize and respect patients' rights, confidentiality, and privacy.

4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.

5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.

6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.

8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.

9. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

10. The resident will demonstrate compassion and sensitivity when explaining do not resuscitate orders and communicating complex patient prognoses.

Trauma and Acute Care Surgery Service– Alan Tyroch MD, Susan McLean MD, Alejandro Rios Tovar, MD, and Grace Ng, MD

PGY-3

A. Medical Knowledge

1. The resident should be familiar with all organ-based trauma scoring systems.

2. The resident should learn in detail the management of intra-abdominal injuries. Examples include injuries of the liver, spleen, stomach, intestine, colon, pancreas, kidney, bladder, urethra, and diaphragm.

3. The resident should understand rationale and indications for the operative as well as non-operative management of the injured patient.

4. The resident should understand the rationale and indications for the use of adjuncts to both operative and non-operative management of injured patients. Examples include utilization of therapeutic interventional radiological techniques.

5. The resident should understand the pathophysiology of traumatic brain injury, altered mental status and spinal cord injury. The resident should also be able to discuss stabilization and initial treatment of patients with severe neurologic injuries.

B. Patient Care

1. The resident should assume responsibility for the care of all operative patients on the trauma service.
2. The resident should examine every patient admitted to the service, ensure that all injuries and co morbid medical problems have been identified, and ensure that adequate therapeutic and diagnostic plans have been made.
3. The resident should ensure that all prophylactic precautions are taken to prevent complications such as DVT, stress gastritis, pressure ulceration, and aspiration pneumonia.
4. The resident should make daily rounds and have full knowledge of the medical problems and progress of all operative patients on the service.
5. The resident should see every consult and ensure that proper disposition has been made.
6. The resident is responsible for ensuring proper posting in the operating room, ensuring that all information regarding communicable illness has been relayed, and alerting the operating room personnel about specific instrument and equipment needs.
7. Under appropriate supervision, the resident should perform intermediate procedures such as:

Exploratory laparotomy	Acquisition of surgical airway
Colostomy, colostomy closure	Emergency thoracotomy
Repair of gastrointestinal injuries	Open splenectomy

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator,
 - b. dealing with the families of critically injured or ill patients,
 - c. ethics of do-not-resuscitate orders,
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient,
 - e. guidance and counseling of families towards and through difficult decisions,
 - f. effective and positive communication with ICU nurses and ancillary ICU personnel,
 - g. asking for organ donation;
5. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management;
6. The resident will work effectively with all members of the health care team.

7. The resident will exhibit effective listening skills and respond to constructive criticism.
8. The resident will serve as admitting trauma physician coordinating care of the trauma patient by communicating with emergency department faculty, resident and nurses.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.
3. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making concerning advanced critical care issues including ventilator management and management of endocrine disorders.
5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
6. The resident will use all such electronic resources to educate and teach others (including their patients, junior residents and medical students).
7. The resident will complete presentations at trauma morbidity and mortality conferences to include trauma mortality and complications related to delayed diagnosis and delayed intervention.
8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will participate as a leader of the academic surgery resident team during trauma resuscitations and trauma rounds on the ward.
4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma surgery patients in particular and patients in general.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture,

values, age, gender, and disabilities.

6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
9. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.
10. The resident will demonstrate compassion and sensitivity when delivering critical prognoses and do-not resuscitate orders.
11. The resident will demonstrate leadership and preserve dignity when delegating responsibility to junior residents and students.

Trauma and Acute Care Surgery Service– Alan Tyroch MD, Susan McLean MD, Alejandro Rios Tovar, MD, and Grace Ng, MD

PGY-4

A. Medical Knowledge

1. The resident should be able to discuss in detail the management of complex traumatic injuries. This includes diagnosis, timing of intervention, and therapeutic options. Examples include traumatic disruption of the thoracic aorta, renovascular injuries, injuries of the portal triad, retrohepatic caval injuries, complex cervical spine fractures, facial fractures, and complex pelvis fractures.
2. The resident should be able to explain in detail advanced surgical procedures for management of injuries in the neck, torso and extremities. Examples include management of tracheal injuries, management of flail chest, and management of the mangled extremity.
3. The resident should be able to summarize areas of trauma surgery in which patient management is controversial and areas in which change is taking place. Examples include management of penetrating neck injuries, management of colon injuries, and management of minimal vascular injuries.

B. Patient Care

1. The resident should be able to direct the entire team through the trauma resuscitation.
2. The resident should be able to correctly triage the diagnostic evaluation of the patient with multiple injuries.
3. The resident should be able to perform advanced surgical procedures to manage injuries in the neck, torso and extremities.
4. The resident should be able to correctly utilize consultants, yet remain responsible for ultimate patient care issues.

5. The resident should be able to manage patients with multiple injuries using operative and non-operative techniques correctly.
6. Under appropriate supervision, the chief resident should perform advanced procedures such as

Liver resection for injury	Repair of abdominal, chest, or pelvic vascular injury
Duodenal diverticulization	Repair of urethral injury
Pancreatic resection for trauma	Nephrectomy for trauma

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator,
 - b. dealing with the families of critically injured or ill patients,
 - c. ethics of do-not-resuscitate orders,
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient,
 - e. guidance and counseling of families towards and through difficult decisions,
 - f. effective and positive communication with ICU nurses and ancillary ICU personnel,
 - g. asking for organ donation;
5. The resident will effectively lead the team delegating responsibility to junior residents and students.
6. The resident will communicate with intern (PGY-1) residents in a supervisor and instructor role for the completion of observed clinical procedures at the bedside on the floor and in the ICU.
7. The resident will effectively lead members of the health care team.
8. The resident will exhibit effective listening skills and respond to constructive criticism.
9. The resident will serve as a clinical instructor acting in proxy of the faculty in their absence during trauma resuscitations effectively communicating with emergency medicine faculty, residents and nurses to ensure effective treatment of the trauma patient.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making.
5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
6. The resident will use all such electronic resources to educate and teach others (including their patients, junior residents and medical students).
7. The resident will help select cases to be reviewed during trauma morbidity and mortality

conference based on quality improvement initiatives.

8. The resident will report any errors noted during morning report or evening checkout rounds to the faculty to facilitate communication and quality improvement initiatives.

9. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.

2. The resident will become familiar with the proper and efficient utilization of surgical intervention.

3. The resident will participate as a clinical instructor of the academic surgery team.

4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.

6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma surgery patients in particular and patients in general.

7. The resident will ensure proper delegation of authority among junior residents and supervise completion of tasks critical to patient care in the ICU and floors including proper supervision of morning report and evening checkout rounds.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.

3. The resident will recognize and respect patients' rights, confidentiality, and privacy.

4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.

5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.

6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.

8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.

9. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

10. The resident will assist faculty in disciplining junior residents with respect and dignity to ensure timely care of the patient.

PGY-5

A. Medical Knowledge

1. The chief resident should be able to discuss in detail the management of complex traumatic injuries. This includes diagnosis, timing of intervention, and therapeutic options. Examples include traumatic disruption of the thoracic aorta, renovascular injuries, and injuries of the portal triad, retro hepatic caval injuries, complex cervical spine fractures, facial fractures, and complex pelvis fractures.
2. The chief resident should be able to explain in detail advanced surgical procedures for management of injuries in the neck, torso and extremities. Examples include management of tracheal injuries, management of flail chest, and management of the mangled extremity.
3. The chief resident should be able to summarize areas of trauma surgery in which patient management is controversial and areas in which change is taking place. Examples include management of penetrating neck injuries, management of colon injuries, and management of minimal vascular injuries.

B. Patient Care

1. The chief resident should be able to direct the entire team through the trauma resuscitation.
2. The chief resident should be able to correctly triage the diagnostic evaluation of the patient with multiple injuries.
3. The chief resident should be able to perform advanced surgical procedures to manage injuries in the neck, torso and extremities.
4. The chief resident should be able to correctly utilize consultants, yet remain responsible for ultimate patient care issues.
5. The chief resident should be able to manage patients with multiple injuries using operative and non-operative techniques correctly.
6. Under appropriate supervision, the chief resident should perform advanced procedures such as
 - Liver resection for injury
 - Duodenal diverticulization
 - Pancreatic resection for trauma
 - Repair of abdominal, chest, or pelvic vascular injury
 - Repair of urethral injury
 - Nephrectomy for trauma

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator,
 - b. dealing with the families of critically injured or ill patients,
 - c. ethics of do-not-resuscitate orders,
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient,
 - e. guidance and counseling of families towards and through difficult decisions,

- f. effective and positive communication with ICU nurses and ancillary ICU personnel,
 - g. asking for organ donation;
5. The resident will effectively lead the team delegating responsibility to junior residents and students.
 6. The resident will communicate with intern (PGY-1) residents in a supervisor and instructor role for the completion of observed clinical procedures at the bedside on the floor and in the ICU.
 7. The resident will effectively lead members of the health care team.
 8. The resident will exhibit effective listening skills and respond to constructive criticism.
 9. The resident will serve as a clinical instructor acting in proxy of the faculty in their absence during trauma resuscitations effectively communicating with emergency medicine faculty, residents and nurses to ensure effective treatment of the trauma patient.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
3. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making.
4. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
5. The resident will use all such electronic resources to educate and teach others (including their patients, junior residents and medical students).
6. The resident will help select cases to be reviewed during trauma morbidity and mortality conference based on quality improvement initiatives.
7. The resident will report any errors noted during morning report or evening checkout rounds to the faculty to facilitate communication and quality improvement initiatives.
8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will participate as a clinical instructor of the academic surgery team.
4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma surgery patients in particular and patients in general.
7. The resident will ensure proper delegation of authority among junior residents and supervise completion of tasks critical to patient care in the ICU and floors including proper supervision of morning report and evening checkout rounds.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes

and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
9. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.
10. The resident will assist faculty in disciplining junior residents with respect and dignity to ensure timely care of the patient.
11. The resident will assist in evaluation and remediation of junior residents.

Surgical Intensive Care Unit - Alan Tyroch MD, Susan McLean MD, Alejandro Rios Tovar, MD, and Grace Ng, MD

PGY-1

A. Medical Knowledge

1. The resident should learn in depth the fundamentals of basic science as they apply to patients in the intensive care unit. Examples include anatomy, physiology and pathophysiology of the cardiovascular, respiratory, genitourinary, gastrointestinal, musculoskeletal, hematologic, and endocrine systems.
2. The resident should understand the rationale for admission and discharge criteria in the ICU.
3. The resident should understand factors associated with assessment of preoperative surgical risk. Examples include evaluation of the high risk cardiac patient undergoing non-cardiac surgery.
4. The resident should understand fluid compositions and the effect of the losses of such fluids as gastric, pancreatic and biliary from fistulas at various levels.
5. The resident should understand the indications for, and complications of blood component therapy.
6. The resident should be able to discuss the pathophysiology of respiratory failure.

7. The resident should be able to demonstrate an understanding of acid-base disorders, including diagnosis, etiology, and instituting appropriate treatment.
8. The resident should be able to discuss the pathophysiology, indications, and complications associated with various modes of mechanical ventilation. Examples include ventilator management of ALI, ARDS and thoracic trauma, as well as weaning from ventilatory support.
9. The resident should understand the role of hormones and cytokines in the graded metabolic response to injury, surgery and infection.
10. The resident should understand the indications, routes and complications of administration of parenteral and enteral forms of nutrition.
11. The resident should understand the risk factors and common pathogens that are associated with nosocomial infections.
12. The resident should understand the factors associated with altered mental status. Examples include traumatic, septic, metabolic and pharmacologic causes.
13. The resident should understand the risk factors associated with stress gastritis.
14. The resident should understand the causes and treatment regimens for gastrointestinal bleeding. Examples include bleeding from upper and lower GI sources.

B. Patient Care.

Under appropriate supervision, the resident should be able to:

1. Perform the following aspects of ventilatory management: Set up initial and advanced ventilator settings, wean patients from ventilator support, and treat common complications of mechanical ventilation including tube thoracostomy.
2. Correctly utilize prophylaxis for stress gastritis in high-risk ICU patients.
3. Initiate appropriate nutritional support through the most optimal route.
4. Manage complications of nutritional support. Examples include hyperglycemia.
5. Assist in managing patients with intracranial hypertension and neurovascular disease.

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures in the intensive care unit.
3. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator,
 - b. dealing with the families of critically injured or ill patients,
 - c. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient,
 - d. effective and positive communication with ICU nurses and ancillary ICU personnel,
4. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
5. The resident will participate in evening checkout rounds and effectively checkout patient information and tasks for completion prior to leaving a shift.

6. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for intervention for intensive care unit procedures and invasive monitoring.

2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with altered mental status and hypotension.

3. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.

4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making concerning patient care in the ICU for enteral nutrition and resuscitation.

5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.

6. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.

2. The resident will become familiar with the proper and efficient utilization of surgical intervention.

3. The resident will participate as an integral member of the intensive care unit team.

4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients in the intensive care unit.

5. The resident will develop an understanding of how to coordinate care between the intensive care unit and rehabilitation settings and utilize community resources to facilitate the delivery of patient care for long-term rehabilitation.

6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of intensive care unit patients.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.

3. The resident will recognize and respect patients' rights, confidentiality, and privacy.

4. The resident will discuss patients and their care with appropriate staff, attending, and fellow residents in private areas or in a private manner and with respectful language.

5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.

6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize

her/his own limitation(s) and take personal responsibility.

8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.

9. The residents will demonstrate compassion when communicating do-not resuscitate orders and difficult prognoses to family members.

10. The resident will understand advanced directives and patient preferences for care in the intensive care unit in reference to religion and culture.

11. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Surgical Intensive Care Unit - Alan Tyroch MD, Susan McLean MD, Alejandro Rios Tovar MD, and Grace Ng MD

PGY-2

A. Medical Knowledge

1. The resident should have an in depth understanding of the basic science related to problems commonly seen in the intensive care unit setting. Examples include sepsis, respiratory failure, coronary ischemia, shock, malnutrition, stress ulceration, nonocclusive intestinal ischemia, antibiotic associated colitis, antibiotic resistance, jaundice, and renal insufficiency.

2. The resident should understand the pathophysiology of hemodynamic instability. Examples include types of shock, cardiac arrest.

3. The resident should know and apply treatments for arrhythmias, congestive heart failure, acute ischemia and pulmonary edema.

4. The resident should understand adjuncts to the analysis of respiratory mechanics and gas exchange. Examples include work of breathing, rapid shallow breathing index, single breath CO₂ analysis and dead space measurements.

5. The resident should understand fluid and electrolyte as well as acid/base abnormalities associated with complex surgical procedures and complications. Examples include massive fluid shifts associated with trauma, shock and resuscitation, high output fistulas and renal failure.

6. The resident should understand the pathophysiology associated with endocrine emergencies in the ICU. Examples include thyroid storm, hyper, hypo-parathyroid states and adrenal insufficiency.

7. The resident should be able to discuss the mechanism of action as well as the spectrum of antimicrobial activity of the different antibiotic classes. Examples include carbapenems, extended spectrum penicillin's and fluoroquinolones.

8. The resident should understand the risk factors that result in multiply resistant organisms. Examples include antibiotic dosing, antibiotic synergy and transmission patterns.

9. The resident should be able to discuss the factors that result in an immune-compromised state. Examples include malignancy, major trauma and steroids.

10. The resident should understand the factors associated with bleeding disorders. Examples include DIC, ITP, hemophilia, coagulopathy associated with shock and hypothermia.

11. The resident should understand the pathophysiology of traumatic brain injury and neural disease. Examples include knowledge of intracranial pressure monitoring and maneuvers to normalize ICP.

12. The resident should be able to discuss the pathophysiology, presentation, and causes of hepatic failure.

B. Patient Care

Under appropriate supervision, the resident should be able to:

1. Insert pulmonary artery, central venous and arterial lines, with and without ultrasound guidance.
2. Resuscitate patients from shock and cardiac arrest.
3. Recognize and treat ischemia and arrhythmias on ECG.
4. Utilize correct class of anti-arrhythmic, vasodilators and diuretics as they pertain to cardiac disease.
5. Correctly determine the protein, caloric, electrolyte, fat and vitamin needs of surgical patients, taking into account their underlying disease process.
7. Correctly diagnose and treat gastrointestinal bleeding associated with ulcers, portal hypertension and lower GI sources.
8. Diagnose cause and appropriately alter treatment regimens to compensate for hepatic failure. Examples include altering fluid, protein and drugs regimens.

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator.
 - b. dealing with the families of critically injured or ill patients.
 - c. ethics of do-not-resuscitate orders.
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient.
 - e. guidance and counseling of families towards and through difficult decisions.
 - f. effective and positive communication with ICU nurses and ancillary ICU personnel.
5. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management
6. The resident will assist in delegating responsibilities to intern residents and students.
7. The resident will learn to assist in ICU rounds for organization of patient care and disposition.
8. The resident will participate in evening checkout rounds and checkout with fellow residents prior to completing their shift to ensure proper continuity of patient care.
9. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for intervention for invasive procedures in the intensive care unit.
2. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
3. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making concerning intensive care unit issues including ventilator associated pneumonia and deep venous thrombosis prophylaxis.
4. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
5. The resident will use all such electronic resources to educate and teach others (including their patients, junior residents and medical students).
6. The resident will participate in evening checkout rounds and help monitor for errors in checkout and patient handoffs notifying faculty, critical care fellows, and chief residents for quality improvement measures.
7. The resident will participate and prepare presentations for trauma morbidity and mortality concerning deep venous thrombosis and ventilator acquired pneumonias and other morbidities of educational value.
8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of invasive intervention in the intensive care unit.
3. The resident will participate as an organizing team leader in the intensive care unit.
4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will develop an understanding of how to coordinate care between the inpatient and rehabilitation settings and utilize community resources to facilitate the delivery of long term rehabilitation based patient care.
6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of intensive care unit patients.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow

residents in private areas or in a private manner and with respectful language.

5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
9. The residents will demonstrate compassion when communicating do-not resuscitate orders and difficult prognoses to family members.
10. The resident will understand advanced directives and patient preferences for care in the intensive care unit in reference to religion and culture.
11. The resident will demonstrate leadership and dignity when delegating responsibility to interns and medical students in the care of intensive care unit patients.
12. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Surgical Intensive Care Unit - Alan Tyroch MD, Susan McLean MD, Alejandro Rios Tovar MD, and Grace Ng MD

PGY-3

A. Medical Knowledge

1. The resident should have an in depth understanding of the basic science related to problems commonly seen in the intensive care unit setting. Examples include sepsis, respiratory failure, coronary ischemia, shock, malnutrition, stress ulceration, non-occlusive intestinal ischemia, antibiotic associated colitis, antibiotic resistance, jaundice, and renal insufficiency.
2. The resident should understand the pathophysiology of hemodynamic instability. Examples include types of shock, cardiac arrest.
3. The resident should know and apply treatments for arrhythmias, congestive heart failure, acute ischemia and pulmonary edema.
4. The resident should understand adjuncts to the analysis of respiratory mechanics and gas exchange. Examples include work of breathing, rapid shallow breathing index, single breath CO₂ analysis and dead space measurements.
5. The resident should understand fluid and electrolyte as well as acid/base abnormalities associated with complex surgical procedures and complications. Examples include massive fluid shifts associated with trauma, shock and resuscitation, high output fistulas and renal failure.
6. The resident should understand the pathophysiology associated with endocrine emergencies in the ICU. Examples include thyroid storm, hyper, hypo-parathyroid states and adrenal insufficiency.

7. The resident should be able to discuss the mechanism of action as well as the spectrum of antimicrobial activity of the different antibiotic classes. Examples include carbapenams, extended spectrum penicillins and fluoroquinolones.
8. The resident should understand the risk factors that result in multiply resistant organisms. Examples include antibiotic dosing, antibiotic synergy and transmission patterns.
9. The resident should be able to discuss the factors that result in an immune-compromised state. Examples include malignancy, major trauma and steroids.
10. The resident should understand the factors associated with bleeding disorders. Examples include DIC, ITP, hemophilia, coagulopathy associated with shock and hypothermia.
11. The resident should understand the pathophysiology of traumatic brain injury and neural disease. Examples include knowledge of intracranial pressure monitoring and maneuvers to normalize ICP.
12. The resident should be able to discuss the pathophysiology, presentation, and causes of hepatic failure.

B. Patient Care

1. Under appropriate supervision, the resident should assist the junior residents with placement of central venous lines, pulmonary artery catheters, and other invasive procedures.
2. The resident should be able to identify and minimize factors associated with nosocomial infections and be able to utilize appropriate adjunctive measures to diagnose and treat nosocomial infection.
3. The resident should be able to utilize pharmacokinetics and drug levels to adjust antibiotic dosing, utilize appropriate combinations of antibiotics to achieve synergy, and appropriately utilize isolation precautions.
4. The resident should be able to appropriately use intracranial pressure monitoring, including interpretation of hemodynamic and ICP data.
5. The resident should be able to initiate therapy to maintain cerebral perfusion pressure and minimize secondary brain injury.
6. The resident should be able to initiate and maintain salvage modes of ventilation such as airway pressure release, bi-level and oscillatory ventilation.

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
3. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator,
 - b. dealing with the families of critically injured or ill patients,
 - c. ethics of do-not-resuscitate orders,
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient,
 - e. guidance and counseling of families towards and through difficult decisions,

- f. effective and positive communication with ICU nurses and ancillary ICU personnel,
 - g. asking for organ donation;
4. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
 5. The resident will work effectively as team leader with all members of the health care team in the intensive care unit.
 6. The resident will understand and facilitate ICU rounds for patient care and disposition.
 7. The resident will participate in evening checkout rounds and ensure proper checkout with fellow residents prior to leaving shift to ensure proper continuity of patient care.
 8. The resident will serve as resident intensive care unit leader and delegate responsibilities to junior residents and medical students.
 9. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
3. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making concerning complex intensive care unit ventilator management and long term patient rehabilitation issues.
4. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
5. The resident will use all such electronic resources to educate and teach others (including their patients, residents and medical students).
6. The resident will prepare presentations for trauma morbidity and mortality conference to review mortalities in the intensive care unit and complex complications.
7. The resident will assist in the identification of errors during checkout proceedings reporting these errors to chief residents, critical care fellows, and faculty to improve quality care measures.
8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention in the intensive care unit.
3. The resident will participate as a team leader for the intensive care unit resident team.
4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will develop an understanding of how to coordinate care between the inpatient and rehabilitation settings and utilize community resources to facilitate the long term rehabilitation.
6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of the intensive care unit patient.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
9. The residents will demonstrate compassion when communicating do-not resuscitate orders and difficult prognoses to family members.
10. The resident will understand advanced directives and patient preferences for care in the intensive care unit in reference to religion and culture.
11. The resident will demonstrate leadership and dignity when delegating responsibility to interns and medical students in the care of intensive care unit patients.
12. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Night Consult Service (Trauma and Acute Care Surgery) - All Faculty

PGY-1

A. Medical Knowledge

1. The resident should understand the principles of Advanced Trauma Life Support.
2. The resident should be able to identify different forms of shock associated with the injured patient. Examples include hemorrhagic, neurogenic, cardiogenic and septic shock.
3. The resident should understand the indications for, and different types of agents used in prophylactic and therapeutic antibiotic use.
4. The resident should understand appropriate fluid and electrolyte resuscitation.
5. The resident should understand the basic principles in the diagnostic evaluation of single organ system injury.

6. The resident should understand his or her role in the trauma resuscitation team, and be able to perform the appropriate tasks of that role. The resident must be familiar with trauma protocols.
7. The resident should be able to discuss the costs, risks and expected information obtained from non-invasive diagnostic tests to evaluate the injured patient. Examples include plain films, ultrasonography and CT scanning.
8. The resident should understand the costs, risks and expected information obtained from invasive diagnostic tests to evaluate the injured patient. Examples include wound exploration.

B. Patient Care

1. The resident must be aware of his or her limitations and know when to call for help.
2. The resident should assist with resuscitation in trauma patients presenting to the emergency department.
3. The resident should assume responsibility for care of all patients on the hospital ward including initial assessment, evaluation of daily progress, and initial assessment of new problems.
4. The resident should be able to assess patients on the ward when called for cross-coverage. Examples include evaluation of patients with fever, oliguria, hypotension, respiratory insufficiency, and intractable pain.
5. The resident should assume responsibility for discharging patients, including dictating the discharge summary, writing prescriptions, and ensuring appropriate follow-up.
6. Under appropriate supervision, the resident should perform basic operative cases such as:
 - Insertion of central venous lines
 - Laceration repairs
 - Placement of thoracostomy tubes

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will acquire a working knowledge in the psychosocial issues concerning:
 - a. communications with patient on the ventilator.
 - b. dealing with the families of critically injured or ill patients.
 - c. ethics of do-not-resuscitate orders.
 - d. dealing with multiple consultants and coordinating multiple recommendations in the care of the critically ill patient.
 - f. effective and positive communication with ICU nurses and ancillary ICU personnel.
5. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
6. The resident will work effectively with all members of the health care team.
7. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.

2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.
3. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making.
5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
6. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
4. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
5. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma and patients.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attending, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.

PGY-2

A. Medical Knowledge

1. The resident should learn in-depth the fundamentals of basic science as they apply to the clinical practice of general surgery and, more specifically, to the practice of endocrine surgery, colorectal surgery, hernia surgery, open and laparoscopic gastrointestinal surgery. Examples include elements

of wound healing, physiological principles of endocrinology, management of fluid and electrolyte balance, and surgical anatomy and surgical pathology of the intra-abdominal organs.

2. The resident should be able to demonstrate knowledge of the principles and rationale for management of surgical patients, including preoperative assessment, perioperative management and postoperative care of patients. Examples include assessment of patient risk, selection of patients for inpatient surgery, knowledge of anesthetic options for procedures, and principles of postoperative pain management and wound care.

3. The resident should be able to efficiently utilize and interpret diagnostic laboratory testing. Examples of appropriate tests include serum chemistries, liver function tests, arterial blood gas analysis, hematological profiles, coagulation tests and thyroid function studies.

4. The resident should be able to efficiently utilize and interpret diagnostic radiological tests. Examples of the types of studies include chest x-ray, computed tomography, radio nucleotide scintigraphy, ultrasonography, arteriography and gastrointestinal studies.

B. Patient Care

1. The resident should assume responsibility for all consultations from the emergency department for general surgery and trauma admissions his/her assigned service, including performing an advanced history and physical examination, writing admission orders, and reviewing appropriate diagnostic tests.

2. Under appropriate supervision, perform basic surgical procedures such as:

Flexible and rigid proctoscopy

Laparoscopic and open appendectomy

Hernia repair (inguinal, femoral, umbilical)

Drainage of breast abscess – Incision Drainage of perirectal abscess

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.

2. The resident will perform an accurate and complete history and physical examination.

3. The resident will serve as admitting doctor for consults communicating effectively with emergency department faculty, residents and nursing staff.

4. The resident will respond to pages and see consults in an expedient fashion.

5. The resident will serve as the nighttime trauma admitting resident and effectively communicate during trauma resuscitations and evaluations.

6. The resident will learn to communicate effectively with critically ill and intoxicated patients in the emergency department.

7. The resident will work effectively with all members of the health care team.

8. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.

2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.

3. The resident will manage data efficiently and maintain record documentation in a timely, concise,

and understandable (legible and interpretable) manner.

4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making for critically ill and trauma patients in the emergency department.

5. The patient will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions for consults to develop appropriate diagnoses and therapeutic care plans.

6. The resident will use all such electronic resources to educate and teach others (including their patients, interns, and medical students).

7. The resident will participate in trauma and general surgery morbidity and mortality conferences making presentation on cases where there was a delayed diagnosis or delayed therapeutic intervention or on cases of educational value.

8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.

2. The resident will become familiar with the proper and efficient utilization of surgical intervention from the emergency department.

3. The resident will participate as an admitting doctor from the emergency department and respond to consults on the floor.

4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients and ensure timely diagnosis and treatment of surgical consults.

5. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma and general surgery consults with effective triage from the emergency department and wards to the intensive care unit or operating room.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided in the emergency department and with ward consults.

3. The resident will recognize and respect patients' rights, confidentiality, and privacy.

4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.

5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.

6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize

her/his own limitation(s) and take personal responsibility.

8. The resident will demonstrate compassion for those patients who are critically ill and administer surgical consultation and analgesia in a timely fashion.

9. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.

10. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Night Consult Service (Trauma and Acute Care Surgery) - All Faculty

PGY-3

A. Medical Knowledge

1. The resident should learn in depth the management of common surgical conditions that present to hospitals, including (but not limited to) upper and lower gastrointestinal bleeding, small and large bowel obstruction, pancreatitis, biliary obstruction, cholecystitis, and the acute abdomen.

2. The resident should be able to recognize and stratify co-morbid conditions in the patient with surgical illness.

3. The resident should be able to discuss management options for patients with co-morbid medical conditions to reduce the risk of morbidity and mortality, including treatment of the co-morbid condition, postponing the operation, and altering the type of operation or choosing a less invasive procedure.

4. The resident should be able to correctly diagnose and understand principles of treatment of common surgical complications and surgical emergencies. Examples include electrolyte imbalance, failure of homeostasis, surgical infection, renal failure, pulmonary insufficiency, cardiac abnormalities, shock, peritonitis, limb ischemia, gastrointestinal hemorrhage, hypocalcaemia, neck hematoma and adrenal insufficiency.

B. Patient Care

1. The resident should assume responsibility for the care of all consult patients from the emergency department, including close supervision of the PGY 2 as they perform the direct care of these patients.

2. The resident should discuss patient progress and any new problems with the attending faculty.

3. Under appropriate supervision, the resident should be able to perform intermediate operative procedures such as:

Emergency laparotomy for the acute abdomen

Colectomy with colostomy

Laparoscopic cholecystectomy for cholecystitis

Repair of incarcerated hernias

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.

2. The resident will perform an accurate and complete history and physical examination.

3. The resident will advise patients regarding the indications, anticipated benefits, and risks and

complications of bedside and operative procedures.

4. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.

5. The resident will work effectively with all members of the health care team. The resident will serve as admitting doctor for consults communicating effectively with emergency department faculty, residents and nursing staff.

6. The resident will respond to pages and see consults in an expedient fashion.

7. The resident will serve as the nighttime trauma admitting resident and effectively communicate during trauma resuscitations and evaluations.

8. The resident will learn to communicate effectively with critically ill and intoxicated patients in the emergency department.

9. The resident will be expected to communicate a complete therapeutic plan to the chief resident and faculty.

10. The resident will be expected to help educate fellow residents in the emergency department and medicine services as to patient therapeutic plans and diagnosis.

11. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.

2. The resident will demonstrate the ability to determine the physical findings and develop a differential diagnosis in a patient with abdominal pain.

3. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.

4. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making for emergency department and floor consults.

5. The resident will learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions and form therapeutic plans for admitted/consulted patients.

6. The resident will use all such electronic resources to educate and teach others (including their patients, junior residents, and medical students).

7. The resident will participate in trauma and general surgery morbidity and mortality making presentations to communicate delayed diagnoses and complications of delayed surgical intervention or other cases of educational value.

8. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.

2. The resident will become familiar with the proper and efficient utilization of surgical intervention. .

3. The resident will participate as the admitting consult resident effectively triaging patients to the operating room and intensive care unit.

4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients admitted to surgical wards and in the emergency department.
5. The resident will understand the basic principles of a multidisciplinary approach to the treatment of trauma and general surgery patients admitted through the emergency department and on the medical wards.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will demonstrate compassion for those patients who are critically ill and administer surgical consultation and analgesia in a timely fashion.
9. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
10. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Night Consult Service (Trauma and Acute Care Surgery) - All Faculty

PGY-4

A. Medical Knowledge

1. The resident should learn in depth the principles of management of complex surgical problems seen in the tertiary hospital setting. Examples include recurrent thyroid cancer, recurrent hyperparathyroidism, Barrett's esophagus, intestinal fistulas, and transected bile ducts.
2. The resident should be able to correctly describe the pathophysiology of multisystem problems of the alimentary tract and digestive system, including hormonal interactions.
3. The resident should be able to accurately analyze the medical preparation of patients for complex operations.

4. The resident should be able to accurately describe the surgical options for patients with complex problems, including an analysis of the risk vs. benefit for all procedures.
5. The resident should be able to accurately explain the physiologic rationale for the following gastrointestinal operations: vagotomy, pyloroplasty, gastric resection for ulcer disease, small bowel resection, stoma formation, and drainage of pancreatic pseudocysts (open internal vs. open external vs. percutaneous).
6. The resident should be able to accurately describe advanced operative procedures performed by the practicing general surgeon. Examples include thyroidectomy, parathyroidectomy, Heller myotomy, surgical procedures for gastroesophageal reflux, surgical procedures for gastroduodenal ulcer disease, bariatric procedures, subtotal colectomy, abdominoperineal resection, and adrenalectomy and neck dissection for thyroid cancer.

B. Patient Care

1. The resident should assume overall responsibility for all patients consults, including close supervision of the junior residents who are caring for the patients directly.
2. The resident should personally examine all patients who develop new problems in the emergency department and ensure that the attending has been notified.
3. The resident should serve as teaching assistant in appropriate cases for junior residents.
4. Under appropriate supervision, the resident should be able to perform intermediate operative procedures such as:

Emergency laparotomy for the acute abdomen and trauma

Total and partial gastrectomy

Enterectomy with primary anastomosis

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management;
5. The resident will demonstrate leadership in supervising junior residents in trauma resuscitations and surgical consults.
6. The resident will communicate effectively to supervise interns in performance of procedures in the emergency department and medical wards.
7. The resident will provide feedback for junior residents and assist in their decision-making.
8. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
3. The resident will learn to develop clinical questions, search the literature effectively, and use

evidence-based criteria to determine the value of information for decision making;

4. Learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
5. The resident will use all such electronic resources to educate and teach others (including their patients, residents and medical students).
6. The resident will know the pathophysiology, supportive care, and surgical indications in a patient with bowel obstruction.
7. The resident will assist in the determination of which complications will be presented at the general surgery morbidity and mortality conference.
8. The resident will identify errors in checkout occurring in morning report and evening checkout rounds and will report these errors to faculty to help with quality improvement initiatives.
9. The resident will learn to discipline junior residents and assist in remediation processes.
10. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will participate as a leader of the consult service determining patient flow and timely diagnostic and therapeutic intervention.
4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of patients in the emergency department and medical wards.
7. The resident will understand the necessity for junior resident supervision and observation in the clinical setting to train interns in bedside procedures and in the operating room.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will understand how to deliver constructive criticism and supervise junior residents.
9. The resident will learn to assist in junior resident remediation with dignity and respect.
10. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
11. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Consult Service- All Faculty

PGY-5

A. Medical Knowledge

1. The chief resident should learn in depth the principles of management of complex surgical problems seen in the tertiary hospital setting. Examples include recurrent thyroid cancer, recurrent hyperparathyroidism, Barrett's esophagus, intestinal fistulas, and transected bile ducts.
2. The chief resident should be able to correctly describe the pathophysiology of multisystem problems of the alimentary tract and digestive system, including hormonal interactions.
3. The chief resident should be able to accurately analyze the medical preparation of patients for complex operations.
4. The chief resident should be able to accurately describe the surgical options for patients with complex problems, including an analysis of the risk vs. benefit for all procedures.
5. The chief resident should be able to accurately explain the physiologic rationale for the following gastrointestinal operations: vagotomy, pyloroplasty, gastric resection for ulcer disease, small bowel resection, stoma formation, and drainage of pancreatic pseudocysts (open internal vs. open external vs. percutaneous).
6. The chief resident should be able to accurately describe advanced operative procedures performed by the practicing general surgeon. Examples include thyroidectomy, parathyroidectomy, Heller myotomy, surgical procedures for gastroesophageal reflux, surgical procedures for gastroduodenal ulcer disease, bariatric procedures, subtotal colectomy, abdominoperineal resection, and adrenalectomy and neck dissection for thyroid cancer.

B. Patient Care

1. The chief resident should assume overall responsibility for all patients consults, including close supervision of the junior residents who are caring for the patients directly.
2. The chief resident should personally examine all patients who develop new problems in the emergency department and ensure that the attending has been notified.
3. The chief resident should serve as teaching assistant in appropriate cases for junior residents.
4. Under appropriate supervision, the resident should be able to perform intermediate operative procedures such as:

Emergency laparotomy for the acute abdomen and trauma
Enterectomy with primary anastomosis

Total and partial gastrectomy

C. Interpersonal and Communications Skills

1. The resident will create and sustain ethically sound relationships with patients.
2. The resident will perform an accurate and complete history and physical examination.
3. The resident will advise patients regarding the indications, anticipated benefits, and risks and complications of bedside and operative procedures.
4. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management;
5. The resident will demonstrate leadership in supervising junior residents in trauma resuscitations and surgical consults.
6. The resident will communicate effectively to supervise interns in performance of procedures in the emergency department and medical wards.
7. The resident will provide feedback for junior residents and assist in their decision-making.
8. The resident will exhibit effective listening skills and respond to constructive criticism.

D. Practice-Based Learning and Improvement

1. The resident will recognize the indications for surgical intervention.
2. The resident will manage data efficiently and maintain record documentation in a timely, concise, and understandable (legible and interpretable) manner.
3. The resident will learn to develop clinical questions, search the literature effectively, and use evidence-based criteria to determine the value of information for decision making;
4. Learn to utilize the computer, personal digital assistant (PDA), and web-based resources to make patient care decisions.
5. The resident will use all such electronic resources to educate and teach others (including their patients, residents and medical students).
6. The resident will know the pathophysiology, supportive care, and surgical indications in a patient with bowel obstruction.
7. The resident will assist in the determination of which complications will be presented at the general surgery morbidity and mortality conference.
8. The resident will identify errors in checkout occurring in morning report and evening checkout rounds and will report these errors to faculty to help with quality improvement initiatives.
9. The resident will learn to discipline junior residents and assist in remediation processes.
10. The resident will know when to call for assistance.

E. Systems-Based Practice

1. The resident will make appropriate and timely referrals.
2. The resident will become familiar with the proper and efficient utilization of surgical intervention.
3. The resident will participate as a leader of the consult service determining patient flow and timely diagnostic and therapeutic intervention.

4. The resident will actively partner with health care managers and providers to assess, coordinate, and improve the health care provided to patients.
5. The resident will develop an understanding of how to coordinate care between the inpatient and outpatient settings and utilize community resources to facilitate the delivery of patient care.
6. The resident will understand the basic principles of a multidisciplinary approach to the treatment of patients in the emergency department and medical wards.
7. The resident will understand the necessity for junior resident supervision and observation in the clinical setting to train interns in bedside procedures and in the operating room.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, gender, and disabilities.
6. The resident will address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will understand how to deliver constructive criticism and supervise junior residents.
9. The resident will learn to assist in junior resident remediation with dignity and respect.
10. The resident will be responsive to the needs of the patient and society, keeping self-interest in appropriate perspective.
11. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

PGY-4 Private Hospital Rotations

Definitions of Supervision

Supervision of Residents

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care. This information should be available to residents, faculty members, and patients. Residents and faculty members should inform patients of their respective roles in each patient's care.

The program must demonstrate that the appropriate level of supervision is in place for all residents

who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision – the supervising physician is physically present with the resident and patient.

Indirect Supervision - with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

PGY-4 Rotations are community, academic and hybrid surgeons

Participating Hospitals: UMC, Providence Hospital: Memorial and Transmountain Campuses, El Paso Day Surgery Center, Foundations Surgical Hospital of El Paso, UT Southwestern

Surgical Oncology (Dr. Konstantinidis) (Hospitals: Providence Hospital-Memorial Campus and Transmountain Campus, UMC)

PGY-4

Description of rotation: This rotation provides an in depth experience with Gastrointestinal Cancers (including but not limited to stomach, pancreas, liver, metastatic colorectal cancer, peritoneal surface malignancies and retroperitoneal sarcomas) and Skin and Soft Tissue Cancers

(melanoma, other skin cancers and extremity sarcomas). It entails patients seen in two clinic areas and operations performed in 3 hospitals. It also includes weekly tumor board.

Faculty: Ioannis T. Konstantinidis, MD, FACS, FSSO. Surgical Oncologist. Board Certified in General Surgery and Complex General Surgical Oncology.

A. Medical Knowledge

1. Knowledge of tumor staging based on the TNM classification system for malignancies.
2. Management of malignancies, including screening, diagnosis, medical and surgical treatment options, and follow-up.
3. Discuss prognosis based on staging, resectability and functional status of the patient.
4. Indications for prophylactic surgery vs. palliative surgery vs. surgery with curative intent.
5. Components and interventions involved in palliative care.

B. Patient Care

1. Treatment of patients with the abovementioned malignancies in the hospital and outpatient settings.
2. Intraoperative ultrasound in the operating room under direct supervision for: evaluation of liver tumors, soft tissue tumors, guidance for resection or biopsy.
3. Under direct supervision, the resident should be able to perform complex surgical oncology procedures with curative or palliative intent including gastrectomies, hepatectomies, pancreatectomies, cytoreductions with HIPEC, radical resection of soft tissue tumors and wide local excision of skin cancers.
4. Consults and history/physical for surgical oncology patients under indirect supervision.
5. Rounds on inpatients under indirect supervision with documentation of daily physical findings and lab values in the chart.
6. The resident will write no orders, perform no procedures under indirect supervision and will provide no independent care in the emergency department or inpatient wards.

C. Interpersonal and Communications Skills

1. Presentations on new and established patients to faculty.
2. Communication with nurses, ancillary staff, case managers and all hospital employees under indirect supervision.
3. Communication with referring and consulting physicians, physician assistants, and nurse practitioners under indirect supervision.
4. Communicate with patients and appropriate members of their families about oncologic prognoses, complications of oncologic operations, and operative findings of cancer under direct supervision.
5. The resident will maintain clear, concise, accurate, and timely medical records including but not limited to history and physical examination documentation, consultation notes, and progress notes under indirect supervision.

D. Practice-Based Learning and Improvement

1. The resident will attend and present at tumor board for patients seen.

2. The resident should use books, journal articles, operative videotapes, internet access, and other tools available to learn about neoplastic diseases and treatment of patients with cancer.

E. Systems-Based Practice

1. The clinical resident should understand the team approach to treatment of cancer patients and be able to discuss how surgical oncologists interface with other services including medical oncology, radiation oncology, visiting nurses, and hospice care.
2. The clinical resident should understand the financial implications of cancer treatment, including hospital/physician costs, loss of employment time, outpatient chemotherapy, and nursing home care.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care for surgical oncology.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided in cancer patients.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with Dr. Konstantinidis in private areas or in a private manner and with respectful language.
5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities on cancer care.
6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will be expected to participate in the delivery of oncological prognoses with compassion and sensitivity to the patient's understanding of their condition.
9. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered cancer care.

Surgical Oncology (Dr. Landeros) (Hospitals: Providence Hospital, El Paso Day Surgery Center)

PGY-4

A. Medical Knowledge

1. The resident should be able to demonstrate knowledge of tumor staging based on the TNM classification system for malignancies. Examples include extremity soft tissue sarcoma, melanoma, and other cutaneous malignancy.
2. The resident should learn in depth the management of malignancies, including screening, diagnosis, medical and surgical treatment options, and follow-up.
3. The resident should be able to discuss prognosis for patients with cancer based on tumor site, pathology, stage, and the functional status of the patient.

4. The resident should be able to perform advanced assessment of risk/benefits for all interventions relevant to cancer management.
5. The resident should be able to discuss the difference between and indications for prophylactic surgery vs. palliative surgery vs. surgery with curative intent. The resident should be able to demonstrate knowledge of the patient factors (e.g. staging information) that may recommend one approach over another.
6. The resident should be able to demonstrate a thorough understanding of components and interventions involved in terminal care.

B. Patient Care

1. The resident should work closely with Dr. Landeros under direct and indirect supervision and assume a major role in the care for designated patients, including inpatient and outpatient surgical oncology patients.
2. The resident should be able to perform ultrasound in the clinic and operating room under direct supervision for: evaluation of breast diseases, screening for liver metastases, evaluation of lymph nodes and soft-part tumors, guidance of tissue sampling procedures.
3. Under direct supervision, the resident should be able to perform advanced surgical procedures in cancer patients such as radical resection of soft tissue tumors, amputations, wide local excision of melanoma, sentinel lymph node staging, completion lymphadenectomy, gastrectomy, extended abdominal lymphadenectomy, liver resection, and colon and rectal resections.
4. The resident should be able to perform consults and history/physical for surgical oncology patients under indirect supervision.
5. The resident will perform rounds on inpatients under indirect supervision with documentation of daily physical findings and lab values in the chart.
6. The resident will write no orders, perform no procedures under indirect supervision and will provide no independent care in the emergency department or inpatient wards.

C. Interpersonal and Communications Skills

1. The resident will be able to clearly, accurately, and succinctly present pertinent information to Dr. Landeros regarding newly admitted patients under indirect supervision.
2. The resident will understand the need to keep Dr. Landeros aware of all progress of all critical care unit patients and will alert the respective faculty of new problems on the service under indirect supervision.
3. The resident will clearly, accurately, and respectfully demonstrate communication with nurses, peers, ancillary staff and all hospital employees under indirect supervision.
4. The resident will clearly, accurately, respectfully, and professionally demonstrate communication with referring and consulting physicians, physician assistants, and nurse practitioners under indirect supervision.
5. The resident will learn to clearly, accurately, and respectfully communicate with patients and appropriate members of their families about oncologic prognoses, complications of oncologic operations, and operative findings of cancer under direct supervision.
6. The resident will maintain clear, concise, accurate, and timely medical records including but not

limited to history and physical examination documentation, consultation notes, and progress notes under indirect supervision.

D. Practice-Based Learning and Improvement

1. The resident will understand the coordination of office based oncologic procedures for early diagnosis of thyroid and breast cancer.
2. The resident will attend and present at tumor board for patients seen with Dr. Landeros.
3. The resident should use books, journal articles, operative videotapes, internet access, and other tools available to learn about neoplastic diseases and treatment of patients with cancer.

E. Systems-Based Practice

1. The clinical resident should understand the team approach to treatment of cancer patients and be able to discuss how surgical oncologists interface with other services including medical oncology, radiation oncology, visiting nurses, and hospice care.
2. The clinical resident should understand the financial implications of cancer treatment, including hospital/physician costs, loss of employment time, outpatient chemotherapy, and nursing home care.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care for surgical oncology.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided in cancer patients.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with Dr. Landeros in private areas or in a private manner and with respectful language.
5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities on cancer care.
6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
8. The resident will be expected to participate in the delivery of oncological prognoses with compassion and sensitivity to the patient's understanding of their condition.
9. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered cancer care.

Cardiothoracic Surgery Service

PGY-4 (UT Southwestern Cardiothoracic Surgery)

A. Medical Knowledge

1. The resident should understand advanced basic science as applied to cardiac, esophageal, and pulmonary physiology. Examples include the pathophysiology of atherosclerosis, pathophysiology and natural history of pulmonary malignancy, pulmonary function abnormalities in chronic obstructive pulmonary disease, and frequency/death rates of thoracic malignancies.
2. The resident should learn about the diagnosis and management of mediastinal tumors.
3. The resident should understand the indications and appropriate tests available for screening patients for thoracic disease. The resident should be able to discuss risk factors for cardiac/pulmonary/esophageal disease, typical presenting symptoms, and patterns of coexistence such as COPD and coronary artery disease in smokers.
4. The resident should be familiar with diagnostic tests available to detect and categorize cardiac disease. Examples include the treadmill exercise test, dipyridamole thallium scintigraphy, adenosine echocardiography, MUGA scan, CT-based coronary calcification score, CT angiography, catheter-based coronary angiography.
5. The resident should be able to perform advanced assessment of indications and risk/benefit for all interventions in patients with cardiovascular disease. Examples include optimal medical management, endovascular procedures, coronary bypass, and heart transplantation.
6. The resident should understand the stepwise evaluation and management of the patient with an asymptomatic lung lesion.
7. The resident should understand changes in pulmonary function after lung resection and be able to determine whether a lung lesion is resectable on the basis of baseline pulmonary function tests.
8. The resident should be familiar with valvular heart disease, including natural history, presentation, diagnosis, available therapeutic options, and postoperative management.
9. The resident should be familiar with the evaluation and management options for patients with esophageal disease, including functional disorders, traumatic injuries (perforation and caustic injuries), and neoplasm's.

B. Patient Care

1. The resident should function as a member of the cardiothoracic team and assume responsibility for all care on his or her assigned patients in the operating room and perioperative arena under direct supervision.
2. The resident should be able to demonstrate ability to manage thoracic and cardiovascular surgery patients in the critical care setting including management of patients who may or may not require surgical intervention such as those with endocarditis, pleural effusion, and empyema under direct supervision.

3. Under direct supervision only the, the resident should be able to perform more advanced procedures such as:

- | | |
|---------------------------------------|------------------------------------|
| Open and video-assisted decortication | Mediastinotomy and mediastinoscopy |
| Pulmonary wedge resection | Lobectomy and pneumonectomy |
| Thoracotomy Lung biopsy | Thymectomy Chest wall resection |

4. The resident should perform no procedures and write no orders under indirect supervision and hold no independent authority for patient care in the intensive care unit or emergency department. All patient care decisions will be made under direct supervision only with final attending decision making authority.

C. Interpersonal and Communication Skills

1. The resident will identify risks factors for cardiothoracic disease and perform a perioperative risk assessment based on history and physical examination of the patient.
2. The resident will understand and articulate the instructions for operations on cardiac patients.
3. The resident will maintain therapeutic and ethically sound relationships with patients.
4. The resident will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
6. The resident will work effectively with others as a member of the cardiothoracic care team.
7. The resident will introduce themselves as representatives of Texas Tech and the cardiothoracic group so they can scrub cases, but have no signatory or independent authority.

D. Practice-Based Learning and Improvement

1. The resident will utilize textbooks, journal articles, internet access, and other tools to learn advanced concepts in cardiothoracic surgery.
2. The resident will participate in cardiothoracic surgery conferences and reviews of morbidity and mortality.

E. Systems-Based Practice

1. The resident should understand the interrelationship of the cardiothoracic surgeon, pulmonologist, cardiologist, medical oncologist, and rehabilitation specialist in the overall management of the patient with cardiothoracic disease.
2. The resident should be aware of community programs for risk factor modification smoking cessation clinics.
3. The resident should be aware of community screening programs such as cholesterol screening and vascular laboratory outreach programs.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided under indirect supervision.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with appropriate staff, attendings,

and fellow residents in private areas or in a private manner and with respectful language to complete indirect supervision.

5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.

6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;

8. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

9. The resident will introduce themselves as representing Texas Tech and Dr. Santoscoy's group under direct supervision only for operative cases and care of cardiothoracic patients under the direction of the attending surgeon.

Pediatric Surgery Service (Dr. Howe, Dr. Walker, Dr. Lawrence) (El Paso Children's & Providence Hospital)

PGY-4

A. Medical Knowledge

Resources:

Online at TTUHSC: Operative Pediatric Surgery and Pediatric Surgery by Coran

https://www.pedsurglibrary.com/apsa/view/PedSurg%20Resource/1884020/all/STEPS_presentation_s

https://www.pedsurglibrary.com/apsa/view/PedSurg%20Resource/1884019/all/Resident_and_Student_Handbook

1. The resident should learn in depth the fundamentals of basic and embryologic science as applied to congenital anomalies. Examples include embryologic development of the peritoneal cavity, normal rotation and fixation of the abdominal viscera, the physiologic changes of birth, fluid and electrolyte requirements by weight, normal physiologic parameters in newborns and children, VACTERL association, imperforate anus, congenital diaphragmatic hernia, intestinal atresia, tracheoesophageal fistula and major physiologic and anatomic differences of babies and children compared to adults.

2. The resident should be able to recognize, diagnose, and initiate treatment for complex surgical problems and emergencies unique to the neonatal pediatric surgical patient, including resuscitation, evaluation of coexistent abnormalities, diagnostic tests, and treatment options in premature newborns and infants. Examples include biliary atresia, tracheoesophageal fistula, congenital diaphragmatic hernia, omphalocele, gastroschisis, imperforate anus, meconium ileus, Hirschsprung's disease, malrotation, mid-gut volvulus, intestinal atresias, necrotizing enterocolitis, intestinal obstruction, congenital abdominal masses, ovarian cyst, intestinal duplication, Meckel's diverticulum and non-accidental trauma.

3. The resident should learn the assessment and management logistics of a multi-discipline pediatric trauma system in which patient care is delivered by Pediatric Surgery trauma teams, Pediatric Critical Care teams, Pediatric Emergency Medicine teams, numerous physician assistants and advanced trauma surgery nurse practitioners.
4. The resident should learn the appropriate adjuvant and surgical treatment for pediatric solid tumors. Examples are hepatoblastoma, hepatic cell carcinoma, teratoma, germ cell tumors, Wilm's tumor, neuroblastoma, and rhabdomyosarcoma.
5. The resident should learn to assess and treat newborn, infants and children with surgical amenable critical care problems. Examples include venous and arterial access, feeding access, hemo- and peritoneal dialysis access, supplemental enteral and parenteral nutrition strategies, and pediatric ventilator management modalities.

B. Patient Care

1. The resident should assume responsibility for committed participation in a service management team consisting of pediatric surgery faculty, pediatric resident peers, advanced surgical nurse practitioners and physician assistants for the care of all patients under direct and indirect supervision.
2. The resident should assume shared responsibility for care of all Pediatric ICU and Neonatal ICU patients with a critical care management team consisting of NICU personnel and pediatric surgery faculty. Responsibilities include daily assessment, comprehensible and appropriate communication between surgical and non-surgical teams and comprehensive documentation under indirect supervision; accompanied by bedside operative procedures under direct supervision.
3. The resident should be able to participate in surgery under direct supervision for problems in neonates and all children with complex surgical problems. Examples of such procedures are:
 - Insertion of central venous catheter and arterial line in infants
 - Exploratory laparotomy and stoma formation for necrotizing enter colitis
 - Pull through procedure for Hirschsprung's disease
 - Thoracotomy for tumor removal
 - Video assisted thoroscopic surgery (VATS) for empyema
 - Assessment for bilaterality in inguinal hernia
 - Nissen fundoplication (laparoscopic and open)
 - Splenectomy (laparoscopic and open)
 - Repair of intestinal atresia
 - Operative reduction of intussusception
 - Exploratory laparotomy for trauma
 - Posterior sagittal anoplasty for imperforate anus
 - Repair of chest wall deformity
 - Pyloromyotomy
 - Repair of incarcerated inguinal hernia

- Nephrectomy for Wilm's tumor

C. Interpersonal and Communication Skills

1. The resident will demonstrate clear, accurate, and succinct communication to faculty regarding newly admitted patients as a part of indirect supervision.
2. The resident will demonstrate clear, accurate, and respectful communication with nurses, peers, ancillary staff and all hospital employees as a part of indirect supervision.
3. The resident will demonstrate clear, accurate, respectful, and professional communication with referring and consulting physicians, physician assistants, nurse practitioners, and other residents.
4. The resident will demonstrate clear, accurate, and respectful communication with patients and appropriate members of their families about identified disease processes, complications, the expected courses, operative procedures, and operative findings.
5. The resident will maintain clear, concise, accurate, and timely medical records including but not limited to history and physical examination documentation, consultation notes, and progress notes.
6. The resident will create and sustain ethically sound relationships with patients.
7. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patients regarding their health and health management.
8. The resident will understand the consent process and the role of the parent obtaining consent.
9. The resident will understand how to screen the family for issues of child abuse and neglect.
10. The resident will understand how to educate the families about long-term patient care issues.
11. The resident exhibit effective listening and counseling skills.

D. Practice Based Learning and Improvement

1. The resident should use textbooks, journal articles, Internet access, and other available tools to learn about diseases of infants and children.
2. The resident will understand how to assist in service-based clinics on a weekly basis under indirect supervision.

E. Systems-Based Practice

1. The resident will demonstrate communication with families, referring physicians, and consultants, under the supervision and direction of the attending.
2. The resident will have an appreciation of pediatric conditions that warrant treatment in a medical setting that is designed to meet the special needs of infants and children.
3. The resident will understand the close interactions between pediatrician and pediatric surgeon in the care of children and infants with surgical illness.
4. The resident will be able to discuss the problem of child abuse, including identifying injuries consistent with abuse, understanding the need to admit victims for protection, and knowing how to contact the appropriate authorities to report suspected cases of abuse.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.
6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate sensitivity to family cultural and educational issues when obtaining consent for pediatric patients.
8. The resident will demonstrate sensitivity when screening for child abuse and neglect.
9. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility.
10. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

**Colorectal Surgery Service - Dr. Nathaniel Ng and Dr. Vid Fikfak
Hospitals (UMC and THOP-Transmountain and Memorial Campuses)**

PGY-4

A. Medical Knowledge

1. The resident will gain knowledge of diagnosis, management, treatment options (surgical/non-surgical), long-term prognosis, complications, patient risk, and cost considerations associated with general concerns of the colorectal patient including fluid management, drug dosage, nutrition, blood replacement, and metabolic management.
2. The resident will gain knowledge of anal/rectal function to include normal physiologic functions of the colon, rectum, and anus, and the disorders that may cause abnormal function.
3. The resident will gain knowledge of anorectal diseases including hemorrhoids, anal fissure, anal rectal abscesses and fistula, pruritus ani, and condylomata acuminata.
4. The resident will gain knowledge of tumors of the colon, rectum, and anus, including the diagnosis, staging, and treatment options for these diseases.
5. The resident will gain knowledge of diagnosis and treatment of colorectal injuries including foreign bodies.
6. The resident will gain knowledge of dysfunctional problems of the colon and rectum to include rectal prolapse, volvulus of the cecum or sigmoid colon; and megacolon secondary to laxative abuse.

7. The resident will gain knowledge of chronic inflammatory bowel disease including the diagnosis, non-surgical management, and surgical treatment for complications of ulcerative colitis and Crohn's disease.

8. The resident will gain knowledge of infectious diseases involving the colon and rectum to include diagnosis and management of sexually transmitted diseases and acute infections.

B. Patient Care

1. The general surgery resident will learn to perform a complete colorectal examination, including historical factors of pertinence to colorectal diseases under indirect supervision.

2. The resident will perform anoscopy, rigid proctoscopy, and flexible colonoscopy under direct supervision.

3. The resident will develop advanced operative skills necessary to complete those procedures common to colorectal surgeons under direct supervision.

4. The resident will perform initial evaluation and follow-through of all patients admitted to the service under indirect supervision.

5. The resident will be responsible for pre- and postoperative patient care under indirect supervision.

6. The resident will participate in the operating room and endoscopy suite under direct supervision.

7. The resident will take part in daily rounds with Dr. Gomez.

8. The resident will perform daily morning rounds and consults under indirect supervision.

9. The resident will perform no procedures independently and will have no signatory authority to write orders or make independent decisions that affect patient care.

C. Practice-Based Learning and Quality Improvement

1. The resident will exhibit self-directed learning.

2. The resident will demonstrate improvement in clinical management of patients by continually improving colorectal-related knowledge and skills during the rotation.

3. The resident will participate in tumor conferences and morbidity and mortality conferences at community hospitals.

D. Interpersonal and Communication Skills

1. The resident will establish rapport with patients and their families.

2. The resident will perform a patient-centered medical interview.

3. The resident will engage patients in shared decision-making and participate in family discussions.

4. The resident will effectively and considerately communicate with team staff in a manner that promotes care coordination.

5. The resident will discuss patient's fears regarding anorectal diseases.

6. The resident will discuss patient's fear of stomas and their impact on self-image.

E. Systems-Based Practice

1. The resident will demonstrate understanding of medical delivery systems as they relate to both inpatient and outpatient resources.

2. The resident will perform with multidisciplinary teams by coordinating care and effectively

working with colorectal surgeons and other providers in a team setting.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.
6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate sensitivity and compassion when describing prognosis for colorectal cancer.
8. The resident will demonstrate sensitivity and compassion when consenting for and describing potentially embarrassing anorectal conditions.
9. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
10. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Colorectal Surgery Service (Dr. Gomez) (Hospitals: Providence Hospital, Legent Hospital)

PGY-4

A. Medical Knowledge

1. The resident will gain knowledge of diagnosis, management, treatment options (surgical/non-surgical), long-term prognosis, complications, patient risk, and cost considerations associated with general concerns of the colorectal patient including fluid management, drug dosage, nutrition, blood replacement, and metabolic management.
2. The resident will gain knowledge of anal/rectal function to include normal physiologic functions of the colon, rectum, and anus, and the disorders that may cause abnormal function.
3. The resident will gain knowledge of anorectal diseases including hemorrhoids, anal fissure, anal rectal abscesses and fistula, pruritus ani, and condylomata acuminata.
4. The resident will gain knowledge of tumors of the colon, rectum, and anus, including the diagnosis, staging, and treatment options for these diseases.
5. The resident will gain knowledge of diagnosis and treatment of colorectal injuries including

foreign bodies.

6. The resident will gain knowledge of dysfunctional problems of the colon and rectum to include rectal prolapse, volvulus of the cecum or sigmoid colon; and megacolon secondary to laxative abuse.

7. The resident will gain knowledge of chronic inflammatory bowel disease including the diagnosis, non-surgical management, and surgical treatment for complications of ulcerative colitis and Crohn's disease.

8. The resident will gain knowledge of infectious diseases involving the colon and rectum to include diagnosis and management of sexually transmitted diseases and acute infections.

C. Patient Care

1. The general surgery resident will learn to perform a complete colorectal examination, including historical factors of pertinence to colorectal diseases under indirect supervision.

2. The resident will perform anoscopy, rigid proctoscopy, and flexible colonoscopy under direct supervision.

3. The resident will develop advanced operative skills necessary to complete those procedures common to colorectal surgeons under direct supervision.

4. The resident will perform initial evaluation and follow-through of all patients admitted to the service under indirect supervision.

5. The resident will be responsible for pre- and postoperative patient care under indirect supervision.

6. The resident will participate in the operating room and endoscopy suite under direct supervision.

7. The resident will take part in daily rounds with Dr. Gomez.

8. The resident will perform daily morning rounds and consults under indirect supervision.

9. The resident will perform no procedures independently and will have no signatory authority to write orders or make independent decisions that affect patient care.

C. Practice-Based Learning and Quality Improvement

1. The resident will exhibit self-directed learning.

2. The resident will demonstrate improvement in clinical management of patients by continually improving colorectal-related knowledge and skills during the rotation.

3. The resident will participate in tumor conferences and morbidity and mortality conferences at community hospitals.

D. Interpersonal and Communication Skills

1. The resident will establish rapport with patients and their families.

2. The resident will perform a patient-centered medical interview.

3. The resident will engage patients in shared decision-making and participate in family discussions.

4. The resident will effectively and considerately communicate with team staff in a manner that promotes care coordination.

5. The resident will discuss patient's fears regarding anorectal diseases.

6. The resident will discuss patient's fear of stomas and their impact on self-image.

E. Systems-Based Practice

1. The resident will demonstrate understanding of medical delivery systems as they relate to both inpatient and outpatient resources.
2. The resident will perform with multidisciplinary teams by coordinating care and effectively working with colorectal surgeons and other providers in a team setting.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
3. The resident will recognize and respect patients' rights, confidentiality, and privacy.
4. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.
6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
7. The resident will demonstrate sensitivity and compassion when describing prognosis for colorectal cancer.
8. The resident will demonstrate sensitivity and compassion when consenting for and describing potentially embarrassing anorectal conditions.
9. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
10. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Laparoscopic Surgery Service

Surgeon: Dr. Clapp, MD FACS-(Hospitals: Providence Hospital)

PGY-4

A. Medical Knowledge

1. The resident should be able to demonstrate knowledge of laparoscopic surgery setup including proper troubleshooting of a laparoscopic system.
2. The resident should learn in depth the management of upper gastrointestinal conditions addressed by laparoscopy including reflux disease, hiatal hernias, and achalasia.

3. The resident should be able to discuss laparoscopic surgical complications and the prevention of occult laparoscopic injury.
4. The resident should be able to perform advanced assessment of risk/benefits for all interventions relevant to advanced laparoscopic surgery.

B. Patient Care

1. The resident should work closely with Dr. Arellano and assume a major role in the care for designated patients, including inpatients and outpatients under indirect and direct supervision.
2. The resident should be able to perform diagnostic laparoscopy in the operating room for the treatment of incarcerated inguinal, ventral and hiatal hernias and acute abdominal conditions under direct supervision.
3. Under direct supervision, the resident should be able to perform advanced laparoscopic surgical procedures to include:

Hiatal hernia repair	Nissen fundoplication
Heller myotomy	Inguinal hernia repair
Incisional hernia repair	Common bile duct exploration

4. The resident will participate in morning rounds and perform consultation under indirect supervision.
5. The resident will perform no procedures independently and will have no signatory authority and write no orders that affect patient care.

C. Interpersonal and Communications Skills

1. The resident will demonstrate clear, accurate, and succinct communication to Dr. Arellano regarding newly admitted patients under indirect supervision.
2. The resident will demonstrate clear, accurate, and respectful communication with nurses, peers, ancillary staff and all hospital employees under indirect supervision.
3. The resident will demonstrate clear, accurate, respectful, and professional communication with referring and consulting physicians, physician assistants, nurse practitioners, and other residents under indirect supervision.
4. The resident will demonstrate clear, accurate, and respectful communication with patients and appropriate members of their families about identified disease processes, complications, the expected courses, operative procedures, and operative findings.
5. The resident will maintain clear, concise, accurate, and timely medical records including but not limited to history and physical examination documentation, consultation notes, and progress notes under indirect supervision.
6. The resident will create and sustain ethically sound relationships with patients.
7. The resident will demonstrate the ability to explain the rationale for tests ordered and treatments recommended, obtain informed patient consent, and educate and counsel patient's regarding their health and health management under indirect supervision.

D. Practice-Based Learning and Improvement

1. The resident should use books, journal articles, operative videotapes, internet access, and other tools available to learn about complex laparoscopic surgical intervention.

2. The resident will participate in morbidity and mortality conferences at community hospitals.

E. Systems-Based Practice

1. The clinical resident should understand the team approach to treatment of advanced laparoscopic surgery patients and be able to discuss how surgeons interface with other services including gastroenterology and interventional radiology to deliver optimal care.

2. The clinical resident should understand the financial implications of advanced laparoscopic surgical care including reduced hospital length of stay and improved time to return to work.

3. The resident should understand the cost-benefit analysis of laparoscopic versus open surgery.

F. Professionalism

1. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.

2. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.

3. The resident will recognize and respect patients' rights, confidentiality, and privacy.

4. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.

5. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.

6. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.

7. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;

8. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Transplant Surgery Service – University of Texas Southwestern Medical Center

PGY-4

A. Medical Knowledge

1. The resident will develop and understanding of the specific clinical problems encountered in recipients of organ transplants, especially the liver.

2. The resident will learn through experience participating in the management and by review of pertinent medical literature, become knowledgeable regarding criteria of organ donation.

3. The resident will understand the social and ethical issues relating to organ supply and recipient designation and selection.

4. The resident will understand the pathophysiology and clinical manifestations of more common diseases causing liver failure.

5. The resident will understand the timing of referral for transplant evaluation based on the natural history and clinical manifestations of those diseases commonly resulting in the need for liver transplantation.

6. The resident will become aware of the clinical problems specific to transplant patients.

B. Patient Care

1. The resident will understand utilization of the clinical examination as well as diagnostic, biochemical and microbiologic tests and radiologic intervention in the management of the immunocompromised patient.

2. The resident will be familiar with the management of the following in the transplant patient: hypokalemia, fluid balance, diabetes, fever of unknown origin, hypertension, sepsis, wound infection and malnutrition.

3. The resident will learn the manifestations of transplant rejection.

4. The resident will understand the roles of renal nuclear scans, ultrasonography, arteriography, and biopsy in the diagnosis of liver graft dysfunction.

5. The resident will develop a detailed understanding of the longitudinal care of the (potential) recipient both before and after transplant.

6. The resident will develop an expertise in formulating a comprehensive hepatic transplant consultation.

7. The resident will appreciate the complexities of planning and implementing cadaveric hepatic transplantation.

8. The resident will become competent in the management of post-transplant hepatic patients.

9. The resident will gain operative experience in judgment and technically demanding cases that require high levels of intellectual and manual skill.

10. The resident will become thoroughly familiar with the anatomy of the retroperitoneal-portal-hepatic and inferior vena caval arterial and venous area. Understand the technical variations between arterial and venous anastomoses.

11. Develop an understanding of the problems associated with performing vascular anastomoses in the deep restricted fields typically encountered in hepatic transplant.

C. Interpersonal and Communication Skills

1. Demonstrate compassion for the families of donor organs when appropriate.

2. Discuss the ethical implications of transplantation with recipient patients.

D. Practice Based Learning and Improvement

1. The resident will participate in any quality review or morbidity and mortality conferences held at the Texas Transplant Institute in San Antonio.

E. Systems Based Practice

1. Discuss the organ shortage and societal solutions to address the ethical implications of living donor transplants.

2. Discuss the costs and ethics of the transplant process including organ donor collection organizations, waiting lists and state/Medicare/Medicaid reimbursement for organ transplant services.

F. Professionalism

1. The resident will treat the faculty, nurses and ancillary staff of Texas Transplant Institute with the utmost authority and respect while visiting their institution.
2. The resident will respect all rules and restrictions of transplant/organ collection agencies while participating in organ harvest operations.
3. The resident will demonstrate an awareness of the importance of the physician's own attitudes and beliefs and how they can affect patient care.
4. The resident will demonstrate punctuality by exhibiting timely responses to pages, evaluating patients, and the requests of faculty, staff, and patients and by providing timely documentation of patient assessment and the care provided.
5. The resident will recognize and respect patients' rights, confidentiality, and privacy.
6. The resident will be expected to discuss patients and their care with appropriate staff, attendings, and fellow residents in private areas or in a private manner and with respectful language.
7. The resident will be expected to demonstrate sensitivity to and awareness of the impact of the patient's culture, values, age, and gender, disabilities.
8. The resident will be expected to address (bring to light) any ethical issues that may arise in the care of the patient.
9. The resident will demonstrate compassion, integrity, and respect for others and will recognize her/his own limitation(s) and take personal responsibility;
10. The resident will be accountable to patients, society, and the profession and will actively promote comprehensive and continuing patient-centered care.

Vascular Surgery Division – Dr. Aidinian and Dr. Viney (UMC, Midland Memorial Hospital)

PGY-4 Resident

Description of the Rotation

The Vascular Surgery rotation, under the oversight of Dr. Aidinian, the PGY-4 resident will be responsible for providing care for a wide variety of patients with vascular surgery conditions. The PGY-4 resident will be responsible for the comprehensive care of a full spectrum of vascular surgery patients. The PGY-4 resident will be responsible for coordination of the pre-operative counseling and arranging for appropriate specialty consultations/assistance. The PGY-4 resident provides educational oversight of the medical students on the service and ensure they are present and punctual for all conferences, and they also ensure compliance of the resident team with duty hour and other regulatory guidelines. The PGY-4 resident will be responsible for making rounds each morning on all vascular surgery patients.

Suggested Reading

In addition to sections from the major surgical textbooks (e.g. *Greenfield's Surgery and Cameron*) and the Decker curriculum, you should inquire of Dr. Aidinian as to special contemporary articles for advanced reading.

General Schedule of Activities

Monday: Patient rounds, Cath Lab

Tuesday: Patient rounds, morning wound care clinic

Wednesday: Patient rounds, operating room

Thursday: Patient rounds, TTU academic conference, afternoon clinic procedures

Friday: Clinic

Call: Expected to come in for overnight/weekend call cases (in compliance with duty hour and other regulatory guidelines).

Rotation Goals

At the completion of this rotation, the PGY-4 resident will meet the educational objectives outlined below. This should be accomplished through a combination of exposure to clinical situations

supplemented by independent scholarly activity using *Greenfield's Surgery*, the Decker website and curriculum, and specific references suggested throughout the rotation by faculty.

Competency Based Goals and Objectives

A. Medical Knowledge

1. The PGY-4 resident should be able to demonstrate a thorough knowledge of:
2. The anatomy and physiology of the aorta and its peripheral branches.
3. The anatomy, physiology and pathophysiology of the following: aneurysmal disease, claudication, compartment syndrome, fibromuscular dysplasia, hypercoagulable syndromes, thoracic outlet syndrome, venous thrombosis/embolism, thrombophlebitis, venous stasis disease, and varicose veins.
4. Understand the basics of non-invasive vascular laboratory.
5. Understand the basics of wound care as applied to patients with ischemic extremities or venous insufficiency ulcers.
6. Pre-Operative workup and post-operative follow up for patients undergoing common vascular procedures to include: Carotid endarterectomy, open and endovascular abdominal aortic aneurysm repair, treatment of aortoiliac occlusive disease, dialysis access creation, treatment of acute/chronic mesenteric ischemia, lower extremity bypass/endovascular treatment for arterial occlusive disease, and varicose vein surgery.

The PGY-4 resident should be able to describe the surgical approach to the following:

7. Insertion of a central venous catheter, to include a dialysis catheter, utilizing an ultrasound for guidance.
8. Insertion of an arterial line with and without ultrasound guidance.
9. Endovenous ablation of saphenous vein.
10. Creation of an arteriovenous fistula for dialysis access using both autologous and synthetic grafts.
11. Cut down to access and control the femoral vessels.
12. Performing an Arteriogram.
13. Placement of an inferior vena cava filter.
14. Open and endovascular treatment of abdominal/thoracic aortic aneurysms.
15. Open and endovascular treatment of carotid stenosis.
16. Open and endovascular treatment of claudication and peripheral vascular occlusive disease.

The PGY-4 Resident will be responsible for attending all education conference while on the rotation. Additionally they will be responsible for preparing themselves for all educational conferences.

B. Patient Care

PGY-4 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.

PGY-4 Resident:

1. Will demonstrate, by direct observation by an attending staff, that they can perform a thorough head to toe physical exam on a routine Vascular Surgery patient in both the clinic and inpatient setting.
2. Will demonstrate manual dexterity appropriate for their level in training. This will be accomplished through practice in the clinic, Cath lab and operating room.
3. Will develop and execute patient care plans appropriate for that of a PGY-4 Resident. Care plans will include patients seen in the clinic, emergency department and in the in-patient setting. All care plans will be discussed with a staff member prior to disposition.
4. Monitor the entire spectrum of post-operative care of vascular patients in both the ward and ICU setting.

C. Practice Based Learning and Improvement

PGY-4 Resident must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. PGY-4 Residents are expected to develop skills and habits to be able to meet the following goals:

1. Critically evaluate published literature in peer reviewed journals and texts, and formulate an evidence based therapeutic plan on patient for whom they provide care.
2. Analyze their medical and surgical complications and present them at Morbidity and Mortality Conference in a systematic, constructive and educational manner.
3. Prepare in advance for clinical activities and educational conferences.
4. Apply clinical trials data to individual patient management.
5. Develop a method to record and track over time the results intervention and procedures performed by the individual resident.
6. Be actively involved in the teaching the members of their team (medical students and nurse practitioners), and ancillary staff.
7. Actively participate and contribute to academic and clinical discussions/conferences.
8. Present patients for discussion during rounds and with appropriate literature references to support planned intervention.
9. Understand the role of study design and the use/misuse of statistical analysis in review of the results of published research.
10. Demonstrate the ability to use information systems to obtain pertinent information regarding surgical issues and problems.
11. Use information technology to manage and provide patient-related information.

D. Interpersonal Skills and Communication

PGY-4 Resident must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. PGY-4 Residents are expected to:

1. Communicate compassionately and effectively with patients and family members regarding treatment plans. They will defer to attending staff when appropriate.

2. Communicate care plans for patients on their team in a timely and effective manner with members of their team, fellow physicians, nurses, ancillary staff, and health related agencies.
3. Communicate concise but complete sign outs to the night team or other services to ensure appropriate continuity of care.
4. Demonstrate mastery of complete and concise presentations of history and physical exams for morning report, rounds, or in the clinic.
5. Work effectively as a leader of a health care team.
6. Maintain comprehensive, and timely, medical records.

E. Professionalism

PGY-4 Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. PGY-4 Residents are expected to demonstrate:

1. An understanding that patient needs supersede self-interest, and that above all patient privacy and autonomy must be protected.
2. An understanding of the importance of all members of the health care team (other physicians, nurses, technicians, pharmacists, ancillary staff, etc.). Additionally they will treat all members of the health care team with respect and recognize the value added by each member of the team.
3. Behavior that is consistent with high standards of moral and ethical values.
4. Ensure that both they and their team is prompt for all conferences, clinics, rounds, and operative cases.
5. Answer pages and return phone calls promptly.
6. Keep case logs and duty hour logs up to date per the residency handbook guidelines.

F. Systems Based Practice

PGY-4 Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Chief Residents are expected to:

1. Develop a cost effective algorithm for preoperative workup, to include cardiac evaluation, for vascular surgery patients.
2. Appropriately incorporate the recommendations of medical consultants into patient care plans.
3. Learn and apply basics of appropriate documentation, in both the inpatient and outpatient setting.
4. Follow up on all tests and imaging studies, in a timely manner, which are ordered to ensure prompt and smooth transitions from levels and locations of care.
5. Participate in identifying system errors and implementing potential systems solutions.
6. Coordinate the flow of a patient's care from the initial consultation through the postoperative follow up period.

G. Competency Assessment

Formal, evaluations of the PGY-4 resident will be completed at the end of the rotation block and will include evaluations from the following:

1. Attending Staff: evaluations will be based on interaction with the resident in the clinic, during rounds on the ward and in the operating room.

2. Nursing Staff: Nursing staff will provide feedback based on interactions with the resident in the clinic.

3. Other oral and written feedback may be given throughout the rotation as necessary.

H. Supervision

PGY-4 Residents will be given more autonomy in the care of the patients, which will be commensurate with their level of maturity as a surgeon. Patients will have a clearly defined attending vascular surgeon, and the PGY-4 Resident will at minimum discuss their patient's progress on a daily basis with the attending vascular surgeon. Supervision by staff will either be direct supervision, when appropriate, or indirect supervision with staff readily available.

(The medical knowledge, patient care skills and core competencies listed above represent what has been identified by the American Board of Surgery and the Accreditation Council for Graduate Medical Education (ACGME) Surgery Residency Review Committee as the basic expectations for surgical resident training and does not represent an all-inclusive list of conditions, procedures or competencies about which a resident may be expected to be familiar with throughout this rotation.)