Resident Welcome

Resident Handbook: Department of Surgery, General Surgery

Welcome to the University of Nevada, Las Vegas School of Medicine Department of Surgery in Las Vegas. This Handbook describes policies regarding your responsibilities as a surgery resident. Always confirm with the Program Director for any updates or changes, as required by ACGME, UNLV GME office, or other governing authorities. Your schedules and service assignments will be made by the Program Director in conjunction with the Chief Residents. On each service, you are expected to work under the direction of the Chief Resident and be available for all service obligations, such as daily rounds and operative procedures. When you are on call, living quarters are available to you at all of the affiliated teaching institutions.

There are surgical libraries in the departmental office on the 4th floor of 1701 W. Charleston site and on the 5th floor of the 2040 W. Charleston building. You also have access to the University of Nevada, Las Vegas School of Medicine Library online. We expect you to make use of these facilities and online resources for your own educational needs. You have subscription to SCORE portal, which contain the structured content for your weekly education curriculum.

The contractual relationship for categorical General Surgery residents begins on July 1 of your initial year with the program and is renewed annually if promotion is granted. The duration of your training will be five or six years, depending on your participation in an optional research year, which usually follows completion of the second year.

The specific financial conditions are outlined in your standard contract. Moonlighting is not allowed while you are a resident. Included in this Handbook are both the procedures for disciplinary action and the resident grievance procedures. The department complies with various institutions' quality assurance methods which are available from the GME office.

Disclaimer: The Department makes every effort to make timely update to this Handbook. Whenever there appears to be inaccurate or inconsistent information, always check with the Program Director for the most up-to-date policies and instructions. Whenever there are apparent conflicts or discrepancies with UNLV GME policies, ACGME policies, or ABS requirements, again check with Program Director for the proper interpretation of any rules or regulations. This written document serves as a quick reference, but in no way does it replace constant and open communication between you and the faculty of the Department to insure your success in the program.

Contact Information

Resident Handbook: Department of Surgery, General Surgery

Welcome to the Department of Surgery, University of Nevada, Las Vegas School of Medicine. Below is a list of contact names and numbers that you might find useful.

Exploration of the Department of Surgery website will provide some information about the academic, clinical, and research interest of our faculty as well as our Residency, Clerkship and Fellowship Programs.

The main office is located in Las Vegas.

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Selection Processes and Guidelines

Resident Handbook

I. Eligibility

A. These policies conform to ACGME Institutional Requirement and policies of the UNLV office of GME.

B. Summary:

- Students eligible to be accepted into the University of Nevada, Las Vegas School of Medicine Department of Surgery residency programs include qualified graduates of LCME approved US or Canadian medical schools or AOA accredited schools.
- Such student candidates for residency are selected on the basis of their academic accomplishment and the estimation of their preparedness for graduate medical education training.
- The Department of Surgery participates in both NRMP and JSGMESB (Air Force match), and comply with the rules and regulations of both match processes.
- The Department does not discriminate against qualified applicants based upon gender, ethnicity, race, age, religion, national origin, sexual orientation, disability, marital status, or veteran status.

II. Selection Process

A. The selection process outlined here concerns students matched through the NRMP. Students matched through the Air Force are selected by the military.

B. The recruitment process consists of accurate and appropriate methods of promoting and describing the program, including information that are updated from time to time for accuracy in this Handbook and on the Department website.

C. Students must complete their applications thru ERAS. Criteria used in initial screening of students include, but are not limited to, (a) academic excellence and achievement; (b) behavior, communication skills and professionalism; (c) letters of recommendations; and (d) USMLE I score. USMLE II is not required but highly recommended.

D. Decisions for interview are based predominantly on the initial screening criteria.

E. A personal interview is mandatory. Applicants at the interview stage will receive, as complete as possible, a disclosure as to the curricular, rotational and academic expectations of the residency program, and to the available benefits and regulations of the program.

F. The selection process includes academic faculty and residents.

G. The selection group or committee meets to exchange opinions on candidates. In addition to strictly objective criteria, the committee also considers other qualifications about an applicant, including but not limited to, whether an applicant's career goal is best served by the stated mission of the Department.

H. The Program Director, the Associate Program Director, and the Chairman of the department are key members of final selection.

I. A rank order of applicants is generated to select the most qualified candidates and is entered into NRMP.

J. All candidates are subject to the Match process.

K. As soon as possible after the Match, the Department will interact with newly selected students to begin the process of orientation and to enter into a contract.

Supervision Policy: General Surgery

Resident Handbook

I. Purpose

To establish guidelines for supervision for residents enrolled in the General Surgery residency training program at the University of Nevada, Las Vegas School of Medicine.

II. Policy

Medical staff physicians supervising residents in the general surgery program have the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of patient care delivered. Supervision is exercised through observation, consultation, role modeling and by directing the learning of the resident. Documentation of supervision is the written or computer-generated medical record of evidence of a patient encounter that reflects the level of supervision provided by a supervising medical staff physician.

The General Surgery residency training program utilizes standards and criteria for supervision of residents as put forth by the Residency Review Committee for Surgery of the Accreditation Council for Graduate Medical Education.

III. Procedure

A. Ultimate responsibility for the care of a patient rests with the attending physician in inpatient, outpatient, and operating room resident experiences

B. The program director and/or individual attending must determine the level of supervision required to provide appropriate training and to assure quality of patient care

   1. This is level determined by resident capabilities, based on criteria set in the Milestones, -AND-

   2. By the level of complexities and the needs of each patient encounter.

C. To ensure patient safety and quality patient care while providing the opportunity to maximize the resident educational experience, all resident activities are supervised:

   1. Supervision may be exercised through a variety of methods. The supervising physician may be a faculty member, or a more advanced resident or fellow.

I. Direct supervision: In some activities the resident may be supervised directly by the physical presence of the supervisor.

II. Indirect supervision: other circumstances, the resident may be adequately supervised by the immediate availability on site of the supervising faculty member, fellow, or senior resident physician,

III. The resident may be adequately supervised indirectly by means of telephone and/or electronic modalities.

IV. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

2. PGY1 residents will be supervised either directly or indirectly with direct supervision immediately available on site.

3. Residency program coordinator will ensure that residents know which supervising attending staff physician is on call and how to reach this individual.

D. Supervision of general surgery residents is based on level of training. Interns are supervised by more senior residents who are supervised by chief residents and ultimately the attending. Residents rotating on other services are supervised by those more senior to them and the attending.

E. The program director with faculty input will delegate patient care responsibilities to residents in a way that will allow them to assume progressive authority and responsibility, conditional independence and a supervisory role in patient care based on individual assessments in accordance with their level of training, experience, and demonstrated clinical competence.

F. Inpatient and ambulatory assignments have been developed commensurate with residents' abilities and with appropriate supervision as outlined in level specific, rotation specific goals and objectives.

G. General Surgery residents will be provided with prompt and reliable systems for communication and interaction with supervisory physicians.

H. All non-emergent invasive procedures will have the prior approval of the attending physician.

I. Patient care rendered by a resident physician may not be contrary to the management approved by the attending physician unless it is directed by the appropriate department chairman in accordance with the Medical Staff by-laws of each hospital or training site.

J. Resident physicians with documented competencies will supervise assigned medical students.

K. Residents will be responsible for conveying information to the supervising attending staff member for a given patient shall include but not be limited to the following situations:

1. Notification and review of a consultation in the emergency room or inpatient setting

2. Admission of a patient to the hospital inpatient service

3. Consideration of performing an elective invasive procedure
4. Notification of the performance of an emergent invasive procedure
5. Review of a patient's postoperative condition with the responsible attending staff whenever it deviates from the expected course, deteriorates, or within 24 hours after the procedure when the patient is stable and the postoperative course unremarkable
6. A patient leaving against medical advice
7. A patient and/or family asking to talk with attending staff
8. A patient demonstrating new hostile, suicidal, homicidal or psychotic ideations
9. Difficulties in interaction with other residents and attendings caring for a patient in common
10. Possible violations of hospital policies regarding the care of a patient
11. Possible violations of local, state or federal laws regarding the care of a patient
12. Abnormal test results
13. Change in a patient's condition, even if expected (including death)
14. Need for an increasing level of acuity of care
15. Decision by patient or individual with power of attorney to make medical decisions for the patient, to initiate or change end-of-life categorization status
16. Transfer of a patient (e.g., to a different level of care, another inpatient service, another attending's service, etc.)
17. Consideration of discharge of a patient from the hospital and discharge planning
18. Discharge of a patient from the hospital

L. With the exception of a life or death emergency, at no time can a resident be supervised by a relative. The term "relative" is defined by state statute and University policy as any person who is within the third degree of consanguinity or affinity. Consanguinity is a blood relationship within a family of the same descent. Affinity is a marriage or other legal relationship (such as adoption) formally recognized by the State of Nevada. Relationships within the third degree of consanguinity or affinity are defined as:

1. The employee's spouse, child, parent, sibling, half-sibling, or step-relatives in the same relationship;
2. The spouse of the employee's child, parent, sibling, half-sibling, or step-relative; The employee's in-laws, aunt, uncle, niece, nephew, grandparent, grandchild or first cousin.

IV. Attending Staff Supervision and Responsibility

Attending staff are responsible for, and must be personally involved in, the care

provided to individual patients in inpatient, outpatient, and operating room settings. When a resident is involved in the care of the patient, the responsible attending physician must maintain personal involvement. The attending physician oversees the care of the patient and provides the appropriate intensity of resident supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the oversight of the responsible attending physician or be personally furnished by the attending physician. Attending staff responsibilities include:

A. Inpatient:

1. Attending physician is identified in the chart
2. Meet with the patient within 24 hours of admission
3. Document supervision with progress note(s) by the end of the day following admission
4. Follow local admission guidelines for attending notification
5. Ensure discharge is appropriate
6. Ensure transfer from one inpatient service to another inpatient service is appropriate
7. Resident participation in the management of patients in the perioperative period, both in the intensive care and the non-acute patient care units is supervised by a qualified faculty member and this supervision is documented in inpatient progress notes. Frequent consultation with faculty members is an essential part of both safe and excellent clinical care, and optimal resident teaching. Recognizing the value of the so-called "chain of command," it is appropriate for junior level residents to report to senior-level residents and/or the chief residents. Therefore, much of the interface between the resident staff and faculty occurs at the chief resident level.

B. Outpatient:

1. Attending physician is identified in the chart
2. Discuss patient with resident during initial visit; document attending involvement by either an attending note or documentation of attending supervision in the resident progress note.
3. Countersign note: All outpatient clinics at all participating institutions are supervised by a qualified faculty member and this supervision documented in all clinic notes. Faculty schedules are structured to provide residents with this continuous supervision. Attending notes are added to resident notes to comply with Medicare/Medicaid requirements. Typically, residents are given the opportunity to see patients then present the history to the faculty on a case by case basis. As they progress through training, residents are increasingly encouraged to report their interpretation of the patient presentation and test results, suggest provisional

diagnoses, and recommend further diagnostic testing and preliminary treatment plans. Particular emphasis is placed on ensuring an opportunity for follow-up care of surgical patients, so that the results of surgical care may be evaluated by the responsible residents.

C. Emergency Department/ Consultations

1. An attending physician must always be accessible by phone and will evaluate the patient within 24 hours
2. Discuss with the resident doing a given consultation within 24 hours
3. Document supervision of a given consultation by the end of the next working day
4. Residents called to see inpatients on other services for general surgery consultation or called to the emergency room are supervised by a qualified faculty member and this supervision is documented in inpatient progress notes. The resident will usually see the patient and perform an initial assessment then telephone the faculty member that is on-call. Junior residents will generally review the case with the Chief Resident prior to calling the attending. In an urgent situation, such as a trauma case, the resident and faculty member may perform the initial assessment simultaneously to expedite care. Under no circumstances will a resident make an independent determination to admit, transfer, or discharge a patient without personal discussion of the case with the on-call faculty member. All calls from outside facilities requesting to transfer patients to the general surgery service will go directly to the faculty member.

D. Surgery/Procedures

1. Attending physician will be notified if surgery needs to be performed.
2. Attending meets with the patient and the individual with power of attorney to give operative consent before the procedure/surgery
3. Attending staff will discuss indications, risks, complications, alternatives and benefits of surgery and will obtain the surgical consent
4. The attending staff will document agreement with the proposed surgery/procedures
5. The attending physician countersigns the procedure note
6. Surgical supervision: All surgical cases at all participating institutions are supervised appropriately by qualified faculty and this supervision documented in all surgical notes. Faculty schedules are structured to provide residents with this continuous supervision. The degree to which the resident independently performs technical maneuvers during surgery is to be determined at the discretion of the faculty member and may change from case to case and even from minute to minute within the same case

depending on the difficulty of the case or changes in patient health status. It is expected that residents have a progressively more active role in procedures of increasing levels of difficulty as they mature through the residency.

E. Sign initial Do Not Resuscitate (DNR) orders and document compliance with local DNR and categorization policies

V. PGY1 resident supervision: The following tasks for PGY-1 residents will be supervised directly until they have demonstrated competencies for the particular task. The resident must maintain records of demonstration of competencies.

A. History and Physical

B. Central Line Insertion (Both subclavian AND internal jugular)

1. Residents must follow the entire policy of supervision for Central Venous Catheter insertion that is detailed in the UNLV GME Handbook, Section III.

C. Chest tube Insertion

D. At UMC, all endotracheal intubations MUST be directly supervised by an anesthesiologist or an emergency medicine attending, regardless of resident level of training.

Sign In and Sign Out Rounds: General Surgery

Resident Handbook

The 6AM & 6PM Sign in & Sign out Rounds will be held in the OR Conference Room. It is located across the hall from the men's locker room. **The door code is 1473#**.

The room has LCD, computers, tables, chairs, white board, and phones. This computer can be used to access patient information, lists, PACS, and learning resources.

Trauma Sign in & Sign out rounds occur in the trauma resuscitation unit, in the trauma conference room at 7 AM & PM.

Use the sign out document template and/or patient list generated from EPIC.

Transition of care must involve two way communication, that could be accomplished either face-to-face or via telephone. Transition of care information must include, at a minimum:

a. Identification of patient, including name, medical record number, and date of birth
b. Identification of admitting/primary/supervising physician and contact information
c. Diagnosis and current status/condition (level of acuity) of patient
d. Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
e. Outstanding tasks – what needs to be completed in immediate future
f. Outstanding laboratories/studies – what needs follow up during shift
g. Changes in patient condition that may occur requiring interventions or contingency plans
h. Code status (if appropriate)

Procedure Logs: General Surgery

Resident Handbook

Certain procedures require target numbers, the minimal number of procedures that must be performed under direct supervision, before a resident (usually a new PGY1 resident) is credentialed to do a specific procedure under indirect supervision. It is the resident's responsibility to keep a record of the procedures they have been performed and to have the faculty or senior resident sign off on procedures they have supervised.

Residents are also required to log their procedures in the ACGME Case Log. It is the resident's responsibility to acquire these numbers and return the signed form to the Program Coordinator so the list of credentialed residents can be updated in New Innovations and forward to hospitals.

Operative Log: General Surgery

Resident Handbook

It is the responsibility of each resident to keep an up-to-date log of all cases in which you were the operating surgeon, teaching assistant or first assistant. This log should include the patient's name, MR#, age, diagnosis, date of procedure, procedure performed, CPT code and complications. ALL categorical, preliminary residents in General Surgery are to enter their cases in the ACGME's Resident Case Log System. Each resident will be given a log-in name and password. For instructions on entering cases please view the tutorial available on the ACGME website under "Case Log Information". Do not rely on the operating room or medical record for this data as it is your responsibility to keep accurate data on cases you participate in.

Residents are expected to enter their cases on a weekly basis. The Program Director will review case entry information monthly. Any resident not up to date with entering cases may be removed from service and the OR until the cases are entered. This log is required in order for you to successfully complete the program and be allowed to take your board examination.

- A minimum of 850 operative procedures in five years as operating surgeon, including at least 200 in the chief resident year. Applicants may count up to 50 cases as teaching assistant toward the 850 total; however TA cases may not count toward the 200 chief year cases. The 850 case requirements include non-operative trauma and critical care (see below).
- A minimum of 40 cases in non-operative trauma (code 99199), of which 10 cases must be Trauma Team Leader Resuscitation (code 92950). See ACGME Non-operative Trauma for more details.
- A minimum of 40 cases in surgical critical care, with at least one in each of the seven categories: ventilatory management; bleeding (nontrauma); hemodynamic instability; organ dysfunction/failure; dysrhythmias; invasive line management and monitoring; and parenteral/enteral nutrition. These are logged separately via code 99292. See section below.
- Residents will be required to have participated as teaching assistant in a minimum of 25 cases by the completion of residency. These only are allowed in the 4th and 5th year of training.
- Residents will be required to have performed 250 operations by the conclusion of the PGY-2 year. These can include operative procedures performed as surgeon or first assistant, as well as operative exposures (e-codes) and endoscopies. Since the ABS does not receive residents' operative data until the application for certification, the RRC-Surgery will track this requirement through its case log system.

Critical Care Index Case Log

The ACGME required the documentation of surgical critical care. The Critical Care Index Cases (CCIC) log was developed to provide documentation of resident management of a broad scope of critical care patients as follows. The code for these cases is 99292.

1. Each resident will develop a log of at least 40 critical care patients who represent the broad scope of critical care index management. Do not submit 40 of the same category.
2. Each of the patients listed in the log should include the management of at least 2 or the 7 categories listed in #4 below.
3. The completed logs should include experience, with at least one patient in all seven of the categories.
4. The categories are:
   - Ventilatory Management (>24 hours on a ventilator)
   - Bleeding (a non trauma patient requiring more than 3 units of blood/products and monitoring in ICU settings)
   - Hemodynamic Instability (requiring inotropic/pressor support)
   - Organ Dysfunction/Failure (etiology/mode of management, i.e., renal, hepatic, cardiac failure)
   - Dysrhythmias (requiring drug management)
   - Invasive Line Management and Monitoring (Swan-Ganz, A-lines, etc.)
   - Parenteral/Enteral Nutrition
5. See ACGME Surgical Critical Care Logging website for complete guideline.

Defined Category Minimum Numbers for General Surgery Residents and Credit Role

Review Committee for Surgery

Defined category minimums, and discreet cases within each category, are in effect for residents graduating in 2018. Beginning with the January 2020 ACGME annual program review, the Review Committee will use these defined minimums to assess graduate Case Logs.

Category		Minimum
Skin, Soft Tissue		**25**
Breast		**40**
	Mastectomy	5
	Axilla	5
Head and Neck		**25**
Alimentary Tract		**180**
	Esophagus	5
	Stomach	15
	Small Intestine	25
	Large Intestine	40
	Appendix	40
	Anorectal	20
Abdominal		**250**
	Biliary	85
	Hernia	85
	Liver	5
	Pancreas	5
Vascular		**50**
	Access	10
	Anastomosis, Repair, or Endarterectomy	10
Endocrine		**15**
	Thyroid or Parathyroid	10
Operative Trauma		**10**
Non-operative Trauma		**40**
	Resuscitations as Team Leader	10
Thoracic Surgery		**20**
	Thoracotomy	5
Pediatric Surgery		**20**
Plastic Surgery		**10**
Surgical Critical Care		**40**
Laparoscopic Basic		**100**
Endoscopy		**85**
	Upper Endoscopy	35
	Colonoscopy	50
Laparoscopic Complex		**75**
Total Major Cases		**850**
	Chief Year Major Cases	200
	Teaching Assistant Cases	25

05/2019

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Minimum Case Requirements by PGY-3

Residents must have at least 250 operations by the beginning of their PG-3 year, effective with applicants who began residency in July 2014.

- The 250 cases can include procedures performed as Operating Surgeon or First Assistant.
- Of the 250, at least 200 must be in the defined categories, endoscopies, or e-codes (see below for information on e-codes).
- Up to 50 non-defined cases can be applied to this requirement.

These requirements are in effect for residents graduating in 2020, and will be assessed beginning with the 2021 ACGME annual program review.

E-Codes: General surgery residents can use e-codes to receive ACGME Case Log credit for vascular surgical procedures. E-codes allow more than one resident to take credit for an arterial exposure and repair. The resident who accomplishes the exposure should add an "E" to the case ID for the system to allow credit for a second procedure on the same patient. The relevant CPT codes to use are: 35201 (Repair blood vessel, direct; neck); 35206 (upper extremity); 35216 (intra-thoracic without bypass); 35221 (intra-abdominal), and 35226 (lower extremity). Four categories are available under Trauma for residents to enter arterial exposures.

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Credit Roles for General Surgery Residents

Residents must function in the role of Surgeon for a minimum of 850 operative procedures over the five years of residency. Of these 850, at least 200 must be accomplished as a Chief Resident.

A resident is considered the Surgeon only when he or she can document a significant role in the following aspects of management:

- determination or confirmation of the diagnosis
- provision of pre-operative care
- selection and accomplishment of the appropriate operative procedure
- direction of the post-operative care

For multi-procedure operations, residents must record all procedures performed and indicate which procedure will count as the primary procedure. When more than one resident is involved in the same patient/same day/same operation/procedure, a senior resident may take credit as Surgeon, while another resident may take credit as First Assistant; or, a senior resident may take credit as Teaching Assistant while a more junior resident takes credit as Surgeon Junior. If two residents perform different procedures on the same patient (different CPT codes), then each may take credit as Surgeon.

Abbreviations for use in the Case Log System

SC = Surgeon Chief: Used for cases credited as "Surgeon" during the 12 months of Chief experience

SJ = Surgeon Junior: Used for cases credited as "Surgeon prior" to Chief experience

TA = Teaching Assistant: Used when a Chief Resident is working with a junior resident who takes credit as "Surgeon Junior"

- The minimum required number of TA cases may be reported during the PG-4 and 5 years. All TA cases will count toward the total major cases, and will count in the defined categories, but will not count towards the 200 minimum cases needed to fulfill the operative requirements for the Chief year.

FA = First Assistant: Used when a resident assists another surgeon with an operative procedure and when he or she is not the primary Surgeon; FA cases are not credited toward the total number of major cases

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ABS Resident Performance Assessments: General Surgery

Resident Handbook

Applicants to the General Surgery Qualifying Exam will be required to obtain during residency at least six operative performance assessments and six clinical performance assessments conducted by their program director or other faculty members.

- When signing an individual's application, the program director will be asked to attest that these twelve assessments have been completed. However the applicant bears ultimate responsibility for ensuring these assessments are performed while in residency. The completed assessment forms will not be collected by the ABS.
- Please see the list of approved attendings to obtain these assessments from. The evaluation forms are available on the ABS website, and in New Innovations.

ABS Resident Assessments: Approved Attendings

Procedure	Attending
Total Mastectomy	Baynosa
Partial Mastectomy	Baynosa
Thyroidectomy	Kirgan
Parathyroidectomy	Kirgan, Ham
Open Inguinal Hernia repair	Baynosa St. Hill

Open Ventral Hernia repair	Baynosa St. Hill
Laparoscopic Ventral Hernia repair	Barber, Baynosa St. Hill
Laparoscopic Inguinal Hernia repair	St. Hill, Baynosa
Laparoscopic cholecystectomy	Baynosa Barber Kirgan St. Hill
Laparoscopic Appendectomy	Baynosa, Kirgan, Barber St. Hill
Laparoscopic colectomy	Bardakcioglu
Colectomy/ Small Bowel Resection	Bardakcioglu
AV Fistula	Shen

ACGME Requirement: Quality Improvement Project

Resident Handbook

All residents are required to complete a QI Project during the residency. Residents can opt to perform a QI project as a team, or alone.

QI project preceptor: Dr. Randy St. Hill

Dr. St. Hill will present the QI project deadline at the beginning of the year.

ABS Requirement for FLS and FES

PASSING FES and FLS is required to sit for ABS board exam.

FES- ABS requires all ABS eligible general surgeons to complete a standard curriculum in the use of endoscopic techniques. This new requirement will apply to certification applicants who complete their residency training in the 2017-2018 academic year or thereafter.

During their general surgery residency, applicants will be required to have completed the ABS Flexible Endoscopy Curriculum.

FLS is a comprehensive web-based education module that includes a hands-on skills training component and assessment tool designed to teach the physiology, fundamental knowledge, and technical skills required in basic laparoscopic surgery. Our goal is to provide surgical residents, fellows and practicing physicians an opportunity to learn the fundamentals of laparoscopic surgery in a consistent, scientifically accepted format; and to test cognitive, surgical decision-making, and technical skills, all with the goal of improving the quality of patient care.

FLS was designed for surgical residents, fellows and practicing physicians to learn and practice laparoscopic skills to have the opportunity to definitely measure and document those skills. The FLS Test measures cognitive knowledge, case/problem management skills and manual dexterity. The FLS program content has been endorsed by the American College of Surgeons (ACS) and is a joint educational offering of SAGES and ACS. FLS is also CME accredited.

Clinical Experience and Education Work Hours

Resident Handbook

Please refer to ACGME General Surgery Program Requirement VI.F for complete guideline.

Maximum hr/wk
Clinical and educational work hours is limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, and clinical work done from home.

Minimum time off between scheduled duty periods
Residents have 8 hours off free of duty between scheduled clinical or education periods.

Residents have 14 hours free of duty after 24 hours of in-hospital duty.

Mandatory off-duty time
Residents have 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.

Maximum length of duty period
A maximum of 24 hours of continuous duty in the hospital.

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

In unusual circumstances, residents may, on their own initiative (not compelled), remain beyond scheduled hour to: provide care to a single severely ill or unstable patient; provide humanistic attention to the needs of a patient or family; or, to attend unique educational events.

The resident must document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director will review each submission of additional service and track both individual resident and program-wide episodes of additional duty.

These additional hours of care or education will be counted toward the 80-hour weekly limit.

Maximum frequency of in-house night float call
Night float rotations will not exceed two months in duration, four months of night float per PGY level, and 15 months for the entire program.

Maximum In-House On-Call Frequency
Residents will be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

Home call
Time spent on patient care activities by residents on at-home call counts toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every third-night limitation, but satisfies the requirement for one day in seven free of clinical work and education, when averaged over four weeks.

Residents who experience excessive clinical duties while on Home Call that precludes adequate rest or personal time, must inform the Site Director, so that, if necessary, the resident can rest and continuity of care can be arranged.

Moonlighting
Not allowed.

Evaluation and Advancement of PGY Status

Resident Handbook

Policy: Resident Advancement

General Criteria (PGY I-V)

For yearly advancement, the general surgery resident must perform to the satisfaction of the Clinical Competency Committee. Criterion involve:

1. adherence to standards of conduct and behavior outlined elsewhere in this resident handbook;
2. adequate clinical performance on each assigned rotation with attainment of objectives for knowledge and clinical skills;
3. satisfactory attendance at education opportunities,
4. adequate academic performance on examinations.

Specific

1. Residents will be advanced based on performance as graded by faculty on the competency as well as milestone based evaluations. These will be reviewed on a twice annual basis by the faculty and chief residents.
2. Standards of conduct and behavior
   Specific standards of conduct and behavior can be found in the University of Nevada, Las Vegas School of Medicine House Staff manual. These are fundamental, ethical, and professional standards generally accepted by the medical profession.
3. Clinical performance
   Attainment of the goals and objectives for knowledge and clinical skills is evaluated by all members of the teaching faculty specifically for each rotation. These include the acquisition of:
   - Basic knowledge of pathophysiology; anatomy, and surgical management of a variety of surgical areas
   - Operative skills
   - Analytical and decision-making skills including ability to gather information and use it effectively
   - Professional characteristics such as reliability; punctuality, and ability to manage work load effectively

- Communication skills such as the ability to present patients and problems with clarity and accuracy
- Timely completion of administrative duties including notes, orders, operative reports, and discharge summaries

4. Other important characteristics to develop as a resident:
    - Be professional. Develop a respectful, courteous manner with patients, families, faculty, other staff and fellow residents.
    - Demonstrate respect for the attending and operative procedure by appropriately preparing for cases; reviewing patient and disease process, operative approach, technical saliency, and perioperative management.
    - Total care of the patient includes proper sign-out and coordination within the surgical team and with the attending surgeon.
5. Once yearly, the standardized examination the general surgery resident will be responsible to be prepared for is the American Board of Surgery In-Service Training Examination (ABSITE). This test has been validated nation-wide and provides an excellent means to assess the resident's overall basic science and clinical knowledge base. It also lends itself to statistical analysis and allows comparison of the resident's progress to other residents in the same year training across the United States. This examination format provides the closest preparation for the qualifying examination of the American Board of Surgery. Each year, residents are required to complete the American Board of Surgery In-Service Training Examination. Performance on this examination will be used to supplement ongoing resident evaluations and faculty discussions in determination and evaluation of resident performance.

Residency Non-Reappointment Criteria

1. A mean rating of < 3.0 on all Resident Evaluations is unacceptable and will require immediate remediation determined by the Program Director.
2. Upon receiving < 30 percentile on the ABSITE, the resident will be placed on Academic Probation with the corresponding letter of counseling in his/her file. A prescribed written program of study or corrective plan will be formulated by the Program Director for the resident to remediate this probation status.
3. Failure of two rotations or receiving < 30th percentile on two consecutive American Board of Surgery In-Service Training Examinations will result in a **Residency Contract Notice of Non-reappointment**
4. Evaluation and Recommendation from the Clinical Competency Committee may result in non-renewal, probation or non-progression in advancement of PGY year level. Please refer to the Clinical Competency policy in the Resident Handbook.

Resident Expectations and Levels of Responsibilities

Resident Handbook

Expectation of Each PGY Year

PGY - I

During this year the resident is expected to acquire fundamental skills in the diagnosis of surgical diseases and the establishment of therapeutic plans. During this year, the resident will function as a junior resident on multiple services and in this capacity will frequently be performing admission history and physical examinations. These experiences should be used by the resident to develop the capacity to diagnose surgical illnesses and begin to formulate diagnostic and therapeutic strategies.

Procedurally, the residents are expected to become facile in the performance of several procedures. Specific documentation of supervised training in History and physical exam, placement of chest tubes, insertion of central venous catheters, endotracheal intubation is required and must be documented on the provided forms. In addition, the resident is expected to begin to develop in-depth knowledge of anatomy in the operating room, and to develop polished skills in the areas of suturing, knot tying, and performance of minor surgical procedures.

PGY - II

This year is really an extension of the first year in terms of goals and responsibilities. Again, this level resident is likely to be a junior resident on one of the multiple services and as such will continue to do the majority of admission history and physical examinations. Again, the goal is for the resident to develop sophisticated capabilities in the realms of surgical diagnosis and planning of therapy. At this level, the resident is also expected to begin to develop and demonstrate competency in more sophisticated areas of patient management, such as in the intensive care unit.

Procedurally, the resident is expected to become increasingly facile in the operating room with instrument technique, including sewing and knot tying. At this level, the resident is frequently allowed to perform modestly advanced surgical procedures under supervision, but the principal goal for this year is developing skills in patient care rather than operative technique.

PGY -III

In many ways, this is the most challenging year of the residency as the resident progresses from a junior resident to a more senior resident status. Although rarely the most senior resident on any service, the resident in this year is frequently exposed to significant responsibility on the different services.

At this level, the resident is expected to develop the capability of appropriately focusing diagnostic and therapeutic strategies and to develop skills as an independent patient caregiver. In addition, at the procedural level, the resident will be expected to develop competence in planning and carrying out routine surgical procedures including but not limited to such operations as cholecystectomy, inguinal herniorrhaphy, and similar operations.

PGY - IV

At this level, the resident will function as a chief resident on the pediatric, vascular, thoracic and transplant service at UMC, as a chief resident at the (VA), and as a senior resident on the trauma service and EGS service at UMC. During this year, the resident is expected to develop the ability to independently diagnose surgical disease and develop additional diagnostic and therapeutic strategies. By the end of the year, the resident should be fully competent in the independent management of routine surgical disease in terms of diagnosis and patient management.

Procedurally, the resident is expected to develop competence in the areas of vascular and thoracic surgery during this year. Advancement in general surgery operations will be as deemed appropriate by the surgical faculty. By the end of the year, the resident should be capable of performing many surgical operations with minimal assistance and guidance and should be judged ready to move to the fifth year where sophisticated and advanced surgical procedures are carried out.

PGY - V

The chief resident year is the year during which the resident must make the final transition to be able to demonstrate the capability of independent thought and action. Although this is always carried out under faculty supervision, the resident must clearly be able to independently develop diagnostic strategies, to meet all challenges of postoperative care, including that of critically ill patients, and to plan and perform major operations in an expeditious and safe fashion. Satisfactory completion of the American Board of Surgery requirements for admission to the Certifying Examination is mandatory. These requirements are published by the American Board of Surgery.

General levels of Responsibilities

All Residents are expected to:

1. Complete course work and testing to obtain Basic and Advanced Cardiac Life Support and Advanced Trauma Life Support certification.
2. Analyze and understand the contents from major surgical textbooks: Greenfield, ACS Surgery: Principles and Practice, and The Physiologic Basis of Surgery over the course of the year.
3. Prepare for, attend, and actively participate in educational core activities including; lectures, Oral Discussion Sessions, Exams, and the Evidenced Based Surgery Sessions.
4. Attend and actively participate in the SCORE Portal Modules

5. Participate actively in all discussions in Mortality and Morbidity Conference.
6. Attend and actively participate in the ABSITE review.
7. Describe the pathophysiology applied to surgical diseases.
8. Demonstrate knowledge of normal and distributed physiology causing surgical diseases.
9. Apply physiological knowledge to the clinical and operative management of surgical diseases.
10. Apply investigatory, analytical, and evidence-based approaches to clinical decision making.
11. Apply knowledge of anatomy to the diagnosis and treatment of patients, both in and out of the operating room.
12. Formulate diagnostic treatment plans with thorough understanding of the basic science principles applicable to surgery.
13. Demonstrate knowledge of the principles associated with the diagnosis and management of critically ill patients including multiple organ system normality's and abnormalities.
14. Understand the concepts of complex wound care.
15. Attend and actively participate in the Surgical Skills Program.
16. Complete the American Board of Surgery In-Training Examination.
17. Adhere to the GME 80 hour duty hours policy
18. Fulfill clinic and all call obligations
19. Critically evaluate students and faculty related to their educational experiences
20. Dress and act in a professional manner

Resident Duty Hours and On-Call Schedules

Physicians are expected to have a keen sense of personal responsibility for continuing patient care that is not automatically discharged at any given hour or day. Clinical events in general surgery take place 24 hours a day, seven days a week. In no instance should the resident go off duty until the proper care and welfare of their patients has been ensured. Resident on-call schedules are prepared monthly by the administrative chief resident and reviewed by the program director. Attending physicians are expected to provide backup so that patients receive safe and effective care.

The night surgery/call resident is responsible for all surgical services and consults after taking a report of patients on the service. Updated patient lists are to be coordinated between cross-covering residents.

There will always be a senior resident available. The junior resident has primary call responsibilities for the inpatients and consults. The senior residents are to support the primary call resident. Every patient admitted or discharged must be presented to the more senior resident and the attending must be notified. As experience is gained, less interaction is required. Any time a junior resident needs help or counsel, the more senior resident should be called. The primary call resident should never hesitate to

counsel with a more senior resident. All consults should initially be discussed or seen by the senior resident.

Specific Resident Responsibilities

PGY 1 Residents

1. Acquire self-confidence and the ability to develop differential diagnoses and management plans through history and physical examination.
2. Perform pre and post-operative care of patients with the basic understanding of pathophysiology as applied to surgical diseases.
3. Understand the principles involved in operations, handling of tissues, dissection of tissues planes, suture-ligature techniques and masters "simple" operative procedures.
4. Master techniques of using and placing NGs, Foleys, IVs, CVPs, arterial lines, and standard aseptic techniques.
5. Demonstrate initial management of life threatening surgical illnesses and be adept at resuscitation.
6. Prepare for and formulate an operative plan prior to operations.
7. Demonstrate good judgment, safety, and effective technical skills in operative cases.

PGY 2 Residents

1. Demonstrate responsibility for overall care of patients and continue to develop operative skills.
2. Demonstrate proficiency in emergency room diagnosis and treatment for surgical diseases, including a mastery of evaluation of the acute abdomen.
3. Become adept in patient care and demonstrate proficiency at triage.
4. Understand complex operative procedures; fine tune operative skills.
5. Formulate diagnostic and treatment plans applicable to surgery.
6. Perform independently the placement of arterial lines, central venous catheters, chest tubes, and advanced CPR.
7. Become adept at the management of all aspects of the ICU patient including: TPN, ventilators, and invasive access.
8. Demonstrates good judgment, safety, and effective technical skills in operative cases.

PGY 3 Residents

1. Become adept at endoscopic procedures and surgical intensive care.
2. Perform complex operative procedures and acquire a thorough understanding of abdominal surgery.
3. Perform overall evaluation and management of surgical patients.

4. Be able to outline pre, intra and post-operative treatment plans in detail.
5. Demonstrate a thorough understanding of operative indications and contraindications.
6. Demonstrate good judgment, safety, and effective technical skills in operative cases.

PGY 4 Residents

1. Demonstrate independence in the evaluation and management of all aspects of patient care.
2. Be proficient at treating surgical diseases and handling standard operative procedures with a thorough understanding of surgical pathophysiology.
3. Understand the social and economic needs of patients; demonstrate good understanding of ethical dilemmas.
4. Demonstrate good judgment, safety, and effective technical skills in operative cases.
5. Demonstrate the ability to supervise junior residents in performing H&Ps, and surgical procedures under faculty supervision.

PGY 5 Residents

1. Perform difficult surgical procedures continue to fine tune surgical skills both in and out of the operating room.
2. Understand surgical pathophysiology and therapeutic support systems in order to achieve optimal recovery for the patient with limit morbidity.
3. Perform non-standard, or counter example cases; consider exceptions.
4. Demonstrate good judgment, safety, and effective technical skills in operative cases.
5. Demonstrate the ability to teach junior residents in the setting of the emergency room, and operating room under the supervision of the attending.

Educational Goals and ACGME Competencies

Resident Handbook

I. General

A. Understand the inseparable link between continuity of and commitment to patient care within the educational process as a physician and surgeon.

B. Develop a program for and become responsible for self-education with guidance from staff and faculty and with an eye for long-term continuing medical education.

C. Participate in the required scheduled educational activities of this residency program. This includes attendance and participation in scheduled conferences, including Quality Improvement Conference, the weekly resident didactic lectures, specialty teaching conferences, weekly scheduled teaching rounds, and Grand Rounds.

D. Learn to be dedicated to the provision of high quality, compassionate, and cost effective care.

E. Correlation of ACGME Competencies with curriculum and PGY levels of training and competence: each of six competencies are references as expectations of achievement by PGY.

II. PGY-I and PGY-II

The primary interest in the first two years of the residency program is learning to diagnose surgical illnesses, provide routine care on the wards and critical care in the intensive care units. Of secondary importance are learning the basics of operating room technique. Consequently, the primary activities in the first year are oriented around the ward activities including learning and developing the specific capabilities of chest tube insertion, endotracheal intubation, and insertion of all types of venous catheters. By the end of the first two-year block the resident should be very competent in and confident about his or her ability to care for sick surgical patients, both on the floor and in the intensive care setting. Furthermore, the resident will be assured in their ability to diagnose surgical disease and appreciate urgent situations in need of expeditious surgical intervention.

These goals will be achieved by interaction on services at UMC and at the VA. On the services, the junior resident functions as part of a team led by a senior, or chief, resident. The attending surgeon, of course, is the ultimate responsible party in all settings. The junior resident must learn to communicate and be open and honest about responsibilities.

A. ACGME Competency Expectations:

1. Patient Care

i. Appropriate skills for H&P and interviewing techniques
ii. Technical skills, level appropriate
iii. Constructing and implementing management and diagnostic plan

2. Medical Knowledge
   i. Core factual knowledge illness/disease based, level appropriate
   ii. Analytic and deductive reasoning, level appropriate
   iii. Advancement in basic science correlations
3. Practice Based Learning
   i. Application of evidence based medicine, level appropriate
   ii. Self-evaluation, level appropriate
   iii. Evolution informational technology
4. Interpersonal and Communicating Skills
   i. Listening and language skills
   ii. Attentiveness and interest in patient
   iii. Comprehension and awareness of a patient-physician interaction
5. Professionalism: among all healthcare participants
   i. Respect, understanding, empathy
   ii. Sensitivity and awareness of cultural, religious, ethnic, and national origin characteristics
   iii. Collaborative attitudes
   iv. Ethical and legal principles

III. PGY-III and PGY-IV

During these years as a senior resident, the resident is expected to slowly become increasingly responsible for supervision of the care of floor and ICU patients by a team and to be able to make clinically significant decisions regarding their care.

At this level, the resident should be fully able to do all floor and ICU procedures, such as chest tube insertion, intubation, and line insertion. In addition, these are the years when the resident begins to seriously develop operative skills. During these two years, the resident is expected to have a busy operative experience, both as a first assistant and as an operating surgeon under the direction of the surgery faculty.

It is also the responsibility of the senior resident to understand their role as teachers of both junior residents and students. This means also being responsible for ensuring that adequate working conditions and hours are in existence and to discuss this regularly with the program director.

A. Patient Care

1. Counseling, instructive techniques to patients
2. Health promotion and disease prevention modalities
3. Concept of healthcare delivery as a team

B. Practice Based Learning:

1. Scientific evidence as a core for best practice development
2. Mature self-evaluation of experience (portfolio development)

IV. PGY-V

The chief resident is expected to be able to document the ability to function independently as a surgeon and physician by the end of the year. Accordingly, this resident must develop the ability to be completely responsible for supervising and providing care to surgical patients, diagnosing surgical illness and performing independent senior level surgical procedures in the operating room.

Even more than for the senior residents, the chief resident is responsible as a teacher of students and residents and for ensuring that the environment in terms of working hours and conditions is appropriate. The chief resident will confer with the Program Director; an open communication line will exist.

A. Systems Practice

1. Awareness of cost effective practices, resource and therapeutic alternatives and risk/benefit concerns
2. Understanding goals and operations of healthcare systems and managed care
3. Patient advocacy issues.

Resident Administrative Responsibilities

1. **Change of Address, marital status, and additions of dependents.**
    a. The resident must notify the administrative office in writing of any changes in address or home phone number.
    b. If there is an addition in the number of dependents, you must complete the appropriate insurance form and include the dependent's birth certificates within 30 days of the event.
    c. If the resident wishes to add or delete their spouse on their health insurance, they must notify the administrative office and complete the appropriate insurance form.
2. **Medical Records Obligations**
    a. The UMC staff is increasingly concerned about the number of delinquent medical records attributed to residents. Accordingly, the following policy has been instituted.

        - When we receive notification that your incomplete medical records number less than 20, you will receive a phone call from the Residency Coordinator notifying you that you have 48 hours to bring a note from the Director of Medical Records or one of her designated staff members stating that you have completed all available charts. If this note is not in her hand within 48 hours, not including weekend days, then you will automatically spend a day of vacation for every additional day it takes to get your list in. If the notice identifies 20 to 30 delinquent medical records, then you will have 24 hours to bring the Residency Coordinator a note from the Director of Medical Records stating that you have completed all available charts. If this note is not received within 24 hours then again you will spend a day of vacation for each subsequent day until the note is obtained.
        - If we receive notice that you have more than 30 delinquent records, you will immediately be required to spend a day of vacation each day until a note is received by the Residency Coordinator from the Director of Medical Records stating that you have completed all available charts.
    b. Verbal Orders must be signed within 12 hours. Any delinquency in this area violates Joint Commission standards and may result in a loss of this valuable privilege.
3. **Pagers Provided by the Department of Surgery**

a. Pagers are issued to residents when in Las Vegas. Pagers are not portable and must remain in the geographic location issued from.

b. The resident is responsible for seeing that their pager is working properly and to notify the administrative office immediately of any problems.

c. If you are having problems with your personal pager, please have it replaced by the UMC PBX office. If the pager is an on-call pager, please contact the Department of Surgery Administrative offices.

4. Malpractice Insurance Liability Claims

a. It is extremely important that all information concerning any potential malpractice insurance claims be discussed with the University of Nevada, Las Vegas School of Medicine Office of the General Counsel at the earliest possible moment.

b. This is the only person that any claim should be disclosed/discussed with, other than a representative of your malpractice company who will contact the resident involved directly. It is imperative that there is no discussion with anyone else, regardless of who may be involved or should pose any questions

c. If you should have any questions concerning your coverage, please contact your residency program director. Details can also be found at the UNLV GME Handbook Section VII GME Office Responsibilities Malpractice Insurance and Liability Claims.

5. Resident Working Hours

a. Our policy on working hours is based upon the ACGME general requirements for accredited residency programs and the special requirements for a General Surgery. Details of duty hour restrictions are addressed elsewhere in the Resident Handbook. You must enter your duty hours weekly.

b. Along with your weekly duty hours, you must document your half day/ week outpatient clinic experience in your core rotations.

6. Vacation/Leave Policy

The Vacation Schedule is determined by seniority. The Department of Surgery Leave policy is addressed elsewhere in this Handbook and is consistent with the policy of UNLV GME.

7. Moonlighting Policy

Surgery Residents are not permitted to moonlight during their clinical rotations.

Resident Responsibilities to Medical Students

Resident Handbook

Residents must complete Residents as Teachers (RAT) modules, administered by the UNLV office of GME.

Resident Responsibilities to Junior Students

Students in the Longitudinal Integrated Curriculum will rotate in Las Vegas at UMC and outpatient clinics. Residents are important teachers. Residents will also need to abide by all codes of conduct regarding student treatment. Residents will complete Residents as Teachers modules provided by GME. Residents will receive annually goals and objectives of the student curriculum, and student mistreatment policy.

Resident Responsibilities to Senior Medical Students - Subinternship and ICU

The student functions as a sub-intern on the general surgery service. The student is supervised by the general surgery senior residents and faculty. The student will function at an intern level and share duties. The student will participate in departmental didactic sessions, service clinic and all phases of pre-operative evaluation, as well as pre-operative, intra-operative and post-operative care. The student will be assigned on-call responsibilities. Work hours will not exceed 80 hours/week averaged over 4 weeks.

Teaching Rounds

Resident Handbook

Ward teaching rounds are an essential component of resident education. The teams listed below will have rounds once each week. The Chief Resident will contact the responsible faculty member and schedule one hour for teaching rounds. Faculty, along with residents and medical students, will conduct teaching rounds and discuss any of the patients on the service.

Full-time and Clinical Faculty are assigned to the following teams:

Team	Full Time Faculty	Clinical Faculty
UMC 1	Barber Baynosa, J. Kirgan St. Hill	
UMC 2	Bardakcioglu Thornton	Clinical Faculty of Desert West
UMC 3	Ham Sharma Shen	CVT group
ENT	Bigcas Ng Okuyemi Spinner Wang	
PLASTICS	Baynosa, R. Brosious Goldman Pistorio	
PEDIATRIC SURGERY	Chang Jones Scheidler	
UMC 4	Faculty Rounder	Desert West Surgery

TICU	Carroll Chestovich Kuhls Fraser McNickle Saquib Snook	Bruun Streit
VA		Dunn Joffs Losanoff Munn Johnson Horan
USAF		Bruun Dombrowski Martin Peitzmeier Scott Streit

Dress, Grooming and Behavioral Standards

Resident Handbook

The following are standards agreed to by the Resident Forum.

Dress, grooming and personal cleanliness standards contribute positively to the morale and professional image the resident physician presents, and show respect for patients, families and other physicians.

Standards for Dress/Grooming

1. Conservative and professional attire is appropriate when not in operative or working/procedure areas. Shoes should always be clean. Socks or stockings are required.
2. Hair should be neat, clean and arranged in a manner and length that does not interfere with patient care.
3. Proper scrub wear is appropriate only in procedure and patient care areas and operating suites, and should be neat and clean whenever worn outside the immediate patient care areas.
4. Professional attire should be worn at all conferences and clinic experiences (i.e. attending office hours).
5. Protective covering of all kinds (shoe covers, gowns, goggles, gloves, masks and caps) shall be worn only in areas specifically requiring their use (as per OSHA regulations).
6. The following clothing is NOT acceptable or appropriate:
   - Leather or denim shirts, dresses, skirts, jackets or trousers (jeans); tank tops, t-shirts, (shirts without collars)
   - Sheer clothing; tight fitting clothing (leotards, spandex)
   - Oversized or baggy shirts or pants; sweat pants or sweat shirts
   - Uncovered feet, sandals, thongs, moccasins.
7. Other personal adornments NOT acceptable or appropriate:
   - Jewelry that interferes with patient care activities and distracts from the conservative, professional image
   - Visible skin piercing, markings or tattoos (other than appropriate earrings)

Standard for Professional Behavior

Professionalism is how a physician relates to patients, families, other physicians, residents and students, and to nursing and administrative persons at all patient care

facility levels. These professional attitudes include, but are not limited to, courtesy, agreeability, confidentiality, sympathy, helpfulness, respect, and ethical behavior. A positive working relationship with hospital clerical and nursing staff is especially important.

Other Standards

1. **Personal cellular phone calls are NOT acceptable or appropriate (exceptions: critical or urgent patient care needs). When such calls unavoidably interrupt clinical or educational activities, the call should be completed in privacy away from others engaged in the educational activity.**
2. Residents' children are NOT allowed in patient care areas; there are no exceptions and violations may result in disciplinary action.

Authorities

Questions regarding acceptability or appropriateness of these standards should be directed to Chief Residents, Program Director or Department Chair.

Accident Reporting/ Blood borne Pathogens Post Exposure Protocol

Resident Handbook

If you are injured on the job (including needle-sticks, body fluid splash, punctures) **the following procedures must be followed:**

- Immediately contact the Unit Charge Nurse at the hospital.
- The Charge Nurse will meet you to complete an "Employee Report of Accident/Exposure".
- The Charge Nurse will coordinate your treatment and follow-ups and process all the paperwork to the correct people/departments.
- You must also inform your residency coordinator and program director and complete a University of Nevada, Las Vegas School of Medicine C 1 Form.

Complete information is found in the UNLV GME Handbook, Section IX, Human Resources, Blood Borne Pathogens.

Conferences

Resident Handbook

On time **attendance is required** at all conferences. Attendance is monitored and reported to the Program Director and Chairman. Repeated absence from conferences may lead to disciplinary actions. If you are scheduled for a day off or post call it is your responsibility to contact Susan Thompson or Joshua Hill to have your absence excused. Residents participate in committees and structured conferences under the aegis of the School of Medicine and/or UMC staff and the VA staff.

Residents actively participate in the School of Medicine Graduate Medical Education Committee, and a variety of hospital committees, including the Quality Assurance/Quality Improvement Committee, UMC Pharmacy and Therapeutics Committee, and Medical Records Committee.

Quality Improvement Conference ("QIC")

Quality Improvement Conference at UMC for residents at UMC and the Las Vegas VA is held regularly from 8:00 AM to 9:00 AM every Tuesday. Punctuality is necessary and attendance is required.

Objective

The Quality Improvement Conference is meant to be an educational experience. The goal of reviewing adverse patient outcomes is not to air 'dirty laundry'. The intent of QIC conference is to critically assess patient management decisions in an attempt to identify opportunities to improve patient care in the future. In the process, everyone has the opportunity to learn. QIC conference is also an excellent opportunity for the senior and chief residents to prepare for the oral board examination by being required to discuss treatment options and the pros and cons of each option in front of an audience.

Supervising Faculty

Charles St Hill, M.D.
Office: (702) 671-2369
Office location: 1701 W. Charleston Blvd., Suite 400

Rules and Guidelines for QIC Conference

In an attempt to improve the quality of the patient presentations and the educational value of the discussion of adverse patient outcomes, the following guidelines will be followed-

1. All case lists along with complications will be submitted on a weekly basis. These will be sent one week in advance. The reporting period will be Wednesday to Tuesday one week prior to the QIC session. **The case/complications lists will be submitted via email by close of business (5pm) every Wednesday to Dr. St Hill (or a designated substitute) and Susan Thompson and Joshua Hill.**
2. Case lists will include a brief description of pertinent details for all patients that experienced a complication and all deaths. The case description should provide enough detail such that the audience has a good understanding of the patient's presenting symptoms, preoperative preparation, operative management and postoperative course. Wound infections must be listed. Mortalities must be reported even in those cases where surgery was consulted but did not operate.
3. The case lists will be reviewed by Dr. St Hill or his designee. The senior/chief resident on the service will be notified by returned email about which cases are to be discussed in detail at the upcoming QIC conference. (NOTE: All patient deaths will be discussed but not always in detail. Patient complications that are unusual, potentially preventable or that are likely to provide educational benefit to the residents and the audience will also be discussed). Not every service will present a complication in detail every week.
4. Mortalities and morbidities will only be presented by the **most senior resident on the service**, irrespective of whether this resident was directly involved in the patient's care or not. **(If the most senior resident was not involved in the patient's care, it is his/her responsibility to review the available medical records and to discuss the salient aspects of the patient's care with those individuals who had direct contact with the patient)**
    a. If the most senior resident will not be available for the QIC conference, it is still his/her responsibility to get the list/information to Dr. St Hill and Susan Thompson every Wednesday. The next most senior resident on the service will then present the list in QIC conference. Complications and deaths will presented only by a non-senior resident when there is appropriate justification for a presentation by the junior resident involved in the care of the patient. All presentations by junior residents must be approved by Dr. St Hill or his designee prior to the QIC conference. In most circumstances, the complication or death should be presented by the senior resident when he/she returns.
5. Patient presentations are expected to be comprehensive and should include all of the following:
    a. **Pertinent** patient history
    b. **Pertinent** past medical and surgical history
    c. Important physical findings at the time of presentation
    d. **Pertinent** data from the preoperative evaluation, including diagnostic studies and laboratory evaluations. Radiology studies must be presented with relevant images.
    e. What was the preoperative diagnosis and treatment plan?
    f. Operative findings and operative approach
    g. Pathologic findings and microbiology results

   h. Issues in the postoperative course and timing of onset of complications
   i. How complications were identified and treated?
   j. What was the eventual patient outcome?

6. The selected presented mortality or morbidity must be a concise presentation based around at least **one comprehensive, recently published peer reviewed journal article** specifically addressing this complication (not the disease process). The brief discussion of this article should include the pertinent findings and applicable results.
7. All patient presentations will be in PowerPoint format. Presentations must include pertinent images from preoperative diagnostic studies and pathology results with images (the most senior resident should discuss the case with a radiologist and pathologist, where appropriate, and request **their attendance at the conference**. If the radiologist or pathologist is unable to attend, the resident must be prepared to point out important findings on the radiographs or histology specimens for the audience) The resident should also notify the involved faculty member and request their attendance at the QIC conference when the patient is being discussed.
8. Every PowerPoint presentation **must** be submitted to Surgical Skills Lab Coordinator so that the presentations can be loaded onto the computer prior to the conference.
9. The senior residents should be prepared to attribute each adverse outcome to an error in:
   a. Decision making
   b. Technical error
   c. Patient disease
10. The senior resident will also be expected to discuss each of the following:
   a. What factors likely contributed to this patient's adverse outcome? How might they have been modified?
   b. What other treatment options (medical and surgical) were available to treat this patient's condition? What are the pros and cons of the other treatment options?
   c. Based upon this experience, how might you modify your approach if you were presented with a similar patient in the future?
   d. NOTE: an adverse outcome should only be attributed to 'patient disease' when there were no other treatment options available and the care provided to the patient was optimal (i.e. almost never).
11. All PowerPoint presentations must not be more than 10 slides and must include a slide listing the reference(s) utilized in the discussion.
12. The presentation must be no more than 10 minutes.
13. The flow of the conference will thus be:
   a. Every service will be called to present their list of cases for the corresponding week including any complications.

i. If a faculty member wishes clarification on a case or a complication, this must be done briefly but concisely.

ii. The senior should be familiar with each case and complication on his/her list even if he/she was not involved... It is your service.

b. If the QIC Preceptor has identified a case for discussion, that case will be presented immediately after the case list is reviewed.

Other Conferences and Notes

- **Grand Rounds** for the Department of Surgery and are held monthly, first Tuesday at 8:00 a.m. – 9:00 a.m.
- **Graduate Medical Education Committee**. A peer selected resident is a member of the Graduate Medical Education Committee of the School of Medicine and is expected to take part in the meetings held every two months.
- **Resident Forum.** This brings together resident representatives from each program to identify and respond to common resident issues.
- **Interdisciplinary Grand Rounds** are held by the GME office once a month on Tuesday at 12 noon. It is expected that general surgery residents participate in IDGR.

Rotation Schedules

Resident Handbook

Monthly Schedules are determined for the entire year by July 1 of the new academic year. Monthly call schedules are made by the chief administrative resident 1 month in advance of the new month. Schedules are reviewed by the Program Director. Each resident is responsible to verify the schedule to avoid any conflicts.

Travel to Conferences/ Meetings

Resident Handbook

Support for resident travel is ALWAYS contingent upon funding and availability of other residents to care for patients on a resident team.

The Department will support travel by chief residents to the annual ACS congress.

The Department will support travel to meetings where residents will be making an oral presentation of a scientific paper/study in which the Full Time Faculty have participated.

Prior to submission of any papers to regional or national meetings, approval must be obtained from the Chair of the Department of Surgery. Residents must include in the request, the name of the paper, the name of the conference, the location, all authors including the faculty member(s), the duration of travel.

Any resident submitting a paper or an abstract to a regional or national meeting without the Chairman's approval will not receive reimbursement for travel if the paper is accepted for presentation.

Leave Policies

Resident Handbook

The resident is responsible for notifying the program of any type of leave. The Surgery Residency Office requires that a Leave Request Form be completed. The American Board of Surgery (ABS) require programs to report all types of leave, sick, interview time, academic meetings, vacations. In order to ensure you meet the ABS 48 week rule we must have complete and accurate information which is the responsibility of the resident. ABS requires that every resident is engaged in at least 48 weeks of clinical activities in each of the 5 training years. See ABS Leave Policy.
Residents **must complete a leave form** and submit it to the Program Director prior to any type of leave taken. **Any leave taken without prior approval by the program director will be counted as unexcused absence and is subject to disciplinary action. You will be expected to make up the time at the end of that training year.**

- Leave Request Form
- Absence From Work Contact Form

Complete information may be found at the UNLV office GME Handbook Section IX Human Resources Resident Leave Policies.

Evaluations

Resident Handbook

Evaluations of Residents

Written evaluations are solicited from faculty members, nurses, OR nurses, and peers, at the conclusion of each resident rotation.

On a semiannual basis, these evaluations will be used as a basis for discussion of each resident by all faculty members. These discussions will be used to guide residents in areas that need strengthening and will be used to assess the appropriateness of residents' advancement from one year to the next and at the consummation of the program will be used to assess the appropriateness of program completion.

All evaluations of residents and faculty are managed through an electronic software program New Innovations. Residents are given a user ID and password to sign in to record their evaluations of faculty and to review their evaluations.

Evaluations from Patients

Throughout the year random patient evaluations of residents are completed.

Resident Self Evaluation

Residents will complete a self-evaluation annually which will be discussed with the Program Director. At the meeting to discuss the self-evaluation a performance plan will be implemented.

Annual Program Evaluation by Resident

Each year all residents will complete an anonymous evaluation of the program identifying strengths and weaknesses. This evaluation will be used to improve the educational components of the residency program.

Composite Assessment

1. The Program Director of the Department of Surgery will be responsible for the evaluation process.
2. All aspects of clinical competence must be evaluated, including patient management skills, intellectual abilities, manual skills, attitudes, interpersonal relationships, ability to accept constructive criticism and guidance, ability to function as part of the health care team, and the development of professional attitudes consistent with being a physician.
3. Faculty evaluations will be obtained at the completion of each assigned clinical rotation.

4. Residents will regularly be made aware of their progress and of any weaknesses.
5. All aspects of the resident's evaluation will be documented. A permanent record of evaluations will be kept for each resident, and the record will be accessible to the resident.
6. A written composite will be prepared for each resident semiannually and will include a review of the resident's performance during the preceding six-month period of training.

Written Final Evaluation

A written final evaluation will be prepared for each resident who completes the program. The evaluation will include a review of the resident's performance during the final period of training and will verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation will be part of the resident's permanent record.

Resident Evaluation of Faculty

All residents will be expected to evaluate the faculty on their service and the rotation itself. Evaluations are conducted at the end of each rotation all evaluations should be completed in a timely fashion. It is important that residents evaluate the rotations in order to maintain quality in the educational program. A resident committee will review faculty evaluations to ensure that it is an anonymous process prior to distributing comments to the faculty.

Resident evaluations of faculty and the program are aggregated by the program and given out to faculty once a year to ensure anonymity. However it is important to understand that evaluations of residents by faculty are not anonymous—you as a resident can see who is evaluating you. It does not go both ways.

Clinical Competency Committee

Resident Handbook - General Surgery

Introduction

- CCC is required by ACGME for all training programs.
- The CCC as a diverse group of faculty reinforces when a resident is doing well and identifies areas of concern for a resident having problems.
- Discussions of the CCC help differentiate isolated poor performance from a pattern of poor performance.
- CCC helps clarify the areas of concern for a "problem resident" i.e. specific areas of deficiency, inability to function in different settings for example the ICU, OR or the ED.
- Process of CCC allows departments to identify weaknesses in their educational curriculum, rotation schedules and supervision.

Policy

- The University of Nevada, Las Vegas School of Medicine General Surgery Residency Training Program CCC is run in accordance with ACGME requirements.
- The clinical competency committee will meet with a frequency that may exceed that required by the ACGME but not less frequently than twice a year.
- The clinical competency committee will consist of all full time faculty as well as program director and the training program coordinator.
- Regular attendance by all members of the clinical competency committee is expected with a minimum threshold of 75% of meetings attended.
- For senior level residents, the faculty with whom the resident is currently rotating with for the quarter will lead the discussion of the resident and be prepared to discuss current milestone achievement scores and evaluations.
- The most recent resident evaluations will be aggregated and summarized by the program coordinator for review by the clinical competency committee and will include but not be limited to:
    - End of rotation evaluations
    - Direct observation checklists for skills i.e. CVL placement, other procedural skills
    - 360° or multisource evaluations (nurses, colleagues, students, patients, other ancillary health care personnel)
    - Semi-annual evaluations by the program director
    - Attendance records for conferences
    - ABSITE scores

  - Professionalism score cards
  - Procedure log
  - Any other assessment information available i.e. praise cards and concern cards
- Aggregated data will be collected semi-annually for presentation and feedback during the semi-annual resident reviews.
- A single overall report for each resident regarding the General Surgery Milestones Project will be formulated semi-annually based on agreement and consensus by the entire clinical competency committee and will be presented by the Program Director to the resident during their semi-annual review.
- Outcomes of the clinical competency committee will be reported to ACGME in a frequency determined by ACGME.
- The clinical competency committee will make recommendations to the program director regarding promotion, remediation, or dismissal for each resident.

Program Evaluation Committee

Resident Handbook - General Surgery

The goal of this Program Evaluation Committee (PEC) is to oversee curriculum development and program evaluations for the General Surgery Residency Training Program.

The PEC of General Surgery Residency Program will meet annually. The PEC will have at least three members, two program faculty and one trainee from the program, unless there are not enrolled trainees in the program. Faculty members may include physicians and non-physicians from the General Surgery Residency Training Program.

The committee's responsibilities are to:

- Plan, develop, implement, and evaluate educational activities of the program;
- Review and make recommendations for revision of competency-based curriculum goals and objectives;
- Address areas of non-compliance with ACGME standards;
- Review the program annually using evaluations of faculty, residents or clinical fellows, and others;
- Document on behalf of the program, formal, systematic evaluation of the curriculum at least annually and render a written Annual Program Evaluation (APE), which must be submitted to the GMEC annually in the Annual Program Director Update;
- Monitor and track each of the following:
  - Resident performance;
  - Faculty development;
  - Graduate performance including performance on certifying examination;
  - Program quality; and
  - Progress in achieving goals set forth in previous year's action plan.
- Review recommendations from the Clinical Competency Committee.

The PEC will be provided with confidential resident/clinical fellow and faculty evaluation data by the program's administrative staff in order to conduct their business.

The program director is ultimately responsible for the work of the PEC. The program director must assure that the annual action plan is reviewed and approved by the program's teaching faculty. The approval must be documented in meeting minutes. The program's annual action plan and report on the program's progress on initiatives from the previous year's action plan must be sent to the GME office annually.

Communication

Resident Handbook

Communication with Attendings

1. This is a teaching program; we are all here to learn and teach.
2. Attendings provide an environment in which residents and students learn surgery.
3. If they are fortunate, the attendings will also learn from the residents.
4. None of the above can occur without communication.
5. The attendings can delegate patient care to the residents in varying degree, but responsibility for patient care cannot be delegated to anyone. It remains with the attending. Therefore, the attending **must be made aware** of, and advise and consent thereto, all major therapeutic actions and decisions, and significant changes in the condition of the patient.
    a. *What are significant changes? Some are easy to ascertain:*
        - All admissions, discharges, consultations
        - Patient dies
        - Patient bleeds
        - Patient arrests
        - Patient refuses treatment
        - Patient leaves the hospital
        - Wound infection, dehiscence or evisceration
        - Patient complications

    b. *Some are not so easy:*
        - Some fevers
        - Some vomiting
        - Some bowel movements
        - Some drainage
        - Some x-ray and laboratory findings, both positive and negative

    c. *All of these MAY be significant if they affect diagnosis, prognosis, or therapy.*

    d. A good general rule to guide you is "**no surprises for the attending or chief resident**." The attending must be aware of the resident's thoughts, and the resident must be aware of the attending's thoughts. This can only occur with communication between them.
6. Major therapeutic decisions are not the purview of the junior resident. The junior resident should be guided by the senior resident, and the senior by the chief.

The junior resident's findings and assessment should be affirmed by a more senior resident to avoid miscommunication with the attending. The senior or chief should be the resident communicating with the attending.

7. **ALL patients should be seen and examined by the most senior residents on the service prior to calling the attending.**

Communication and Charting

1. If there is no note, **you were not there**.
2. Medical students are not yet physicians. They cannot write physicians' notes. **ALL student notes must be signed by a resident.**
3. Patients should be seen at least twice daily by a physician. Patients can be most unstable following surgery; they deserve a visit within a few hours postoperatively, for your peace of mind.
4. If something happens to the patient, or if some significant test result is received, or if some physical findings change, and it is not documented in your note, **you were not aware of it**.
5. If a note is illegible, **it does not exist**.
6. If your signature is illegible, **you do not exist**.
7. If a Doctor's Order is illegible, it could result in **malpractice and medical errors**.
8. There is no such thing as too many notes; incomplete and inadequate charts are far too common. When writing a note, think of what you observed, what you were looking for, what influenced your decisions, what decisions you made, what actions you have undertaken, what your expectations and plans are, and include these in your chart note.
9. The patterns you establish in your residency regarding chart completion will remain with you for the rest of your career.
10. **Personal argument, criticism of individuals, or criticism of quality of care do not belong in the medical record**. If the progress of the patient is in question or care issues are discussed, they should be outside the chart, and consensus among all who are managing the patient should be obtained. The chart record should reflect this consensus.

Communication with Nursing Staff

1. Nurses are hard to find and in short supply. Resident applicants are many, exceeding available positions. They are as valuable as to the patient team as you are, if not more so.
2. Many nurses have been around patient care longer than you have. They may actually be able to teach you something. **Learn from them**.

Communication with Patients

1. Patients are frightened. They are as comfortable in a hospital as you are on the witness stand in a court of law. They are most afraid of the unknown. A well informed patient becomes a cooperative and trusting patient.

2. Patients do not understand "medicalese." **Speak in common English**. One way to make sure a patient understands you is to have him/her repeat back what you just said (Close the loop).
3. Do not be afraid to admit that you do not know the answer to a question. Be truthful with your patients. Let them know that you will find the answer and get back to them.
4. Never predict the future. However, it is reasonable to provide patients with reasonable expectations.
5. Never leave a patient thinking that you did not have enough time for them. Patients would like to think they are the most important patient to you. Time is the most precious commodity. Patients appreciate your time.
6. Patients want to know that you care what happens to them, and that you are trying your best. That is all they ask of you (most of the time). It is up to you to convince them that you care.
7. Treat all patients as you would like to be treated (the Golden Rule). Better yet, treat patients as they want to be treated (the Platinum Rule).
8. Remember that actions speak louder than words, and patients hang on your words, your actions, and your body language.

Fatigue Mitigation and Well-Being

Resident Handbook

1. The Department recognizes the critical importance of resident well-being. In resident clinical duty assignments, efforts are made to:
    a. protecting resident time with patients
    b. minimizing non-physician obligations
    c. providing administrative support
    d. promoting progressive autonomy and flexibility
    e. enhancing professional relationships

2. Resident Fatigue:
    a. Annually, residents and attendings must complete the Sleep Alertness and Fatigue Education (SAFER) module (or similar education module) provided by the UNLV office of GME. The goal of the formal education is for the learners to:
        i. recognize the signs of fatigue and sleep deprivation;
        ii. understand alertness management and fatigue mitigation processes;
        iii. use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
    b. In the event that a resident is unable to perform their patient care responsibilities due to excessive fatigue, the resident must inform the program director. It is the responsibility of the program director, not the resident, to identify alternate provision for continuity of patient care
    c. When fatigued, resident has the following options to avoid unsafe driving conditions home:
        i. sleep at one of the multiple provided call rooms in the hospital
        ii. use taxi or ride-share services, the cost of which will be reimbursed by the department.
        iii. The PD will help arrange a ride home.

3. UNLV director of wellness conducts quarterly, mandatory didactics. The topics of these sessions include, but not limited to:
    a. management of resident time before, during, and after clinical assignments
    b. recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.
    c. efforts to enhance the meaning that each resident finds in the experience of being a physician
    d. identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions.
    e. identify those symptoms in themselves and how to seek appropriate care.

4. The Department encourages residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence. Moreover:
    a. The residents and faculty complete annual wellness survey conducted by the UNLV office GME.
    b. The residents are encouraged to self-monitor their wellness through the ACS web tool, Physician Well-being Index.

5. Residents are given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their regular duty hours. Absences from regularly assigned clinical duties must be reported to the PD. Residents have, through their mandated insurance coverage, access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

6. Residents unable to attend work, due to circumstances including but not limited to fatigue, illness, and family emergencies:
    a. Resident can take time off without fear of negative consequences.
    b. Resident must inform the Program Director of any absence.
    c. The Program Director, not the resident, is responsible to make alternative arrangement for continuity of patient care.

Nellis AFB General Surgery Rotation

Prior to Rotation

- Speak to the previous resident about expectations, flow, and current patients.
- Produce your call schedule > 7 days prior to your start date and forward it to Dr. Scott
- GET COMPUTER ACCESS! (this may seem intuitive, but apparently it is not) Please contact the GME office on base at 702-653-2499 or 99MDG.DME@us.af.mil 2-3 weeks in advance of your start date.

Organization

- The team consists of a PGY 3 General Surgery resident, a PGY 1 Family Medicine resident, and a fourth year medical student.
- General Surgery Faculty
  - Colonel Richard Standaert
  - Maj Daniel Fiumecaldo
  - Maj Scott Schwiesow
  - Maj Garrett Friedman (Colorectal)
  - Lt Col William Scott (Associate Program Director)
  - Lt Col Jason Compton
  - Maj Ashley Martin
- Vascular Surgery Faculty
  - Major Danielle Dombrowski
- Plastic Surgery Faculty
  - Lt Col Benjamin Monson
  - Maj Carole Villamaria
- ENT Faculty
  - Lt Col Anna Tsai
  - Lt Col Wolfgang Beumer

All Residents

- The practice on base is bread and butter General Surgery.
- The pace may be slower than you are accustomed, but do not get lackadaisical.
- Cases
  - You are welcome at any General Surgery or Vascular Surgery case.
  - The specialty surgeons (ENT, Plastics, Urology) are usually more than willing to have you as well. Please confirm with them in advance to the case.
  - COME PREPARED! You will be asked questions about the patient and operation being performed during the case. This is for your education. Your pre-op preparation will determine the level of

participation you will have in the case. If there are questions about how to prepare for a case speak with Dr. Scott.

- Call
  - This will be your first experience with Home Call. Use it to develop your decision making skills. Some day you will be an attending getting called at home.
  - Go see the patient... If you have questions about a consult ask the attending on call.
- Inpatients
  - Daily AM resident rounds. Then touch base with attendings prior to OR start.
  - Notes will be finished ideally before the OR, but by noon at the latest.
- Clinic
  - You are welcome at any General Surgery attending clinic.
  - The ACGME requires you to attend a minimum one half-day of clinic per week.

Active Duty Residents

- You are Air Force officers and will be held to the same expectations as the rest of us.
- Uniform of the Day: ABUs
  - You will come to work during duty hours in ABUs or PTUs.
  - 99th Medical Group scrubs will not be worn in or out of the hospital.
- Dress and Appearance standards will be followed IAW AFI 36-2903
- Be mindful of Customs and Courtesies.
- Know your hierarchy
  - Wing Commander: Col Cavan Craddock
  - Group Commander: Col Al Flowers, Jr.
  - Squadron Commander: Col David Steinhiser
  - Chief of Surgery: Lt Col Wolfgang Beumer
  - Flight Commander: Lt Col Anna Tsai
  - Immediate Supervisor: Lt Col William Scott

Conferences

- <u>M&M at UMC</u>: Every Tuesday at 0800
  - All cases completed by General and Vascular Surgery are to be listed. Not just the cases that a resident was involved in.
- <u>Case Conference</u>: Every Friday at 1500
  - Presentation of all scheduled cases for the following week. Be succinct. No PowerPoint. Know what is important to the surgery being performed and how to describe the technique.
  - Review of all emergent cases and admissions the week prior. Be succinct.
  - Discussion of current inpatients and plan for the weekend. Essentially a group sign-out.

- Tumor Board: Second Wednesday of the month at 1530
    - Required attendance unless engaged in clinical activity.
- M&M at Nellis: Second Thursday of the month at 0830
    - Required attendance. This is a passive experience for the resident. You do not need to prepare anything. The OR is shut down during this time-period.

Didactic Schedule

- General Surgery Journal Club: Second Friday of the month at 1600.
    - Present a paper published in a peer-reviewed journal (within the past year) that is relevant to the practice of General Surgery. Submit paper to Dr. Scott one week prior to presentation.
- Family Medicine Resident Lecture: Fourth Friday of the month at 1600.
    - Presentation of basic General Surgery topic to be discussed with Dr. Scott one week prior to presentation.