EXPECTATIONS OF GENERAL SURGERY RESIDENTS
Expectations of Surgery Residents

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Conferences: On time attendance is required at the following conferences. Attendance is taken the first 15 minutes of the conference. If you are more than 15 minutes late to conference you are not counted as in attendance. Attendance is monitored and reported to the Program Director and Chairman. Repeated absence from conferences may lead to disciplinary actions. The Departmental Grand Rounds and Resident Basic Science Conference is Teleconferenced to the VA weekly. There are sign-in sheets for you to sign at the VA. Please remember to sign in so your attendance can be counted.

Departmental Conferences

- **Surgical Grand Rounds**  
  (weekly – Thursday 7-8 am, GBJ Auditorium) – Teleconferenced to the VA.

- **D&C Conference (Quality Assurance)**  
  (weekly – Thursday 4-5 pm, GBJ Auditorium)

- **Resident Basic Science Conference**  
  (weekly – Thursday 8-9 am, GBJ Auditorium) – Teleconferenced to the VA.

- **VAMC Grand Rounds (when assigned to the VA)**  
  (weekly – Friday 7:30-9 am, 2L Conference Room)

Divisional Conferences

**Cardiothoracic Surgery**
- Thoracic Surgery Weekly – Wednesday 4:30-5:30 pm, Main 3 Radiology Conference Rm.
- Cardiac Cath Weekly – Friday 8-9 am, Main 1 Cafeteria Conference Rm.
- Cardiac Surgery Weekly – Saturday 7-9 am, Main 4 ICU Conference Rm.

**General Surgery**
- GI Conference Weekly – Monday 4:30-5:30 pm, Main 3 Radiology Conference Rm.
- General Surgery Weekly – Tuesday 7:45-9:00 am, Main 9 Central Conference Rm.

**Surgical Oncology**
- Surgical Oncology Weekly – Tuesday 7:30 am, Massey Cancer Center Demonstration Rm.
- Breast Weekly – Tuesday 1:00 pm, Massey Cancer Center Demonstration Rm.
- Tumor Board Weekly – Thursday 8:10 am, Massey Cancer Center Demonstration Rm
- GI Weekly – Thursday 1:30 pm, Massey Cancer Center Demonstration Rm.

**Pediatric Surgery**
- Pediatric Surgery Weekly – Tuesday 4-5 pm, Main 7 Conference Rm.
Trauma As Announced

Transplant Surgery
Transplant Weekly – Thursday 12:30-2:00 pm, ACC 4th Floor Conference Rm.

Trauma & Critical Care Surgery
Trauma Weekly – Tuesday 12:45-2:00 pm, Main 9 Central Conference Rm.

Vascular Surgery (MCV & VA)
Vascular Weekly – Thursday 9:00-10am, GBJ Auditorium

VA Conferences (When assigned to the VA service)
Cardiothoracic Weekly Cath Conference Location to be announced
Weekly Thoracic Conference Location to be announced

General Surgery GI Conference Wednesday 8:15-10:00 am, 2K Conference Rm.
Tumor Conference Wednesday 3:00-4:00 pm, 2L Conference Rm.

CONFERENCE PRESENTATIONS

Residents presenting cases in departmental or divisional conferences, should research the most recent data available on the topic of discussion. You should have pertinent laboratory data, x-ray films, and pathology results of educational benefit.

D&C Conference is held weekly where the most senior level resident on the service will present a patient list and complications. The presentation must include:

✓ Service and time frame covered
✓ Number of cases done by each level resident on the service
✓ Total number of cases
✓ Patient age, MR number, and patient initials
✓ Attending and residents on case
✓ List of complications and/or deaths
✓ Residents should be prepared to discuss complications and/or deaths and answer questions regarding the cases.

Interesting Case Presentation for D&C Conference
✓ Residents will give a 3-5 minute presentation on an interesting patient, whether a complication, operation, disease or other interesting facet of care.
✓ A brief literature discussion should be prepared
✓ Discuss complications
✓ Give 2 to 8 teaching points appropriate for that particular case.

The Resident Basic Science Conference schedule is prepared for the year. It is the resident responsibility to prepare the presentation with the mentor and present to the residents. The following week faculty will review, with the residents, the previous week presentation. Residents are expected to have read ahead of time and be prepared to answer questions. There are several General Surgery Textbooks available in the department where you can find information on the topic being discussed.
Textbooks are located in the Conference room on the 16th floor in the Chairman’s Office, The Resident Library on Main 9, and some are in the OR Faculty Lounge on Main 5. This conference is required and attendance is taken and monitored. The conference is Teleconferenced to the VA. Residents at the VA should also prepare for the conference and be prepared to answer questions.

**ABSITE**

All categorical, non-designated preliminary surgery residents, and the designated plastic surgery residents in general surgery are required to take the ABSITE each January. (Usually the last Saturday in January). A score of less than the 35th percentile will result in additional reading/educational requirements of that resident to improve the score.

**CLINIC**

Housestaff are expected to be present in the clinics and on time. This is critical to maintaining continuity of care and a sound educational process.

**OR**

- Patients *must* be seen and evaluated by the operating resident (and intern if possible) before the case begins.
- The operating resident *must* document this by placing a preop note on the chart explaining why the patient is undergoing surgery, the risks/benefits, and that these have been explained to the patient who understands.
- Patients *must* be evaluated by the operating resident postoperative, prior to discharge for all inpatient and outpatient surgeries.
- It is expected that all residents participating in a procedure read about the case ahead of time and understand the indications, technical anatomy, and possible complications for all elective cases.
- The operative schedule is posted at least 24 hours in advance. Textbooks are available in the OR Surgeons’ Lounge and the Resident Library on M9. This is an attainable goal and your responsibility.
- Housestaff should make their best attempt to meet this same standard for urgent and emergent cases for the good of their patients, as well as their own education.
- It is also expected that residents read about the illnesses/conditions of those on their inpatient service.

**OP Reports**

- Operative reports *must* be dictated immediately after the case is completed.
- Residents will lose operating privileges for failure to complete operative reports and/or discharge summaries in a timely fashion.

**Discharge Summaries**

- Discharge summaries should be dictated at the time of, or prior, to the patient’s discharge from the hospital.
- Dictations must be concise and accurate, including only relevant information.
- In order to expedite patient discharge and facilitate attendance in the OR, orders for patient discharge (and dictation) should be entered/written the evening before the discharge is anticipated.

**OP Log**

Expectations
Each resident must keep an up-to-date log of all cases in which you were scrubbed for. You must record them in the ACGME Resident Case Log System. Each resident is assigned a user ID and password. You will receive a manual to assist you in entering cases.

Reports are generated monthly to review resident participation in cases. It is your responsibility to enter your cases on a timely basis. Residents which are delinquent in entering cases may have OR privileges taken away.

Do not rely on the operating room or medical records for this data, as it is often incomplete.

The log is required for you to successfully complete the program and sit for the Qualifying Exam of the American Board of Surgery.

Evaluations

- All residents will be expected to evaluate the faculty on the service, and the rotation itself at the end of each rotation.
- All resident evaluations are anonymous.
- Residents are evaluated by faculty at the end of each rotation.
- Housestaff receive a copy of their evaluation via the New Innovations web-based program.

Residents are expected to participate in the education of the 3rd year medical students during their surgery clerkship. You are expected to teach and foster their education.

Residents must check their mailboxes regularly. The mailboxes are located outside the Surgery Education Office in West Hospital 16th floor North Wing and on the 6th floor of West Hospital, South Wing, in the Graduate Medical Education suite.
POLICY
ON

CLINICAL EDUCATION
AND
SUPERVISION OF HOUSESTAFF
POLICY ON CLINICAL EDUCATION
AND SUPERVISION OF HOUSESTAFF

GENERAL PRINCIPLES

As outlined in the Joint Statement on Resident Supervision issued by the Virginia Commonwealth University School of Medicine, the Department of Surgery subscribes to the philosophy that the most effective learning environment for post-graduate medical trainees is one that allows sufficient freedom for housestaff to share responsibility for decision making in patient care, yet provides adequate faculty supervision and involvement to provide feedback to trainees about their actions and to address the quality and safety of the care rendered to patients. Housestaff are individuals with an M.D., D.O., D.D.S., or equivalent degree who meet the qualifications for graduate education/training in the specialties or subspecialties of surgery or dentistry. In order to preserve this type of learning environment for its teaching program, the Department advocates the following principles as elements of its policy on housestaff clinical education and supervision:

1. Housestaff are regarded as primary physicians for all patients admitted to the teaching inpatient services, emergency rooms and clinics, and, as such, are responsible for the writing of orders, for the maintenance of records and for the execution of diagnostic, therapeutic and discharge plans.

2. Depending on their respective levels of training, it is appropriate and essential that junior housestaff be supervised by more senior housestaff in accordance with site-specific guidelines stated elsewhere in this document.

3. All spheres of housestaff activity will be supervised by attending faculty members who will share responsibility with houseofficers for patient care rendered and who will have ultimate authority for final decision making. The nature and extent of attending physician involvement will vary according to site as outlined below.

SITE-SPECIFIC HOUSESTAFF SUPERVISION

The structure of housestaff-attending interactions and the form that faculty supervision of housestaff takes will vary according to site and type of patient care setting and are summarized below. In general, these rules are uniform for the University hospital, the Veteran’s Affairs Medical Center and other affiliated institutions unless otherwise noted.
Clinical education and supervision of housestaff

Inpatient Teaching Services

1. All patients admitted to the service will be cared for by a patient care team which may include medical students, interns, residents and fellows under the direction of faculty attending physicians.

2. Although decisions regarding diagnostic tests and therapeutics may be initiated by the housestaff, these decisions will be reviewed with the attending surgeons.

3. All patients will usually be seen by the attending and discussed daily with housestaff. Stable patients may not be discussed and/or seen daily.

4. The attending will review the medical record and document his/her involvement in the care of the patient.

5. All transfers to another service and discharges will be approved by the attending in advance.

6. Housestaff are required to notify the patient’s attending, in a timely fashion, independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient’s course including unexpected death, need for surgery or transfer to an intensive care unit or to another service for treatment of an acute problem, or for any other significant change in condition.

7. Attendings or their designee are expected to be available and responsive, either by phone or pager, for housestaff consultation, 24 hours a day for their term on service, their on-call day, for their specific patients.

Emergency Department

1. Supervision in the Emergency Department will be provided 24 hours a day by Emergency Room physicians.

2. All patient admissions to the service will be discussed with an ER physician or the appropriate attending physician unless delay would result in harm to the patient.

3. All patient admission to inpatient units will be discussed with the attending (or his designee) assuming responsibility, as well as notifying the resident team assigned.

4. Housestaff is responsible for receiving all referral calls and for securing approval for activation of the MedFlight Helicopter.

5. All patients evaluated by an intern (PGY-1) will be presented to a more senior resident or attending.

Clinical education and supervision of housestaff

Clinics and Consult Services
1. A faculty attending should be present on clinic site or in unique circumstance available by phone. His/her responsibility will be the supervision of housestaff working in the clinic.

2. All inpatient consultations written by a houseofficer will be presented to an attending, countersigned by that attending, and amended or supplemented by the attending as necessary, in accordance with the MCV Consultation Policy.

**Intensive Care Units**

Housestaff decisions, including senior resident decisions, regarding admission and discharge of patients from the intensive care units, and regarding the performance of specified invasive procedures, may be subject to review by subspecialty fellows and attendings depending on the specific procedural rules for that unit. However, the attending physicians ultimately are responsible for all major patient care decisions.

**Operating Rooms**

1. The faculty is responsible for direct supervision of all operative cases. At a minimum, this means being in the operating room with the housestaff during critical parts of the procedure. For less critical parts of the procedure, the faculty must be immediately available for direct participation.

2. A PGY-4 or PGY-5 may act as a “teaching assistant” on appropriate cases and supervise operative procedures performed by a junior resident, although the attending surgeon retains ultimate responsibility and will be present for the critical portion of the surgical procedure.

**HOUSESTAFF CLINICAL DUTIES AND PRIVILEGES**

**(CUMULATIVE, BY YEAR)**

**PGY-1**

1. The PGY-1 is responsible for primary (initial) performance of physical examination, collection of historical data by housestaff and establishment of a logical differential diagnosis.

2. Responsible for the initiation of appropriate diagnostic and therapeutic orders.

3. Recognizes complications and reports findings to more senior houseofficers or attendings.

4. Presents cases in a concise manner to a more senior house officer and/or attending for review and concurrence with clinical decisions.

5. Reviews and corrects the “work-up” of the students assigned to any patient for whom the house officer is responsible and reviews the criticisms and suggestions with the student.
6. Masters open and laparoscopic skills and surgical techniques appropriate for this level of training and secures adequate supervision for those skills not yet mastered. These skills are marked in the Minimally Invasive Surgery Center and in the operating room.

**PGY-2**


2. Assumes primary responsibility for initiation of appropriate diagnostic and therapeutic orders in ICUs.

3. Teaches students and interns and evaluates their performance.

4. Supervises the performance of procedures by less senior residents and medical students until mastered.

5. Notifies and consults with more senior house officers and/or attendings regarding patient status and major decisions.

6. Assumes responsibility for securing a balanced and appropriate experience in general and gynecologic surgery while on rotation at RMH including proper supervision, case responsibility and work load.

**PGY-3**

1. Responsible for the daily supervision of interns and/or junior residents and medical students when serving as a senior resident on assigned service.

2. Responsible to conduct inpatient and emergency room consultations in a timely fashion and report findings to the appropriate attending physician.

**PGY 4 & 5**

1. Shares ultimate responsibility for patient care with the attending physician and works semi-independently except on major patient care matters and on operative procedures. Administrative responsibilities for operational matters (e.g., rounds, teaching, conferences, patient scheduling) are usually given to this level.

2. On designated services a PGY-4 may assume “chief resident” status and associated responsibilities.

3. May not be responsible for the same patients as a fellow on the service when serving as the “chief resident.”

**PGY 6 - 8**

1. These levels almost always represent customized fellowship training.
2. Fellows function essentially as apprentices to one or a small group of attending specialists engaged in delivery of a usually narrowly-focused, complex and demanding form of patient care.

3. Although fellows may act independently in the general aspects of patient care for which they are fully trained, they work in subspecialty care under the supervision of their mentor(s) at varying levels of independence according to the complexity of the care, their stage of development and the judgment of their mentor(s).

**QUALITY IMPROVEMENT AND MONITORING OF COMPLIANCE**

1. Essential areas of professional competence will be evaluated regularly and in writing by attending physicians, and by housestaff both junior and senior to the resident being evaluated. These evaluations will be monitored by the program director.

2. Procedural competence will be monitored and recorded as part of this evaluation.

3. Based on the program director’s recommendations, those categorical residents whose performance is judged to be satisfactory will be promoted to the next level usually at the beginning of the next academic year.

4. In the case of inadequate performance, the program director or the departmental Housestaff Evaluation Committee may elect to prescribe remedial experiences, or to delay or deny promotion or board recommendation, as appropriate for the deficiencies identified. In extreme cases, the program director may place a resident on probation or dismiss a resident from the program in accordance with university policy.

5. The departmental Quality Assurance Committee will monitor the quality of care rendered to patients served by the department and make recommendations to the Department Chairman and Hospital Administration for any needed changes found through periodic chart audits.
DISTRIBUTION AND REVIEW
Of
Educational Objectives

1. The provisions of this document will be sent in written form to all department members including housestaff.

2. Annual review of this policy will be carried out by the department with revisions made as necessary.

O. R. Procedures Which May Be Performed Under Indirect Supervision

- All surgical procedures are staffed by an attending surgeon.
- In the following cases fellows or PGY-4 or PGY-5 residents may supervise junior level residents in the presence of attending surgeon.

Cardiothoracic Surgery
   1. Bronchoscopy and esophagoscopy
   2. Emergency thoracotomy for trauma or bleeding
   3. Insertion of chest tubes and central lines with or without rib resection

General Surgery
   1. Central line insertions
   2. I&D of simple abscesses including perirectal in non-diabetics

Neurosurgery
   They have no procedures that are not supervised

Oral-Maxillofacial Surgery
   1. Repair of superficial lacerations, I&D of abscesses, wound debridement and wound closure
   2. Closed or open reduction of mandibular and maxillary fractures with fixation, i.e., arch bars, internal fixation or external fixations
   3. Dentoalveolar surgery

Pediatric Surgery
   1. Placement of central lines and chest tubes
   2. I&D of abscesses, repair of lacerations, delayed primary closure of wounds and debridements
   3. Excision of pilonidal cysts, sinus tracts, or abscesses
   4. Endoscopic procedures in upper and lower G.I. excluding colonoscopy

Surgical Oncology
   1. Breast biopsy and superficial excisional biopsy
   2. Insertion of central lines, catheters and chest tubes
   3. I&D of abscesses, delayed closure of wounds, repair of superficial lacerations and wound debridement
4. Tracheostomy  
5. Proctosigmoidoscopy  

Transplantation Surgery  
1. Exploration of AV grafts, I&D of abscesses, delayed closure of wounds and repair of lacerations  
2. Initiation of emergency life threatening procedures, i.e., for hemorrhage  
4. Fasciotomy  
5. Uncomplicated embolectomy of upper and lower extremities  

Urology  
1. Urethral dilatation  
2. Urethrotomy  
3. Circumcision  
4. Scrotal exploration, i.e., hydrocelectomy, vasectomy, orchietomy  
5. Prostate biopsy  

Vascular Surgery  
1. Exploration of AV grafts, I&D of abscesses, delayed closure of wounds and repair of lacerations  
2. Minor amputations  
3. Initiation of emergency life threatening procedures, i.e., for hemorrhage  
4. Fasciotomy  
5. Uncomplicated embolectomy of upper and lower extremities  

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