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| **General Surgery Residency Goals & Objectives** | | | | | | |
| **General Surgery at Central Arkansas VA Health System** | | | | | | |
| **Revised January, 2011** | | | | | | |
| **PGY – 1** | | |  | | | |
| **A. Medical Knowledge** | | |  | | | |
| 1. | FLUID & ELECTROLYTES. The resident should possess an in-depth, working knowledge of normal fluid, electrolyte and acid-base physiology and the causes, clinical manifestations and management of fluid and electrolyte and acid-base disturbances, including hypo- & hyperkalemia, hypo- and hypernatremia, hypo- and hypercalcemia, respiratory & metabolic acidosis, and metabolic alkalosis; | | | | | |
| 2. | WOUND HEALING. The resident should possess a detailed, working knowledge of normal wound healing and the effect of acute and chronic diseases on wound healing. The resident should possess an in-depth knowledge of the pathophysiology underlying chronic wounds and appropriate and modern management strategies; | | | | | |
| 3. | SURGICAL INFECTIONS. The resident should possess a detailed, working knowledge of the pathophysiology and bacteriology of surgical infections and the pharmacology of commonly used antibiotics; | | | | | |
| 4. | NUTRITION & METABOLISM. The resident should possess an in-depth, working knowledge of normal human nutrition and the effects of acute and chronic surgical diseases on normal metabolism. The resident should possess a working knowledge of the use of enteral and parenteral nutrition, including the indications for this therapy and the specific risks. | | | | | |
| 5. | HERNIAS. The resident should possess a detailed knowledge of the anatomy and physiology of the abdominal wall as it relates to abdominal incisions, hernias and hernia repairs. He / she should understand the preoperative assessment of patients with a hernia, the indications for repair, and the operative approaches to inguinal hernia;; | | | | | |
| 6. | BIOMATERIALS. The resident should possess a detailed knowledge of the biomechanics of surgical materials, such as sutures and surgical prostheses such as biologic and synthetic meshes; | | | | | |
| 7 | INFLAMMATION. The resident should possess a detailed knowledge of the physiology and pathophysiology of acute inflammation as it pertains to surgery. This includes the effect of inflammation on local and systemic organ function such as the concept of third-spacing of fluid, the clinical signs of inflammation, and remote organ dysfunction; | | | | | |
| 8.. | HEMOSTASIS & TRANFUSION. The resident should possess a detailed knowledge of the physiology of hemostasis and the indications for and risks of blood component therapy, including infectious complications and transfusion reactions. The resident should also possess an in-depth working knowledge of the causes of coagulopathy, the diagnostic evaluation, and the management of hemorrhage in a coagulopathic patient; | | | | | |
| 9. | SURGICAL COMPLICATIONS. The resident should possess a detailed knowledge of the pathophysiology, clinical manifestations, diagnostic and therapeutic algorithms and prophylactic measures for common surgical complications such as wound infections, venous thromboembolism, respiratory insufficiency, wound dehiscence and postoperative bleeding; | | | | | |
| 10. | SHOCK. The resident should possess a basic knowledge of the types and hemodynamic characteristics of shock, including septic shock, hemorrhagic shock, hypovolemic shock, cardiogenic shock, and neurogenic shock; | | | | | |
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| **B. Patient Care** | |  | | | | |
| 1. | PRE-OPERATIVE CARE. The resident should perform and document a concise, accurate, and thorough history & physical examination, write appropriate admission orders, order & review appropriate diagnostic tests & formulate a basic treatment plan for surgical patients admitted to the hospital either emergently or electively; | | | | | |
| 2. | PRE-OPERATIVE CARE. The resident should write physician orders that include appropriate maintenance fluid and electrolyte replacement, appropriate antibiotic selections, and appropriate venous thromboembolism prophylaxis; | | | | | |
| 3. | PRE-OPERATIVE CARE. The resident should be able to assess a patient requiring a surgical procedure such as *assessment for co-morbid conditions, operative risk, and obtain appropriate preoperative imaging & consultations.* | | | | | |
| 4. | PRE-OPERATIVE CARE. The resident should be able to efficiently utilize and interpret diagnostic laboratory testing. *Examples of appropriate tests include tumor markers, serum chemistries, liver function tests, arterial blood gas analysis, hematological profiles and coagulation tests.* | | | | | |
| 5. | PRE-OPERATIVE CARE. The resident should be able to efficiently utilize and interpret diagnostic radiological tests. *Examples of the types of studies include chest and abdominal radiographs, computed tomography, ultrasonography, arteriography and gastrointestinal contrast studies.* | | | | | |
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| 7. | PRE-OPERATIVE CARE. The resident should be able to prepare a patient for operation including the writing of appropriate physicians orders (that includes appropriate prophylactic antibiotics & venous thromboembolism prophylaxis), obtaining informed consent for basic operations / procedures including consent for blood transfusion, and completion and documentation of a preoperative checklist (that includes diagnosis, planned procedure, indications for operation, preoperative lab, the results of pertinent diagnostic studies, special considerations such as positioning, supplies, type & crossmatch for transfusion operative equipment); | | | | | |
| 8. | OPERATIVE CARE. The resident should demonstrate an understanding of the principles of preparation in the operating room, including sterile technique, use of preoperative antibiotic prophylaxis, the surgical prep, positioning/draping and management of anesthetic-related emergencies. | | | | | |
| 9. | OPERATIVE CARE. The resident should demonstrate the principles involved in operations such as the gentle handling of tissue, dissection of tissue planes, suture and ligature techniques and under appropriate supervision, perform basic surgical procedures such as the placement of central venous lines, *common abdominal operations (e.g., appendectomy, inguinal & umbilical herniorrhaphy), and basic wound care including debridement, delayed primary closure, and drain care* | | | | | |
| 10. | OPERATIVE CARE. The resident should participate in as many operations on the service as possible, including those in which he / she is not the primary resident surgeon; | | | | | |
| 11. | POST-OPERATIVE CARE. Following the procedure, the resident should write a succinct, accurate brief operative note that records the surgeons name, the operation performed, the diagnosis, the operative findings, the estimated blood loss, the estimated I & O’s for the case, and other pertinent facts. The resident should also write post-operative physician orders promptly that includes at a minimum a diet, activity level, medications including antibiotics and venous thromboembolism prophylaxis, and nursing orders;. | | | | | |
| 12. | POST-OPERATIVE CARE. The resident should demonstrate an understanding of the basic principles of postoperative care, including pain control, fluid and electrolyte management, wound management, nutritional support, DVT prophylaxis and antibiotic treatment. | | | | | |
| 13. | POST-OPERATIVE CARE. The resident should recognize and manage common post-operative complications including fever, hemorrhage, oliguria, respiratory distress, wound dehiscence, wound infection, intra-abdominal abscess, ileus, myocardial infarction, congestive heart failure, delirium, and pulmonary embolism; | | | | | |
| 14 | POST-OPERATIVE CARE. The resident should provide and document routine postoperative care including the performance and documentation of daily progress notes, discharge orders and discharge summary, outpatient prescriptions, and ensuring appropriate post-operative follow-up, including visits from a home-health care agency; | | | | | |
| 15. | POST-OPERATIVE CARE. The resident should be able to diagnose and appropriate manage alcohol withdrawal syndromes in surgical patients. | | | | | |
| 16. | OUTPATIENT CARE. The resident must attend and participate in ambulatory surgery clinics held each week for their service. *Activities should include examination & evaluation of new patients, perioperative and postoperative care of established patients, and surgical consultations under the supervision of attending surgeons.* | | | | | |
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| **C. Interpersonal and Communications Skills** | | | | |  | |
| 1. | The resident should communicate effectively with patients and their families across a broad range of socioeconomic and cultural backgrounds. This includes discussions regarding the patient’s disease processes (including complications), the expected courses, operative findings, and operative procedures with assistance from upper level residents and the attending surgeons; | | | | | |
| 2. | The resident should communicate effectively with other team members including attending physicians, senior residents, midlevel providers, nurses and students. The resident must accurately portray critical clinical information in a timely professional manner and work effectively as a member of the general surgery service; | | | | | |
| 3. | The resident should work effectively with physicians from other services, other health professionals such as nurses and therapists, and health related agencies to provide high-quality health care. The resident should clearly, accurately, and respectfully communicate with referring and consulting physicians, including residents in a timely professional manner; | | | | | |
| 4. | The resident must effectively document the practice activities by maintaining clear, concise, accurate, and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries; | | | | | |
| 5. | The resident should counsel and educate patients and their families about the diseases that they or their family member are dealing with and the rationale for the recommended plan of care; | | | | | |
| 6. | The resident will ensure that all student notes are accurate, reflect a proper plan, and are countersigned by a physician each day. | | | | | |
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| **D. Practice-Based Learning and Improvement** | | | | | |  |
| 1. | The resident must identify strengths, deficiencies and limits in his / her fund of knowledge and clinical abilities through self-evaluation and set learning and improvement goals based on those deficiencies; | | | | | |
| 2. | The resident must identify and use appropriate learning activities to improve his / her knowledge in areas of knowledge and clinical deficiencies. In addition to individual study, it is expected that the resident will participate in all clinical (e.g., clinics and operating room) and didactic (e.g., conferences) activities specific to this service in order to improve his / her fund of knowledge and clinical abilities as they relate to the fundamentals of general surgical practice; | | | | | |
| 3. | The resident must incorporate formative evaluation feedback from his / her faculty and senior residents into his / her daily practice; | | | | | |
| 4. | The resident should be able to use information technology to locate high quality evidence from scientific studies related to their patient’s health problems. He / she should be able to analyze the literature for quality and relevance to their patient and be able to assimilate this information into clinical practice; | | | | | |
| 5. | The resident should be able to clearly and accurately educate their patients and families, medical students, residents, and other health professionals about the fundamentals of endocrine and malignant diseases and their medical and surgical management;; | | | | | |
| 6. | The resident must attend all service-specific conferences such as the GI tumor conference, Surgical Grand Rounds, Multidisciplinary GI Conference & the Departmental Morbidity & Mortality conference; | | | | | |
| 7. | The resident must utilize an evidence-based approach to patient care; | | | | | |
| 8. | The resident is expected to have an understanding of the anatomy, physiology, and pathophysiology for each case in which they participate, and will keep track of their operative cases, with the goal of exposure to a diverse and thorough spectrum of gastrointestinal diseases during the rotation. | | | | | |
| 9. | The resident should have a working knowledge of the components of National Surgical Quality Improvement Program (NSQIP) and Surgical Care Improvement Project (SCIP) and its utilization as a tool in practice-based learning and improvement; | | | | | |
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| **E. Systems-Based Practice** | | | |  | | |
| 1. | The resident should be able to work effectively to provide high quality and seamless patient care throughout the health care delivery system including the outpatient clinic, emergency department, inpatient ward, operating room, post-anesthesia care unit, and intensive care unit; | | | | | |
| 2. | The resident should be able to coordinate high quality patient care throughout the health care delivery system by working effectively with consultants, other health care providers such as respiratory therapists, physical therapists, and nurse, discharge planning nurses, and social workers; | | | | | |
| 3. | The resident should incorporate considerations of cost awareness, risk benefit analysis, and evidence-based medicine into their clinical practice | | | | | |
| 4. | The resident should be an advocate for high quality patient care and work to identify ways to optimize care delivery systems; | | | | | |
| 5. | The resident should work effectively with risk managers, quality improvement professionals, and utilization review nurses to enhance patient safety, practice high quality and cost effective patient care; | | | | | |
| 6. | The resident should be familiar with the principles of quality improvement processes including root cause analysis and should participate in identifying system errors and implementing potential systems solutions where possible; | | | | | |
| 7. | The resident should work effectively with discharge planning, utilization review nurses, social workers, and home health care agencies to seamlessly and efficiently move the patient from an in hospital setting to a rehabilitation hospital, skilled nursing facility, or home with or without a home health care agency. | | | | | |
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| **F. Professionalism** | | | |  | | |
| 1. | The resident must be honest at all times; | | | | | |
| 2. | The resident should place the needs of the patient above all the needs or desires of him/herself. | | | | | |
| 3. | The resident should maintain high ethical behavior in all professional activities. | | | | | |
| 4. | The resident should remain compliant with all required training designated by the institution. | | | | | |
| 5. | The resident must demonstrate a commitment to the continuity of patient care through carrying out professional responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead. | | | | | |
| 6. | The resident must understand the institutional policy on duty hours and remain compliant with all duty hour regulations. | | | | | |
| 7. | The resident should be properly and professionally attired at all times while engaged in patient care. | | | | | |
| 8. | The resident should be properly and professionally groomed at all times when engaged in patient care. | | | | | |
| 9. | The resident should demonstrate sensitivity to issues of age, race, gender, and religion with patients, families, and members of the health care team. | | | | | |
| 10. | The resident should at all time treat patients, families, and all members of the health care team with respect, compassion, and integrity. | | | | | |
| 11. | The resident should reliably be present in pre-arranged places at pre-arranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident must notify the appropriate supervisor if he or she will be unable to be present. | | | | | |
| 12. | The resident must attend the mandatory conferences. | | | | | |
| 13. | The resident should serve as a role model and guide for the medical students on the service in terms of professionalism. | | | | | |

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| **PGY – 3** | | |  | | | | | | | |
| In general, the goals and objectives for the PGY – 3 resident on the VA General Surgery Service include the list of goals and objectives listed above for the PGY – 1 residents as a foundation with the addition of the following: | | | | | | | | | |  |
| **A. Medical Knowledge** | | | | | |  | | | | |
| 1. | | SURGICAL INFECTIONS. The resident should possess an in-depth, working knowledge of the clinical features and management of surgical infections, including necrotizing soft tissue infections, intra-abdominal infections, and infections in compromised hosts; | | | | | | | | |
| 2. | | NUTRITION & METABOLISM. The resident should possess an in-depth, working knowledge of assessment of a patient’s nutritional status and management of malnutrition with enteral or parenteral nutrition. It is expected that the resident will be familiar with the potential complications of each of these routes of nutrition and choose the timing and method based upon an appropriate risk:benefit ratio in a surgical or acutely injured patient; | | | | | | | | |
| 3. | | HERNIAS. The resident should possess an in-depth, working knowledge of the clinical manifestations of abdominal wall hernias, the preoperative evaluation and preparation of patients for repair, and the advantages, disadvantages and potential risks & complications of various forms of herniorrhaphy, including inguinal and incisional hernias; | | | | | | | | |
| 4. | | ABDOMEN. The resident should possess an in-depth, working knowledge of the clinical presentation, differential diagnosis and diagnostic algorithm and components of operative and non-operative (where appropriate) management of patients with acute inflammatory conditions of the abdomen, including but not limited to, acute appendicitis, acute diverticulitis, perforated duodenal / gastric ulcer, acute cholecystitis, and acute pancreatitis; | | | | | | | | |
| 5. | | ABDOMEN. The resident should possess an in-depth working knowledge of the causes of peritonitis, the clinical manifestations, as well as the diagnostic and therapeutic strategies, including the preoperative preparation of a patient for operation and the operative approaches to common causes of peritonitis; | | | | | | | | |
| 6. | | ABDOMEN. The resident should possess an in-depth, working knowledge of the pathophysiology, causes, clinical features, and diagnostic and therapeutic approach to a patient with acute intestinal motility disorders such as small bowel and colonic obstruction, ileus, & Olgilvie’s syndrome | | | | | | | | |
| 7. | | BILIARY TRACT DISEASES. The resident should possess an in-depth, working knowledge of the pathophysiology of gallstones and biliary tract disease. The resident should know the clinical manifestations, diagnostic evaluation, and operative management of the common complications of gallstones, including biliary colic, acute cholecystitis, biliary pancreatitis, and choledocholithiasis; | | | | | | | | |
| 8. | | OPERATIVE RISK ASSESSMENT & MANAGEMENT. The resident should possess a detailed understanding of the effect of aging and chronic diseases (such as atherosclerosis and coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, cirrhosis, cancer, AIDS, and chronic renal failure) on normal cardiovascular, respiratory, hepatic and renal physiology. The resident should be able to accurately assess and manage the operative risk of patients with these and other common chronic medical conditions; | | | | | | | | |
| 9. | | OPERATIVE RISK ASSESSMENT & MANAGEMENT. The resident should possess an in-depth, working knowledge of the clinical manifestations, differential diagnosis, and prevention and management of common substance withdrawal syndromes, such as alcohol withdrawal; | | | | | | | | |
| 10. | | CANCER. The resident should possess an in-depth working knowledge of the pathogenesis (including molecular biology), clinical manifestations, diagnostic and staging algorithms, and management strategies for common gastrointestinal malignancies including colorectal cancer, gastric cancer, and pancreatic cancer. | | | | | | | | |
| 11. | | COMPLICATIONS. The resident should possess an in-depth, working knowledge of the differential diagnosis, diagnostic algorithm and therapeutic strategies for the management of patients with acute life-threatening complications of general surgical procedures such as post-operative hemorrhage, respiratory insufficiency, myocardial infarction, hypotension, cardiac arrhythmias, acute renal insufficiency; | | | | | | | | |
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| **B. Patient Care** | | | |  | | | | | | |
| 1. | | PRE-OPERATIVE CARE. The resident should be able to perform and document a concise, accurate, and thorough history & physical examination, write appropriate admission orders, order & review appropriate diagnostic tests & formulate and implement a treatment plan for patients with complex medical and surgical diseases as well as those who are hemodynamically unstable; | | | | | | | | |
| 2. | | PRE-OPERATIVE CARE. The resident should be able to resuscitate an acutely ill patient, such as an individual who is septic, bleeding, or hypovolemic; | | | | | | | | |
| 3. | | PRE-OPERATIVE CARE. The resident should be able to preoperatively assess and medical optimize a patient with significant co-morbid conditions who requires a laparotomy or other major abdominal operation. The resident should be able *to assess and manage serious co-morbid medical conditions, accurately assess operative risk, obtain proper preoperative imaging & consultations, and adjust medical and operative approaches based upon the patient’s risk assessment.* | | | | | | | | |
| 4. | | PRE-OPERATIVE CARE. The resident should be able to obtain informed consent for major abdominal operations such as cholecystectomy, laparotomy, and colectomy; | | | | | | | | |
| 5. | | PRE-OPERATIVE CARE. The resident should be able to evaluate a medically complex or seriously ill patient for an acute surgical condition and render a concise and accurate consultation that details the relevant clinical findings and the diagnostic and therapeutic plan. | | | | | | | | |
|  | | PRE-OPERATIVE CARE. The resident should be able to manage the chronic medical problems of surgical patients such as congestive heart failure, coronary artery disease, hypertension, chronic obstructive lung disease, chronic renal insufficiency, or cirrhosis; | | | | | | | | |
| 6. | | OPERATIVE CARE. The resident should demonstrate expert understanding and possession of the principles involved in operations, such as gentle handling of tissue, dissection of tissue planes, suture and ligature techniques and under appropriate supervision, perform surgical procedures of moderate complexity, such as the *common abdominal operations (e.g., cholecystectomy, inguinal & incisional herniorrhaphy), small bowel resection, partial colectomy, colostomy, exploratory laparotomy with enterolysis, and management of complex surgical infections including wide debridement;* | | | | | | | | |
| 7. | | OPERATIVE CARE. Along with the chief resident, the PGY – 3 resident is the primary operating surgeon on this service, as such it is expected that this individual will participate in the operative management of all of the patients on this service, including those in which he / she is not the primary resident surgeon; | | | | | | | | |
| 8. | | POST-OPERATIVE CARE. Following the procedure, the resident should write a succinct, accurate brief operative note and dictate an operative note that accurately and concisely details the procedure performed. The resident should also write post-operative physician orders promptly that includes at a minimum a diet, activity level, medications including antibiotics and venous thromboembolism prophylaxis, and nursing orders;. | | | | | | | | |
| 8. | | POST-OPERATIVE CARE. The resident should be able to provide postoperative care in a medically complex or unstable patient, including pain control, fluid and electrolyte management, wound management, nutritional support, venous thromboembolism prophylaxis and antibiotic treatment, and management of their comorbid medical conditions; | | | | | | | | |
| 9. | | POST-OPERATIVE CARE. The resident should recognize and appropriately manage common post-operative complications including fever, hemorrhage, oliguria, respiratory distress, wound dehiscence, wound infection, intra-abdominal abscess, ileus, myocardial infarction, congestive heart failure, delirium, and pulmonary embolism; | | | | | | | | |
| 10. | | POST-OPERATIVE CARE. The resident must attend and participate in the surgery clinic for their service. *Activities will include examination and evaluation of new patients, perioperative and postoperative care of established patients, and surgical consultations under the supervision of attending surgeons.* | | | | | | | | |
| 11. | | POST-OPERATIVE CARE. The resident should be able to perform simple and moderately complex general surgical procedures in an office setting under the supervision of the attending surgeon; | | | | | | | | |
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| **C. Interpersonal and Communications Skills** | | | | |  | | | | | |
| The PGY – 3 resident is a senior surgical resident who is expected to be a leader on the surgical team. In addition, to the interpersonal and communication skills defined for a PGY – 1 resident, it is expected that the PGY – 3 surgical resident should exhibit greater competence, across a variety of clinically relevant situations, with these important skills than would the PGY – 1. | | | | | | | | | |  |
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| **D. Practice-Based Learning and Improvement** | | | | | | |  | | | |
| In addition, to the practice-based learning and improvement skills defined for a PGY – 1 resident, it is expected that the PGY – 3 surgical resident should exhibit greater insight (through self-evaluation and formative feedback) into their clinical strengths, deficiencies and limits. The PGY – 3 resident’s ability to locate, identify and assimilate high quality clinical and scientific information should be relatively mature. As such it is expected that the PGY – 3 resident will be an effective teacher for his / her patients and families, medical students, residents, and other health professionals. Lastly, it is expected that the PGY -3 resident will have a relatively sophisticated knowledge of hospital based quality improvement initiatives including the Surgical Care Improvement Project and the National Surgical Quality Improvement Program; | | | | | | | | | |  |
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| **E. Systems-Based Practice** | | | | | | | |  | | |
| In addition to the systems-based practice skills defined for a PGY – 1 resident, it is expected that the PGY – 3 should possess a sophisticated understanding of the health care delivery system within the medical center and the community. The PGY – 3 resident should be an expert in coordinating high-quality, seamless patient care throughout the health care systems. He / she should understand and employ the concept of risk : benefit ratio and evidence-based medicine in their clinical practice. Lastly, the PGY – 3 resident should be an ardent champion for their patients and the institution and should help identify ways to improve the quality of care that is provided at each of our health care institutions; | | | | | | | | | |  |
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| **F. Professionalism** | | | | | | | | |  | |
| In addition to the professionalism skills expected of a PGY – 1 resident, the PGY – 3 resident is expected to be a role model for professional and ethical behavior within the hospital. | | | | | | | | | |  |

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| **PGY – 5** | | | |  | | | | | |
| In general the goals and objectives for the chief resident on the VA General Surgery Service include the list of goals and objectives listed above for the PGY – 1 & - 3 residents as a foundation with the addition of the following: | | | | | | | | |  |
| **A. Medical Knowledge** | | | |  | | | | | |
| 1. | | ENDOCRINE. The chief resident should possess an in-depth, working knowledge of the pathophysiology, clinical manifestations, differential diagnosis, diagnostic algorithm, and operative and non-operative strategies involved in the management of common thyroid disease including thyroid cancer, hyperthyroidism, and thyroid goiter; | | | | | | | |
| 2. | | ENDOCRINE. The chief resident should possess an in-depth, working knowledge of the pathophysiology, clinical manifestations, differential diagnosis, diagnostic algorithm, and operative and non-operative strategies involved in the management of hyperparathyroidism, including parathyroid adenoma and parathyroid hyperplasia. He / she should also possess an in-depth, working knowledge of the molecular genetics, clinical manifestations, diagnostic evaluation, and surgical management of patients with multiple endocrine neoplasia syndromes 1 and 2. | | | | | | | |
| 3. | | ESOPHAGUS. The chief resident should possess an in-depth, working knowledge of the pathophysiology, clinical manifestations, diagnostic evaluation & therapeutic approaches to patients with esophageal malignancies, including the patient with the pre-malignant condition of Barrett’s esophagus. The chief resident should know the details of the operative options for managing patients with esophageal malignancies and pre-malignant lesions, such as Barrett’s esophagus. The chief resident should know relevant adjuvant and neoadjuvant therapies as well as the advantages, disadvantages and risks of various operative approaches to treating patients with esophageal cancer (i.e., transthoracic versus transhiatal approaches; | | | | | | | |
| 4. | | STOMACH & DUODENUM. The chief resident should possess an in-depth, working knowledge of the pathophysiology, clinical manifestations, diagnostic and therapeutic approaches to patients with complicated peptic ulcer disease (PUD). The chief resident should know the operative options for managing a patient with complicated PUD including the selection of the best option for a given clinical scenario and the management of the difficult duodenal stump; | | | | | | | |
| 5. | | STOMACH. The chief resident should possess an in-depth, working knowledge of the pathophysiology, clinical manifestations, diagnostic, staging and therapeutic approaches to patients with gastric neoplasms including adenocarcinoma, MALT, GIST, carcinoid tumors and lymphomas; | | | | | | | |
| 6. | | ABDOMEN. The chief resident should possess an in-depth, working knowledge of the diagnostic and therapeutic approaches to managing a patient with an acute gastrointestinal emergency including perforation with peritonitis & acute gastrointestinal hemorrhage; | | | | | | | |
| 7. | | COLORECTAL DISEASES. The chief resident should possess an in-depth, working knowledge of the pathogenesis (including molecular biology), clinical manifestations, diagnostic evaluation, preoperative staging, and operative planning for a patient with a carcinoma of the colon, rectum or anus. The chief resident should understand the rationale and strategy for adjuvant / neoadjuvant therapy in the management of these patients. | | | | | | | |
| 8. | | PANCREAS. The chief resident should possess an in-depth, working knowledge of the pathophysiology, the clinical manifestations, and the diagnostic and therapeutic approaches (both operative & non-operative) to patients with complications of acute pancreatitis, including pancreatic pseudocyst, pancreatic necrosis, infected pancreatic necrosis, pancreatic ascites, and pancreaticocutaneous fistula; | | | | | | | |
| 9. | | PANCREAS. The chief resident should possess an in-depth, working knowledge of the pathophysiology, the clinical manifestations, and the diagnostic, staging and therapeutic approaches (both operative & non-operative) to patients with pancreatic cancer. The chief resident should understand the use of adjuvant and neoadjuvant therapy in these patients and should have a detailed knowledge of the conduct of a whipple procedure and its potential risks; | | | | | | | |
| 10. | | PANCREAS. The chief resident should possess an in-depth, working knowledge of the pathophysiology, the clinical manifestations, and the diagnostic, staging and therapeutic approaches (both operative & non-operative) to patients with pancreatic cystic neoplasms and endocrine tumors. The chief resident should understand the unique diagnostic and therapeutic approaches to managing patients with these tumors; | | | | | | | |
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| **B. Patient Care** | | |  | | | | | | |
| 1. | | PRE-OPERATIVE CARE. The chief resident should be able to obtain informed consent for complex abdominal operations such as pancreatectomy, abdominal perineal resection, and esophagectomy. | | | | | | | |
| 2. | | PRE-OPERATIVE CARE. The chief resident should be able to evaluate and medically prepare a patient for a complex surgical procedure such as a whipple procedure, total colectomy or esophagectomy; | | | | | | | |
| 3. | | PRE-OPERATIVE CARE. The chief resident should be able to manage the preoperative evaluation and neo-adjuvant and adjuvant therapy for patients with malignancies of the GI tract, such as esophageal cancer, gastric cancer, and rectal cancer. | | | | | | | |
| 4 | | PRE-OPERATIVE CARE. The chief resident should be able to manage the preoperative evaluation and medical management of patients with endocrinopathies, including but not limited to, hyperthyroidism, Graves disease, and pheochromocytoma | | | | | | | |
| 5. | | OPERATIVE CARE. The chief resident should demonstrate expert understanding and possession of the principles involved in operations, such as gentle handling of tissue, dissection of tissue planes, suture and ligature techniques and under appropriate supervision, perform complex surgical procedures, *such as pancreatic resection, total abdominal colectomy, abdominal perineal resection, complex incisional hernia repair, re-operative surgery with extensive enterolysis, vagotomy & gastric resection, and esophageal resection* | | | | | | | |
| 6. | | OPERATIVE CARE. The chief resident is the primary operating surgeon on this service, as such it is expected that this individual will participate in the operative management of the patients on this service as either the primary operating surgeon or the teaching surgeon; | | | | | | | |
| 7. | | POST-OPERATIVE CARE. The chief resident should be able to provide postoperative care in a medically complex or unstable patient, including pain control, fluid and electrolyte management, wound management, nutritional support, venous thromboembolism prophylaxis and antibiotic treatment, and management of their comorbid medical conditions; | | | | | | | |
| 8. | | POST-OPERATIVE CARE. The chief resident should recognize and appropriately manage life-threatening post-operative complications including but not limited to acute respiratory distress syndrome, wound dehiscence, intra-abdominal abscess, myocardial infarction, congestive heart failure, and pulmonary embolism; | | | | | | | |
| 9. | | POST-OPERATIVE CARE. The chief resident must attend and participate in the surgery clinic for their service. *Activities will include examination and evaluation of new patients, perioperative and postoperative care of established patients, and surgical consultations under the supervision of attending surgeons.* | | | | | | | |
| 10. | | POST-OPERATIVE CARE. The chief resident should be able to perform simple and moderately complex general surgical procedures in an office setting under the supervision of the attending surgeon; | | | | | | | |
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| **C. Interpersonal and Communications Skills** | | | | |  | | | | |
| It is expected that the chief resident, by the nature of his or her training and experience should routine exhibit exemplary interpersonal and communication skills in a variety of clinical scenarios. The chief resident should be an accomplished teacher of the more junior residents and the medical students assigned to his service; | | | | | | | | |  |
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| **D. Practice-Based Learning and Improvement** | | | | | |  | | | |
| The chief resident should exhibit insight into their clinical strengths, deficiencies and limits and be able to utilize high-quality evidence to maintain their clinical knowledge and level of practice. The chief resident should actively participate in hospital quality improvement projects, including root cause analyses, in order to improve the quality of care at the institution in which they practice. They should have a mature level of knowledge regarding their participation in national quality improvement programs including the Surgical Care Improvement Project or the National Surgical Quality Improvement Program; | | | | | | | | |  |
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| **E. Systems-Based Practice** | | | | | | |  | | |
| In addition to the systems-based practice skills defined for a PGY – 1 resident, it is expected that the PGY – 5 should possess a mature understanding of the health care delivery system within the medical center and the community. The PGY – 5 resident should be an expert in coordinating high-quality, seamless patient care throughout the health care systems. He / she should understand and employ the concept of risk : benefit ratio and evidence-based medicine in their clinical practice and he / she should be an ardent champion for their patients and the institution and should help identify ways to improve the quality of care that is provided at each of our health care institutions; | | | | | | | | |  |
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| **F. Professionalism** | | | | | | | |  | |
| The chief resident is expected to be a role model for professional and ethical behavior within the hospital. | | | | | | | | |  |