EGS Expectations

1. Intro
2. General expectations
3. Expectations of interns
4. Expectations of mid-level residents
5. Expectations of chief resident
6. Student expectations

I attest that I have received the following expectations and will perform them to the best of my abilities. If any of the below is unclear, I will ask for clarification from the EGS attending on service.

X	X
Signature	Print name

1. Introduction

Welcome to the EGS service. We handle most of the emergent, urgent, and elective general surgery at UAMS. It is a busy and challenging service. Time management and efficiency will be tested for all residents on the service. This service, more than any other, is truly a resident-run service. Luckily, you are not alone in this. The attending staff has grown to be flexible and understand the strain placed on the residents during their time on this service. The APRN complement will also be an invaluable resource on protocols and daily patient management, as well as doing most of the heavy lifting for placement and discharge planning.

2. General expectations

To make this service run as smoothly as possible, we offer the following outline of general expectations for every member of the EGS team, from attending to the intern (broken down by role in subsequent pages).

- **COMMUNICATE**
- The chief resident is the primary source of continuity of care for the patients on the EGS service. While all consults, decisions, issues, and pertinent information should be relayed through the chief, when feasible, this is not always possible. The attending of the day is ultimately responsible for the care, and all of the aforementioned issues must be relayed to the attending promptly.

- **No one is above any task**, and the outlined expectations by role are just a loose guide. If you need help with something, ask. If you don't ask, it is assumed that you are doing it. Patients can be hurt by not performing delegated tasks in a timely fashion.
- Delegate. You don't have to do everything. Use all the resources at your disposal, such as medical students, pharmacists, etc.
- EGS/Trauma guidelines can be found at: https://surgery.uams.edu/divisions/trauma/guidelines/
    - Please save this link and familiarize yourself with the format and where to find pertinent resources before the rotation starts
    - Additional evidence-based reading for common topics can be found at: https://www.east.org/education/publications/landmark-papers-in-trauma-and-acute-care-surgery/emergency-general-surgery
- Be courteous to everyone. You will have better results in accomplishing tasks, and happier patients and coworkers if you treat everyone with respect and humility.
- Be open to learning opportunities in whatever form they take.
- Utilize medical students as members of the team. To do this effectively, you must also teach them. Investing some time at the start to outline expectations and roles can be hugely helpful and save you time in the long run.
- The chief resident will make the decisions as to the exact times and deployment of personnel for operative cases/clinic/etc. In the event of conflict, the EGS attending for the day supersedes.
- **Clinic (Tuesdays and Thursdays) should be attended by everyone not directly involved in the operating room or emergent patient care.**
- See schedule suggestion below:

Weekly events	Monday	Tuesday	Wed	Thursday	Friday	Saturday	Sunday
Morning Rounds	0530	0515	0530	0530	0530	0530	0530
Morning Report	0630	No MR, but we meet at 0615 outside M/M to touch base	0630	0630	0630	0630	0630
M and M		0630					
Grand Rounds		0715					
Clinic		0900-0200ish (check Surgery Clinic schedule in EPIC)		0900 – 1500ish			

ICU Journal Club					1300		
Surgery Resident Conferences				1600 or 1700 - 1800			
PM rounds and Night Checkout	1700 - 1800	1700 - 1800	1700 - 1800	After conference	1700 - 1800	1700 - 1800	1700 - 1800

3. Intern expectations:

- **COMMUNICATE** with your upper levels, APRNs, and attendings.
- **Only report information you know to be true**. Misinformation, even with the best intentions, helps no one. Not knowing something is acceptable. Not knowing something and providing false information is unacceptable and dangerous.
- Take ownership of the patients and get comfortable seeing your patients. Know them, know their families – you will and should be the most frequent face they see. It truly brings us joy when the patients understand all that the junior doctors do for them.
- **Medical students are primarily your responsibility**. Please ensure that they know to round and take responsibility for a couple of patients every day, attend clinic and operating room events. They should actively engage in patient care (wound changes, getting out of bed, enacting plans, etc.). Set expectations early and include them from the start, and they will be more helpful to you.

<u>Daily workflow will look like this:</u>

- Arrive by 0500 and receive checkout from the night intern. Face-to-face checkout regarding new admissions and important events with existing patients should happen.
- Prepare the list with up-to-date labs, vitals, and outputs. Most of this is automated through EPIC, but discuss with your chief resident how best to accomplish this.
- Round with team before morning report. It is expected that all primary patients on the EGS service be seen by the resident team before morning report. Consults and ICU patients can be seen if time allows, but this is not required prior to morning report.
- During morning report, the intern frequently will go to the pre-operative holding area and ensure the pre-op checklist is done for any elective cases scheduled for that day. When this is finished, they should join morning report to run the list with the team and the attending.
- Keep a to-do list of changes, tasks, etc to be accomplished that day and ensure that they are accomplished. The most efficient interns use the computer in the room or on rounds to place orders, etc, as decisions are being made.
- Placing an order in EPIC is often not sufficient to ensure a nursing task, imaging, consult, etc gets done. You will often need to make phone calls or have face-to-face communication about this.
- Daily progress notes on all primary patients (on the floor) and update notes for consults unless instructed otherwise. Along with this, you should update the 'Problem List' in epic with accurate information and use this for your notes. Copy and pasted forward data helps no one.

- Discharge planning with social work and APRN complement.
- Email Kim at KAminnie@uams.edu, Stephanie SRohrer@uams.edu, and Cindy BThomasson@uams.edu with any discharges for the day. They will coordinate the follow-up for our patients in clinic.
- If the above tasks are done, come to the OR and check in or scrub cases.
- If there is clinic, you attend clinic.
- If the upper level and mid level are both scrubbed on different cases, you may need to carry the consult pager and see consults.
- Don't go over your hour limit – if you are close, let uppers or attendings know and we will find a way to get you out of the hospital.

4. Mid-level resident expectations:

- **Consults are your primary responsibility**. The evaluation, work-up, and management of surgical patients is an integral part of your surgical education, and this service will get you lots of "reps" at that process.
- You are also expected to be involved in the operating room on a daily basis. Sometimes, this is because we have two rooms running, and you will be the only resident on a case. You may also "double scrub" a case with a chief resident and allow them to walk you through a case, if appropriate. The chief resident will prioritize cases and be responsible for deploying residents to operating rooms as they see fit.
- Time management and prioritization are key to this service. Defining your priority is not always clear, so when in doubt, ask for help from your upper level or the attending. Don't sit on consults if you can avoid it. If another team calls a surgical consult, you cannot refuse to evaluate it without discussing it with the attending. All consults should be seen as soon as possible, but we understand that isn't always possible. Suppose you are double scrubbed and receive a consult. In that case, **it is your job (not the circulator's or anyone else's) to ensure that the consult doesn't have an emergent issue needing attention now**. If you are the only resident scrubbed on a case, you should make plans to give the consult pager to the intern so they can respond to emergencies and let the attending know, if needed.
- Ideally, the chief resident will be involved in seeing consults with you, whenever possible. If the chief is busy in the operating room, **don't delay staffing a consult** until they are available, however.
- If you receive a consult during your shift, you should try to see it during your shift, when feasible. Again, this isn't always possible and it is acceptable to ask the next shift team to see a consult you haven't (this is especially true of consults received around shift changes).
- Likewise, it is acceptable to scrub out of a case or check out work if you are encroaching upon duty hour restrictions. Make every effort to be efficient and avoid this, but we will understand if it happens. Very few surgery residents will shuck work and your colleagues will understand. We are all in this together and you may have to cover them in other scenarios.
- **You should be prepared to present all consults that you see at morning report the next day**. The chief resident will often take on this responsibility from you, but the intent is for the consult resident to present the consults.

- **Consult notes are your responsibility**, with some room for improvisation (just communicate who will be doing the note, if not you). All consults require a note and staffed with an attending (even intra-operative consults).
- It is okay to staff a consult with the next shift attending if encroaching on shift change and not emergent.

5. Chief expectations:

- **The EGS service is yours to run.** During your time, you will be the primary source of continuity on the service. Attendings and plans may change, but you do not. You can and should be responsible for all of the surgical planning, operations, and post-operative management. Our goal as EGS staff is to get you to the point where you can do that independently. The more that you take ownership of the service and demonstrate efficacy at this, the more autonomy you will receive and the more prepared you will be to transition to an independent general surgeon. Often, residents can develop a tendency to defer to attending plans throughout their rotations through surgical subspecialties. Don't do that on this service – **formulate a plan and advocate for it.** Many of our cases are classic general surgery and fodder for boards, you should have the management down.
- Many of our operations are appropriate for chief or mid-level residents to perform independently, and our hope is for you to do so. **If you don't feel comfortable operating independently, say so. If you feel you can perform an operation independently, say so.**
- All operative cases are the responsibility of the chief resident to ensure they are appropriately staffed with resident coverage. If there is dispute about resident coverage, the on-call EGS attending for the day will have final decision as to the resident deployment.
    - **It is expected that you will communicate with oncoming EGS attending for the next day about resident coverage, the day or evening prior.** Phone call, text, or e-mail are acceptable. i.e. "we have two lap chole's for tomorrow, the 2nd year resident will be doing those with you while I'm in one day surgery with Dr. X's hernias" or "we just have a decub for tomorrow, I would like to TA the intern for that case".
    - **It is our expectation that you be involved in operating room cases whenever possible.** If a case is intern or second year appropriate, you should still come to the OR and TA them on those cases whenever possible. Such opportunities are not always readily available on other services and this is a skill that you will need to develop as you transition to an attending.
- You also have significant control over the operating room schedule (with the obvious caveat that you can't post cases under your name and need to discuss this with attendings). Get comfortable talking to scheduling and OR front desk to help coordinate case timing. Try to get cases done as soon as possible, within reason. Get longer, difficult cases done early in the day and leave shorter, easier cases for later (these can be done by the night shift team, if needed). Post cases as early as possible.
- Don't be afraid to ask for help from your trauma colleagues if you have outstanding cases that need to get done. Our goal is to expedite care for all patients. Along the same line, cover traumas if the trauma resident is in the operating room or multiple activations at once.
- Do your best to see and evaluate all patients. Even if a consult has been seen and staffed, you may find things that the mid-level resident did not, and you will be caring for these patients.

- **Teach the residents and medical students**. If they are lost, the service runs poorly and reflects poorly on us. Setting expectations for them early will save you a lot of headaches in the long run.
- **Talk to families** when possible.

6. Student expectations:

- **Be punctual, engaged, and interested.**
- Ask questions - it may seem intimidating on a busy surgical service, but it shows that you are paying attention if you ask pertinent questions. We don't always know what you don't know, so asking for questions or clarifications can help us gauge that, as well.
- Be kind and courteous to patients and healthcare providers.
- Students should prepare to work every other weekend or one weekend day each week (you may divide this up how you choose). Weekends will be an abbreviated work day of rounding only.
- **See at least one consult per day with the team, or independently if the residents ask you to**.
    - Stay engaged with the mid-level and chief residents and look for these opportunities
    - Many of our consults, operations, patients are classic general surgery topics and good fodder for exams. Having a grasp of many of the core topics for this service will be vital to your surgery clerkship.
- **One student should attend every operative case (unless classroom/ mentor group meetings).**
    - It will be assumed you know how to read the operating room schedule and determine when cases are happening. It is posted for all to see in EPIC and on video screens in the main and outpatient OR's. If you need help finding these at the start of your rotation, ask.
    - You should have some idea how to "scrub" for a case, but if you are unsure, ASK! (the scrub techs and circulators can be of assistance. As usual, be polite and introduce yourself)
    - It is expected that you will **review the chart** and be informed of the patient's history and indications for surgery
    - **Review the anatomy** and conduct of the operation (not always possible for emergent cases, but there is sufficient "heads-up" for most cases)
    - Assist with camera driving, retraction/exposure, cutting, suturing, tying, etc as asked.
    - If you are unable to complete these tasks for any reason, just let us know and we can work with you.
    - Some students are going to pass out every rotation. We are used to it, no big deal. If you start feeling light-headed, let us know and we can scrub you out even if you are in the middle of a task. You risk hurting yourself or the patient if you try to "power through".
- Become a part of the team alongside the residents and APRN's. You should be prepared to:
    - **Present 2 patients to the attending every day** (meaning you know their history, overnight events, numbers, exam, etc).
    - **Help the interns execute on plans made at daily rounds.**
        - You may need to make calls to communicate with nurses, radiology, etc.

    - Perform basic wound care tasks.
    - Place/ remove foleys, NGT's, drains, etc as instructed and when appropriate.
- Attend clinic on Tuesdays and Thursdays in the Surgery Clinic on the 4th floor of the outpatient building.
    - Preference is for students to see follow-up patients and **present to the attendings** (in some cases, you may see patients with the resident or see new patients when instructed to - ask the residents in clinic and they can direct you)
    - Learn the history, indications for surgery, and the operation performed. Then perform a directed history and physical on the post-operative patients.
    - Once you have gathered this information, present it to one of the attendings in clinic unless they direct you otherwise.
    - Write the SOAP note for the patients seen and submit to the attending for read and approval. You should directly discuss with the attending how and who should document the encounter in EPIC as many attendings do this differently.
- Student topics for education/ reading include, but not limited to:
    - Mesenteric ischemia
    - Appendicitis
    - Biliary disease (cholecystitis, choledocholithiasis, gallstone pancreatitis)
    - Hernia
    - Small and large bowel obstruction
    - Colitis
    - Ileus
    - GI bleed
    - Colitis
    - Diverticulitis
    - Soft tissue infections
    - Benign soft tissue tumors
    - Surgical feeding access
    - GERD
    - Peptic ulcer disease