

Program Manual

for

**Vascular Surgery Residency
Integrated Program**

Academic Year 2020-2021

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Overview of the Vascular Integrated Residency Training Program

The New York University Vascular Surgery Residency is a five year clinical training program in surgery the overall goal of which is to develop competent, mature, and ethical vascular surgeons fully equipped to manage the entire spectrum of clinical disease that defines the field of general surgery (as outlined by the American Board of Surgery and the Surgical Council on Resident Education (SCORE) Patient Care Curriculum Outline) for the first three years of the program and then do likewise for Vascular Surgery training in years 4 and 5. To achieve the above goal, NYU has adopted a competency-based surgical training program based on the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies and recently implement milestones.

Because the field of general surgery is broad, the residency is structured to provide wide exposure to the scientific basis of the specialty, to the principal components of the specialty as defined by the ACGME and the American Board of Surgery, and to those sub-specialties about which a general surgeon is expected to have a working knowledge. To reach these educational goals, the residents undertake progressive responsibility (under supervision of the teaching faculty) as experience and knowledge increase as assessed through objective and subjective evaluations. Successful completion of the R1 rotations leads to progressive increase in responsibility in the operating room, wards, and outpatient experience as an R2. As an R3, the resident assumes general surgery and vascular surgery consult responsibility under the direct supervision of chief residents and teaching faculty. The R4 and R5 will be rotating on vascular surgery rotations at Tisch, Bellevue and VA hospitals as chief residents with increased responsibilities from R4 to R5 year.

The Department of Surgery also sponsors an ACGME accredited General Surgery Residency and a Vascular Surgery Fellowships program. The Vascular Integrated residency works very closely with the General Surgery Residency to fully commit to the integrated aspects of the program and to fulfill the requirements set forth by the ACGME and the ABS. The Vascular Surgery residents join the General Surgery residents for core conference for the first two years of the program as well as participate in the Vascular Surgery core conference. The professionalism and quality improvement curriculum is department wide and encompasses all Department of Surgery training programs. Vascular Surgery Fellows work in conjunction with the Chief Vascular Surgery Resident to function as chiefs of the three main teaching sites.

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Program Training Sites

NYU Tisch Hospital Center and Kimmel Pavilion

Training Site Description

550 First Avenue, New York, NY 10016

NYU Tisch Medical Center of New York University Langone Medical Center is an acute-care general hospital. The hospital is a general and tertiary care referral center located in midtown Manhattan. There are approximately 184 beds dedicated to the Surgical Services and 33 Operating Rooms, including a state of the art Hybrid Endovascular Operating Suite. The patient population at NYU Hospital Center is ethnically diverse given its location in New York City. During their rotations at Tisch Hospital, vascular trainees are exposed to an incredibly wide variety of vascular surgical patients and diagnoses, consistent with a large urban academic general and tertiary care center. This includes both routine and complex diagnoses, surgeries and endovascular procedures in the following areas: aortic, cerebrovascular, mesenteric / renal, lower extremity, and venous procedures. Active faculty (including 9 full time board certified vascular surgeons), perform all of their private cases at Tisch Hospital, and vascular trainees are intimately involved in the preoperative, operative, and postoperative care of these patients. Trainees see patients with the Faculty in the clinics at least once per week, evaluate outpatients and perform preoperative assessment, planning, and evaluation, evaluate inpatient and emergency room vascular consultation requests, and participate intimately and extensively in the operative and postoperative care of the inpatient service. In-hospital support includes excellent physician extenders including experienced vascular Nurse Practitioners and Physicians' Assistants. The Hospital and Outpatient Faculty Vascular Clinics have two busy certified Non-Invasive Vascular Laboratories; most of the Vascular Faculty have either RVT (registered vascular technologist), or other appropriate ultrasonography experience and certification.

The trainees have dedicated rotations through the Vascular Laboratory Service, but are also able to participate actively in the performance and evaluation of the studies on a daily basis. Didactic and educational conferences specific to Vascular and Endovascular Surgery are held at least 4 days per week at Tisch Hospital. The Vascular Faculty Suites also include an active and dedicated outpatient Vein Center, whereby trainees gain important experience in the outpatient care, evaluation, and procedural management of patients with varicose veins and venous insufficiency. The Vein Center includes three full time procedure rooms, where a variety of standard outpatient procedures are performed, including endovenous ablation, phlebectomy, and cosmetic sclerotherapy. Finally, the Tisch Hospital rotation includes participation in our Outpatient Vascular Care Center, a dedicated outpatient procedure facility where routine and complex outpatient endovascular procedures are performed, including: arteriography, venography, intravascular ultrasound (IVUS), balloon angioplasty and stenting, and atherectomy procedures. Here, the vascular trainee gains invaluable experience in the performance of these outpatient procedures on appropriately selected patient populations.

Bellevue Hospital Center

Training Site Description

462 First Avenue, New York, NY 10016

Bellevue Hospital Center Bellevue Hospital is the flagship of the New York City public hospitals system, and is a Level I Trauma Center. The patient population is ethnically diverse with large populations of East and South Asians, Eastern European, Hispanic and African American patients. This diverse patient population allows for cultural sensitivity training of our fellows. There are 12 active operating rooms. Bellevue Hospital functions as the premier Vascular and Endovascular referral center for the public hospitals system in New York City, and patients with unusual vascular diagnoses, trauma, or other diagnoses unable to be appropriately managed at other hospitals are frequently transferred to Bellevue for their care. This specifically includes complex aortic diagnoses, including aneurysms and aortic dissections. Additionally, the Bellevue Hospital rotations afford an excellent opportunity for the trainees to gain valuable experience in managing vascular trauma patients with both penetrating and blunt injuries. During their rotations at Bellevue Hospital, vascular trainees are exposed to a wide variety of diverse vascular surgical patients and diagnoses, consistent with a large urban public hospital system. This includes both routine and complex diagnoses, surgeries and endovascular procedures in the following areas: aortic, cerebrovascular, mesenteric / renal, lower extremity, and venous procedures. Because a certain percentage of Bellevue Hospital patients are indigent, trainees are also exposed to unusual end-stage or neglected disease, in patients who unfortunately have not been able to obtain access to routine medical management for vascular disease.

Bellevue hospital has three active Board-Certified Vascular faculty, who perform the majority of the cases here, vascular trainees are intimately involved in the preoperative, operative, and postoperative care of these patients. Trainees see patients in the weekly Vascular Clinic and a weekly Vein Clinic, evaluate outpatients and perform preoperative assessment, planning, and evaluation, evaluate inpatient and emergency room vascular consultation requests, and participate intimately and extensively in the operative and postoperative care of the inpatient service. In the operating room, vascular trainees are afforded an experience of graduated independence, whereby senior trainees can independently perform appropriate vascular surgical and endovascular procedures under the direct supervision of Faculty Attending Staff. In-hospital support includes physician extenders including experienced vascular Nurse Practitioners and Physicians' Assistants. The Hospital has a busy Non-Invasive Vascular Laboratories; most of the Vascular Faculty have either RVT (registered vascular technologist), or other appropriate ultrasonography experience and certification. The trainees are also able to participate actively in the performance and evaluation of the sonographic studies on a daily basis. Didactic and educational conferences specific to Vascular and Endovascular Surgery are held at least 4 days per week at neighboring Tisch Hospital.

Veterans Affair Hospital Manhattan

Training Site Description

423 East 23rd, Street, New York, NY 10010

Manhattan VA Harbor HealthCare System The Manhattan VA Harbor HealthCare System is one of the integrated institutions of the NYU Vascular fellowship. It offers the fellows a wide and excellent spectrum of vascular surgery cases with complex pathology typical of the Veteran population. The Manhattan site is the regional referral site for many of the other surrounding VA facilities which cannot provide complex vascular and endovascular care. During their rotations at the Manhattan VA Harbor HealthCare System vascular trainees are exposed to a wide variety of diverse vascular surgical patients and diagnoses, consistent with a veteran populations with an often significant history of tobacco use. This includes both routine and complex diagnoses, surgeries and endovascular procedures in the following areas: aortic, cerebrovascular, mesenteric / renal, lower extremity, and venous procedures. Because a certain percentage of VA Hospital patients are socioeconomically disadvantaged, trainees are also exposed to unusual end-stage or neglected disease, in patients who unfortunately have not been able to obtain access to routine medical management for vascular disease.

The Manhattan VA Harbor HealthCare System has five active Board-Certified Vascular faculty, who perform the majority of the cases here, vascular trainees are intimately involved in the preoperative, operative, and postoperative care of these patients. Trainees see patients in the weekly Vascular Clinic and a weekly Wound Care Clinic, evaluate outpatients and perform preoperative assessment, planning, and evaluation, evaluate inpatient and emergency room vascular consultation requests, and participate intimately and extensively in the operative and postoperative care of the inpatient service. In the operating room, vascular trainees are afforded an experience of graduated independence, whereby senior trainees can independently perform appropriate vascular surgical and endovascular procedures under the direct supervision of Faculty Attending Staff. In-hospital support includes physician extenders including experienced vascular Nurse Practitioners and Physicians' Assistants. Didactic and educational conferences specific to Vascular and Endovascular Surgery are held at least 4 days per week at neighboring Tisch Hospital.

Advanced Vascular Care, Outpatient

Training Site Description

The Advanced Vascular Care (AVC) site of New York University Langone Medical Center is an outpatient facility tailored towards the elective treatment of vascular pathologies using minimally invasive techniques. The site comprises two rooms with fluoroscopic capabilities, and has a full complement of ancillary staff and nursing with a focus on treating arterial and venous pathologies using endovascular techniques. The patient population at AVC represents a subset of the vascular and endovascular patients from NYU Hospital Center, who require endovascular treatments and who are candidates for undergoing these procedures on an outpatient basis.

During their rotations at AVC, vascular trainees are exposed to the full complement of outpatient elective endovascular treatments, including peripheral arterial, central venous, and arteriovenous access maintenance. The technologies encountered include but are not limited to angiography/venography, balloon angioplasty, stenting, atherectomy, intravascular ultrasound, percutaneous thrombectomy, vena cava filter insertion and retrieval. Active faculty (including 9 full time board certified vascular surgeons), perform a majority of their outpatient elective endovascular interventions at AVC, and vascular trainees are intimately involved in the preoperative, operative, and postoperative care of these patients. As is the paradigm with all NYU outpatients, trainees see patients with the Faculty in the clinics at least once per week, and perform preoperative assessment, planning, and evaluation. In addition, since AVC is integrated into the NYU rotation, didactic and educational conferences specific to Vascular and Endovascular Surgery are attended at least 4 days per week at Tisch Hospital.

Department of Surgery and Division of Vascular Surgery Faculty

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Vascular Surgery Integrated Program Faculty

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Additional Faculty and Services

NYU Tisch/KP Services:	Spencer	Ranson	Vascular	Endo/Onc	MIS
Faculty	H. Leon Pachter Steven Cohen Steven Hofstetter Howard Liang	Paresh Shah Charlene Chao Tanuja Damani Mary Ann Hopkins George Miller Diane Simeone Ted Welling	Glenn Jacobowitz Michael Barfield Todd Berland Neal Cayne Karan Garg Patrick Lamparello Thomas Maldonado Caron Rockman Mikel Sadek	Russell Berman Deborah Axelrod Erica Friedman Amber Guth Karen Hiotis Jennifer Ogilvie Kepal Patel Magdalena Plasilova Daniel Roses Freya Schnabel Richard Shapiro	Christine Ren-Fielding George Fielding Megan Jenkins Marina Kurian Bradley Schwack

ACS	Colorectal	Pediatrics	SICU	Transplant
Charlene Chao Shani Fruchter Christine Malino	Mitchell Bernstein Steven Brandeis Arman Erkan Brian Harlin Marsha Harris Tarik Kirat Rahul Narang Feza Remzi	Howard Ginsburg Jason Fisher Keither Kuenzler Sandra Tomita	Greta Piper Cherisse Berry Michael Klein Leandra Krowsoski	Robert Montgomery Jonathan Berger Nabil Dhager Bruce Gelb Bonnie Lonze Zoe Stewart Anthony Watkins

Bellevue Services:	A - Surgical Oncology	B - General Surgery	Vascular	Trauma	TRACC	Breast/Endo
Faculty	Russell Berman Joe Carter Michael Grieco Ann Lee George Miller	Manish Parikh Patricia Chui Mark Hochberg Julia Park Robert Reader JK Saunders Aku Ude Welcome	Joaney Lugo Karan Garg Mikel Sadek	Spiros Frangos Cherisse Berry Marko Bukur Michael Klein Leandra Krowsoski Manish Tandon	Spiros Frangos Cherisse Berry Marko Bukur Michael Klein Leandra Krowsoski Manish Tandon	Kathie Ann Joseph Erica Friedman Jennifer Ogilvie

VA Services:	General Surgery	Vascular Surgery	Cardiac Surgery
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Training Program Curriculum

Educational Program for Residents in Vascular Surgery Residency

Orientation for New Residents for both General Surgery & Vascular Surgery

The Department has an orientation program for the incoming residents to help them transition from being a medical student to a surgical resident and prepare them for some of the basic tasks they will be expected to perform immediately. The orientation is 2 days before the start of the academic year. For any intern who misses the orientation, the materials are always available through ALEX-online resident portal. The sessions are conducted by both faculty and current residents in the program:

1. How to write notes
2. Communication with Chief residents and Attendings
3. Advanced Care Practitioners (NPs and PAs) and their roles
4. Professionalism- Informed Consent/Bad News
5. R2s - "How to survive your first call"
6. Chief Residents – "What I Expect"
7. R2s – "What I Wish I Had Known"
8. Skills Laboratory Training
 - Knot tying and suturing (basics)
 - OR Etiquette: Hand washing, gowning and gloving
 - Laparoscopic techniques (basics)
 - Critical care overview
9. Clinical Workshop on "How to" do various patient care activities.
 - Discharge a patient
 - Pre-operative patient care
 - Do post-operative patient care

Surgical Skills Training Courses for All Resident Levels- runs throughout the year with available make up sessions

R1 Curriculum

- Instrument handling and identification
- Suture characteristics, knot tying and suturing
- Introduction to the Critical Care Patient
- Airway Management
- Central Venous Line Catheters
- Surgical Airway
- Surgical Planning, Informed Consent & Decision Making
- Surgical Techniques, Drains, Ties, Dissection
- Laparoscopic Skills I
- Laparoscopic Skills II (Complication Avoidance)
- Abdominal Closure
- Conscious Sedation & Bedside Anesthesia
- Surgical Stapling
- Principles of Cautery & Electro-Surgery

- Principles of Surgical Ultrasound
- Trauma Simulation Exercises (SimMan)

R2 Curriculum

- Laparoscopic Appendectomy
- Laparoscopic Cholecystectomy
- Bowel Anastomosis I (hand sewn)
- Bowel Anastomosis II (stapled / left colon)
- Vascular Suture Techniques (basics)

R3 Curriculum

- Bowel Anastomosis
- Vascular Suture – End to End, End to side anastomosis, Grafts and veins
- G.I. Endoscopy Simulator – Upper and lower G.I. simulation modules
- Laparoscopic Suturing
- Breast Ultrasound and Needle Biopsy
- Laparoscopic Animal Lab
- SimMan Trauma Exercises

R4/R5 Curriculum

- Laparoscopic Suturing
- Ranson Pancreatic Sumps - Indications and assembly (even years)
- Abdominal Closure theory, technique and understanding: Understanding Suture & Needle Choices
- Bowel Anastomosis – sewn
- Vascular suturing
- Interventional Vascular – understanding equipment
- Interventional Vascular Simulator
- SimMan Trauma Exercises
- Laparoscopic Animal Lab - optional
 - Nissen Fundoplication
 - Colon Resection
 - Solid organ resection
 - Nephrectomy

Advanced Trauma Operative Management (ATOM) Course for ALL R4s- runs throughout the year

Our trauma team teaches the advanced trauma operative management course to all R4s to prepare them for their trauma rotation as R5s. The residents get to learn about trauma management issues using live animal models and practice surgical intervention for acute trauma. The course is held at Montefiore Hospital's animal lab using pig cadavers.

Advanced Surgical Skills for Exposure in Trauma (ASSET) Course for ALL R2s, R3s and R4s in May each year

The Department of Surgery gets 4 cadaver bodies for 2 days of skills sessions. Dr. Chad Wilson and his team of attendings lead the advanced surgical skills courses for R2s and R3s and R4s.

R2s: Chest tube and cricothyrotomy

R3s: Vascular exposure-Graft including femoral exposure interposition graft, Aorta/branches/iliacs tube graft and SMA exposure-renal artery.

R3s: General surgery procedures include upper GI-Esophagus and Stomach, Colorectal, Hepatobiliary-porta hepatic dissection and Pancreatic Gastro Colic ligament

R4s: Trauma Exposure for Neck, Chest, Upper and lower extremities and Abdomen/Pelvis exposure.

Professionalism (SPICE) Curriculum- runs throughout the year - The Department of Surgery has a robust curriculum on professionalism and interpersonal communications. Below is our resident curriculum for 2013-2014. We inaugurated this curriculum five years ago and have improved and refined these interactive seminars each year. To test these competencies, we instituted annual OSCE (Objective Structured Clinical Examinations) with specially trained actors for our surgical resident learners.

The six interactive, small group sessions are centered on the following topics:

- Medical Malpractice and the Surgeon
- Admitting Mistakes: Ethical and Communication Issues –Error Reporting
- Delivering Bad News: Your Chance to Become a Master Surgeon
- Interdisciplinary Respect: Team Communication
- Working Across Language and Cultures: The Case for Informed Consent
- Self Care and the Stress of Surgical Practice

Patient Safety and Quality Improvement Curriculum

A Patient Safety and Quality Improvement curriculum was designed for all residents rotating on General Surgical service with a One hour conference every other month, led by an attending facilitator. The conference includes a presentation and discussion of the literature pertaining to each safety issue listed below. This is followed by a review of NYU-specific data and comparison to the national data. Attendees conclude with a review of the hospital's policy for each safety issue and a discussion of what can be done at the resident level to improve patient safety and outcome. This curriculum will meet the following goals:

- Competency in Practice Based Learning
- Competency in Systems Based Practice
- Better understand the current health care environment and the roles of the major players (i.e., governmental and non-governmental agencies, hospitals, professional societies and advocacy groups) that shape the practice of medicine
- Be familiar with quality and safety literature
- Learn how to create evidence-based practice guidelines to improve patient safety and outcomes for the hospital as well as our own personal practices

Curriculum includes:

- Overall review of the current health care environment including policy, reimbursement, safety initiatives and measures
- DVT prophylaxis
- Postoperative UTI
- Postoperative wound infection/wound protective devices

- Ultrasound guided CVL placement
- Postoperative confusion/hospital delirium

Team-Training Curriculum

Crisis Management simulation training exercise – a team of residents (R5, R3 and 2 R1s) go through a 15 min simulated patient encounter where the patient is sick and the symptoms are difficult to manage. Residents have to communicate effectively with all parties involved and sign-out to a member of the team at the end of the scenario. We have 2 such exercises in the Simulation Center each month. The goal of this exercise is team-building, effective communication and proper sign-out/transfer of information.

Fundamentals of Surgery for Interns

The *ACS Fundamentals of Surgery Curriculum*[™] is a highly interactive, case-based, online curriculum that addresses the essential content areas that all surgical residents need to master in the early years of training. Developed by the American College of Surgeons Division of Education, the curriculum includes more than 90 simulated case scenarios in which residents are asked to recognize and assess symptoms and signs, order appropriate tests and procedures, evaluate data, and initiate appropriate actions.

The *ACS Fundamentals of Surgery Curriculum* virtual environment:

- builds learner confidence within the safety of a virtual environment
- provides the same learning opportunities for all residents
- emphasizes critical thinking skills
- supplements current educational programs
- is available 24/7 through any computer with Internet access
- provides tools for program directors to track resident progress

Evidence Based Reviews- The Chief Residents run the evidence based review curriculum which is designed by University of Toronto and adopted by American College of Surgeons (ACS). Each academic year there are 7-8 review topics released by the ACS. One chief resident reviews the articles and questions associated with the topic and presents it to the rest of the general surgery and vascular surgery residents on a Wednesday morning core curriculum time.

Training Program Block Schedule

Block Schedule for the NYU Vascular 0+5 Integrated Program

The Block Schedule reflects thirteen four week rotations per academic year (July 1st-June 30th).

Twelve of the four week rotations blocks are for services and one four week rotation block is for vacation.

PGY 1

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1		Site 1	Site 2	Site 2	Site 2	Site 2	Site 2	Site 3	Site 3
Rotation Name	Vasc	Gen Surg	MIS	Endo/Onc	Vacation	Vasc	Trauma	Gen Surg	Surg/Onc	Vasc	TRACC	Gen Surg	Gen Surg
% Outpatient	20	20	20	20		20	20	20	20	20	20	20	20
% Research	0	0	0	0		0	0	0	0	0	0	0	0

PGY 2

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1		Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 3	Site 3
Rotation Name	Vasc	Vacation	Gen Surg	Vasc	Gen Surg	SICU	Gen Surg	Endo/Onc	NF/Endo/Onc	Peds	Gen Surg	Gen Surg	Vasc
% Outpatient	20		30	20	20	0	20	20	20	20	20	20	20
% Research	0		0	0	0	0	0	0	0	0	0	0	0

PGY 3

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 2	Site 2		Site 2	Site 3	Site 3	Site 3
Rotation Name	Vasc	Vasc	Vasc	Vasc	Trauma	Gen Surg	Gen Surg	Vasc	Vacation	Gen Surg	Vasc	Vasc	Gen Surg
% Outpatient	20	20	20	20	20	20	20	20		20	20	20	30
% Research	0	0	0	0	0	0	0	0		0	0	0	0

PGY 4

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 3		Site 3	Site 3
Rotation Name	Vasc Lab	Vasc Lab	Gen Surg	Vasc	Vasc	Vasc	Vasc	Vasc	Vasc	Vasc	Vacation	Vasc	Vasc
% Outpatient	80	80	30	20	20	20	20	20	20	20		20	20
% Research	0	0	0	5	0	0	0	10	0	0		10	0

PGY 5 - Chief

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1		Site 2	Site 2	Site 2	Site 2	Site 3	Site 3	Site 3	Site
Rotation Name	Vasc	Vasc	Vasc	Vasc	Vacation	Vasc	Vasc	Vasc	Vasc	Vasc	Vasc	Vasc	Vasc
% Outpatient	20	20	20	20		20	20	20	20	20	20	20	20
% Research	0	0	5	0	0	10	0	0	0	0	10	0	0

Hopital Sites

- Site 1-Tisch Hospital
- Site 2-Bellevue Hospital
- Site 3-Manhattan VA Hospital

Services

- CV-Cardiovascular Surgical Services
- ENDO/ONC-Endocrine/Oncology
- GEN SURG-General Surgery Services
- MIS-Minimally Invasive Surgery
- PEDS-Pediatric Surgery
- VASC-Vascular Surgical Services

Conferences

Annual UCLA Symposium (Moore Course)

www.cme.ucla.edu

This is a 4-day course which provides an in-depth, comprehensive, and current review of vascular and endovascular surgery, and it is co-sponsored by the Society for Vascular Surgery. It covers four significant categories of topics including open surgery, endovascular procedures, medical management and diagnostic and non-invasive imaging. It is particularly useful for those taking the vascular board examination, and therefore the 5th year integrated resident is to attend this course.

Veith Symposium

www.veithsymposium.org

The Veith Symposium is a 5-day annual vascular event that represents the most cutting edge, comprehensive, and possibly the most well-attended meeting in the field of vascular surgery. It is setup in a series of 5-minute rapid-fire presentations that run the full successively the full duration of each day. It is geared towards all practitioners involved with vascular surgeries, procedures or interventions. It is also run by Dr. Frank Veith, who is on faculty at the NYU School of Medicine and is contributed to heavily by the NYU Vascular Surgery Faculty. All vascular residents are required to attend at least one day of the meeting, at during each year of their training.

Society for Vascular Surgery, Eastern Vascular Society, Society for Clinical Vascular Surgery, etc.

www.easternvascular.org

There are numerous opportunities for the vascular residents to attend one of the many other vascular meetings. These additional opportunities will be granted on an individual basis with priority given based on seniority and to those individuals who have abstracts/papers that are accepted to the meeting.

Didactics

Monday

- **NYU Kimmel**
 - 7-8a – Vascular Surgery Teaching Rounds
 - All Vascular teams from NYU, BH, VA
 - 7-8a – General Surgery/Endo Onc Teaching Rounds
 - Ranson, Spencer, MIS, ACS, and Endo/onc services
 - 7-8a – Colorectal Surgery Core Didactic Lecture
- **Bellevue Hospital Center**
 - 7-8a – General Surgery Teaching Rounds
 - 7:30-9a – Surgical Oncology Tumor Board
 - 7:30-9a- Breast Surgery Tumor Board
 - 7-8a – Vascular Surgery Teaching Rounds
 - All Vascular teams from NYU, BH, VA
- **VA Hospital**
 - 7:30-9A – Surgical Oncology Tumor Board
 - 7-8a – Vascular Surgery Teaching Rounds
 - All Vascular teams from NYU, BH, VA

Tuesday

- **NYU Kimmel**
 - 7-8:30a – Vascular Surgery Core Didactic Conference
 - All Vascular teams from NYU, BH, VA
 - 7-8a – Colorectal Core Conference (M&M, Journal Club, Case Conference)
 - 7-8:30a – General Surgery Teaching Conference
 - Resident Presentation Conference, Hernia Conference, Pancreas Conference (Sept – June only)
- **Bellevue Hospital Center**
 - 7-8:30a – Vascular Surgery Core Didactic Conference
 - All Vascular teams from NYU, BH, VA
- **VA Hospital**
 - 7-8:30a – Vascular Surgery Core Didactic Conference
 - All Vascular teams from NYU, BH, VA

Wednesday

- **NYU Kimmel**
 - 7-7:45a – Core General Surgery SCORE Conference
 - All surgery residents
 - 7-8a – Summer Skills Lab Sessions by class (R1, R2, R3, R4, R5) (July-Aug only)
 - 7-8a – Grand Rounds (monthly)
 - All surgery residents
- **Bellevue Hospital Center**
 - 7-7:45a – Core General Surgery SCORE Conference
 - All surgery residents
 - 7-8a – Summer Skills Lab Sessions by class (R1, R2, R3, R4, R5) (July-Aug only)
 - 8-1pm – General Surgery Academic Day
 - 7-8a – Grand Rounds (monthly)
 - All surgery residents

- **VA Hospital**
 - 7-7:45a – Core General Surgery SCORE Conference
 - All surgery residents
 - 7-8a – Summer Skills Lab Sessions by class (R1, R2, R3, R4, R5) (July-Aug only)
 - 7-8a – Grand Rounds (monthly)
 - All surgery residents

Thursday

- **NYU Kimmel**
 - 7-8a – M&M Conference
- **Bellevue Hospital Center**
 - 7-8a – M&M Conference
 - 8-1pm – Surgical Oncology Academic Day
 - 8-1p – Trauma and SICU Academic Day
- **VA Hospital**
 - 7-8a – M&M Conference
 - 8-1pm – General Surgery Academic Day

Friday

- **NYU Kimmel**
 - 7-7:30a – Vascular Surgery Teaching Rounds
 - All Vascular teams from NYU, BH, VA
 - 7-8a – Summer Skills Lab Sessions by class (R1, R2, R3, R4, R5) (July-Aug only)
 - 7-8a – R5 Chief Resident Oral Board Prep (Feb-June only)
- **Bellevue Hospital Center**
 - 7-7:30a – Vascular Surgery Teaching Rounds
 - All Vascular teams from NYU, BH, VA
 - 7-8a – R5 Chief Resident Oral Board Prep (Feb-June only)
 - 8-9a – Trauma Lecture Series
- **VA Hospital**
 - 7-7:30a – Vascular Surgery Teaching Rounds
 - All Vascular teams from NYU, BH, VA
 - 7-8a – R5 Chief Resident Oral Board Prep (Feb-June only)

All Conference attendance is mandatory. The ACGME requirement for resident conference attendance is 75%.

Goals & Objectives – Overall

NYU Langone Medical Center The Division of Vascular and Endovascular Surgery 0+5 Integrated Residency Goals and Objectives

Over the 5-year training period, the vascular residents will spend a total of 36 months in vascular surgery at NYU Langone Medical Center. During each rotation, a chief resident (PGY5), senior level vascular residents PGY4, will be assigned to the surgical service responsible for running the particular service with the assistance of the senior resident. The team will additionally train mid and junior level general and vascular surgery residents supervised by board certified vascular surgeons. Major reconstructive surgeries and procedures are performed on the service each year. The spectrum of procedures includes stent-graft repairs of the thoracic and abdominal aortic aneurysms done, hybrid procedures of the aorta, and the more traditional conventional open aortic repairs. Open surgical procedures include peripheral revascularization, carotid endarterectomy and dialysis access. Within the operative suites, in addition to the vascular interventional suite are a variety of angiograms, venograms and endovascular procedures. Each resident will have ample opportunity in the operating room to become facile with the use of portable fluoroscopic imaging as all of the attending staff utilizes this equipment for the performance and evaluation of their operative cases.

The service is staffed by at least 11 attending surgeons. The spectrum of residents from junior to chief will insure appropriate responsibility for inpatient care and operative management for both the vascular and general surgery house-staff. Resident purposes while ensuring compliance with work hour regulations.

Outpatient activities comprise an important part of the surgical services rotations. When assigned to VS, residents will spend one day a week in office faculty members in the outpatient offices which includes care for a culturally and socioeconomically diverse population in the outpatient setting. The vascular resident assigned to the outpatient offices will also participate with the Vascular/Wound Care clinics in conjunction with general surgery residents. The residents, supervised by both a vascular surgeon and/or a general surgery surgeon not only see a wide variety of arterial and venous disease in this clinic, but also learn the basic principles of modern wound care. During the resident participation in the outpatient offices or Wound Care Clinic, he or she is expected to play a significant role in the determination of confirmation of the diagnosis and provision of appropriate pre- and post-care services.

Vascular Surgery Service Goals & Objectives

In addition to the Educational Goals & Objectives for Vascular Surgery, the following are the specific goals and objectives that pertain to this service.

Patient Care:

PGY1:

- Demonstrate effective patient history taking and physical examination.
- Clearly present patient information on rounds and in conferences.

- Demonstrate the technical skills required to perform basic surgical procedures under-supervision including amputation, varicose vein excision and femoral artery exposure.
- Demonstrate responsibility for the care of inpatients (exclusive of intensive care patients) on the vascular service, with faculty and senior resident supervision.
- Demonstrate appropriate initial evaluation of outpatients with vascular disease including plans for initial diagnostic evaluation.

PGY2:

- Demonstrate expertise with procedures learned during the previous year.
- Demonstrate responsibility for the care of vascular patients in the intensive care units.
- Perform under supervision operations including arteriovenous access procedures, lower extremity arterial exposure, vein graft anastomosis, carotid artery exposure and assistance on abdominal vascular operations.
- Demonstrate appropriate evaluation of outpatients with vascular disease, including plans for diagnostic evaluation and initial therapeutic planning.
- Demonstrate proficiency in placing percutaneous arterial and central venous catheters.

PGY3:

- Demonstrate expertise with procedures learned during the previous year.
- Perform under supervision inpatient consultations for other services.
- Perform under supervision operations including lower extremity bypass, carotid endarterectomy, exposure of the abdominal aorta through trans- and retroperitoneal exposure, and endovascular aortic and iliac artery aneurysm repair.
- Demonstrate thorough evaluation of outpatients with vascular disease, including diagnostic and therapeutic planning.

PGY4

- Demonstrate expertise with procedures learned during the previous year.
- Take chief resident responsibility for supervising junior residents in the management of patients on the inpatient vascular service.
- Perform under supervision operations including open abdominal aorta aneurysm repair, upper extremity bypass, direct cervical brachiocephalic reconstruction, extra-anatomic bypass, endovascular repair of thoracic aortic pathology, and exposure for thoracic and thoracoabdominal aneurysm.
- Demonstrate complete evaluation of outpatients with vascular disease, including diagnostic and therapeutic planning with minimal faculty supervision.

PGY5:

- Demonstrate the technical skills required to perform all major fundamental and complex vascular procedures, including endovascular as well as traditional surgery.

- Demonstrate competence in the application of clinical and basic science knowledge to make sound pre-operative and intra-operative decisions and to deal with unexpected findings or developments in the operating room independently.
- Perform under supervision complex vascular operations including thoracoabdominal aneurysm repair, excision and replacement of infected bypass grafts, redo carotid endarterectomy, carotid body tumor excision, renal and mesenteric artery bypass and redo abdominal aortic surgery
- Take chief resident responsibility for supervising residents in the management of all patients on the inpatient vascular service.
- Instruct junior residents in basic open operations.
- Provide safe and competent post-operative care including the timely recognition and treatment of surgical complications.
- Independently manage complex vascular patients with minimal faculty supervision in both the outpatient and inpatient setting

Medical Knowledge:

PGY1:

- Learn basic concepts concerning arterial occlusive and aneurysmal disease and venous thrombosis and insufficiency.

PGY2:

- Begin to understand the fundamentals of basic and clinical science as applied to the practice of clinical vascular surgery.
- Acquire detailed knowledge concerning arterial occlusive and aneurysmal disease and venous thrombosis and insufficiency.

PGY3:

- Demonstrate basic knowledge concerning less common arterial, venous and lymphatic disease processes, including diagnosis and treatment options.
- Demonstrate the fundamentals of basic and clinical science as applied to the practice of clinical vascular surgery.

PGY4:

- Demonstrate basic knowledge concerning less common arterial, venous and lymphatic disease processes, including diagnosis and treatment options.

PGY5:

- Demonstrate detailed knowledge concerning all arterial, venous and lymphatic disease processes, including diagnosis and treatment options, using interventional, open and medical management techniques.

- Be knowledgeable about the educational and scholarly activities of vascular surgery by having assumed responsibility for teaching and supervising surgical residents and medical students.

Professionalism

PGY 1 & 2:

- The vascular resident will be expected to adhere to the NYU Langone Medical Center code of conduct. Maintain a professional demeanor, behavior, and always wear appropriate attire. The program will foster a culture of altruism in patient care and use of discretion in private and public communications. Compassionate care while providing privacy and dignity that is a right of all patients. The vascular resident will be expected to maintain an excellent work ethic as well as integrity. Efficient time management, completion of medical records and a punctual attendance at all of the required didactic sessions. The resident will also be free of illicit and illegal substances.

PGY 3 & 4:

- In addition to the goals mentioned for the first two years which remain in effect the vascular residents are expected to be a role model for medical students, and display a constant degree of professional behavior during their intensive patient interaction during this year. The same applies to interaction with colleagues and co-workers.

PGY5:

- In addition to the goals mentioned previously which remain in effect, the vascular resident will be expected to lead by example in the chief year and be role models for medical students and junior residents alike. They must display a constant degree of professional behavior during their daily routine as well as address patients' concerns with dignity and respect, avoid using any abusive language, and dress appropriately for the professional occasion. They must learn to avoid inadvertently disclosing private health information.

Interpersonal and Communication Skills

PGY 1 & 2

- Know how to communicate with patients and their families regarding surgical procedures and medical status of the patient
- Participate actively in the process of obtaining informed consent.
- Inform patients and their families of the risks and benefits of the procedure.
- Interact with hospital staff, peers and attending in a collegial, professional manner.
- Actively participate in the education of medical student and junior residents.
- Participate in discussions and resolution of ethical issues that affect patient care

PGY 3 & 4

- In addition to the goals mentioned for the first two years, which remain in effect, the vascular resident is also expected to develop certain teaching and effective presentation skills, in the form of case presentations on rounds, at conferences and for visiting professors. They will be expected to communicate patient information effectively for proper decision making by their supervisors

PGY 5

- In addition to the goals previously mentioned which remain in effect, the vascular resident is also expected to develop certain teaching and effective presentation skills during the period of residency, in the form of lectures or discussions of various vascular topics, to a variety of audiences including medical students, residents and physicians at teaching rounds, conferences, grand rounds or local postgraduate courses. It is hoped that the resident will also be able to present nationally at least once during the last two years of the residency. In their more senior levels, they are expected to lead the service and coordinate flow of information from the more junior residents to the attending staff level effectively.

Practice Based Learning

PGY 1 & 2

- Learn to utilize a variety of educational resources to examine and improve their patient care practices based on scientific evidence.
- Attend and actively participate in department and team conferences where they learn how to critically review the current literature.
- Actively participate, as feasible, in retrospective studies to examine practice patterns in the institution.
- Become familiar with the concept of quality improvement
- Take opportunity of attending morbidity and mortality cardiovascular conference held once a month and participate in programmatic review of adverse effects including complications in the catheterization laboratory or in the intensive care units when evaluating cardiovascular patients. Effectively use technology to manage information for patient care and self-improvement.

PGY 3 & 4

- In addition to the goals mentioned for the first two years, which remain in effect, the trainees are expected during this year to participate in all vascular morbidity and mortality conferences and develop an understanding of risk factors for complications. They are also expected to develop critical skills in evaluating published research and how it impacts clinical decision-making.

PGY 5:

- In addition to the goals mentioned before which remain in effect, the vascular resident will be expected to participate actively in the Mortality and Morbidity conferences helping in analysis of complications and errors as well as implementing corrective actions reached at these conferences. They must demonstrate an understanding of quality control and continuous improvement processes for vascular care. They are also expected to develop critical skills in basic and clinic research in vascular diseases. During these two years, mostly during the PGY-4 year, the vascular resident is expected to become familiar with the methodology used for both retrospective and prospective investigations, statistical analysis of data, methods of funding research and writing of abstracts and manuscripts. The resident is also expected during this phase of training to learn the basics of laboratory investigation and show an understanding of the concepts being investigated in the division laboratory. It is hoped that each trainee will be able to complete and publish at least one peer review research project during this residency period.

System Based Practice

PGY 1 & 2

- The vascular resident will utilize resources, such as social services, home health care, outpatient services, etc, for effective discharge planning.
- They participate in cost-benefit analysis of workup and treatment options, and participate in the development of a cost-effective patient management plan.
- They are expected to apply the appropriate documentation needed for coding and billing, as well as participate in appropriate discharge summaries.
- The residents will describe and apply the principles of clinical research and use the medical record appropriately.
- They are to participate in patient safety practices such as weekly institutional patient safety rounds, comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) patient safety standards.
- They will assist in assuring the accuracy of patient identification; effectively communicate with the various caregivers.
- They should cooperate in eliminating wrong-site, wrong-patient, wrong procedure surgery using a time-out in operative and bedside procedures, and reducing the risk of health care-acquired infections. They are all expected to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding patient privacy and confidentiality.

PGY 3 & 4

- In addition to the goals mentioned for the first two years which remain in effect, the resident is also expected to learn the expeditious and effective provision of consultation to other services and the interaction with other providers of care to the patients. They will be expected to demonstrate appropriate discharge planning and placement decisions.

They should also become competent with the retrieval of all necessary medical information for the management of their patients.

PGY 5:

- In addition to the goals mentioned before which remain in effect, the vascular resident will be expected to lead the team in planning treatment, admissions, transfers and discharges teaching junior members the proper procedures for functioning appropriately within the established system of care. They must be expert at all the electronic resources for patient care. A thorough understanding of insurance guidelines, billings and patient responsibilities and financial burden are expected. The resident should also achieve an understanding of risk benefit ratios for various interventions both in terms of complications, expected benefits, quality of life and financial costs to the health care system, the patient and society.

Goals & Objectives – By Site, Rotation & Clinical year

NYU School of Medicine

Department of Surgery

NIGHT FLOAT

Tisch Hospital and Bellevue Hospital Center

SENIOR RESIDENT

GOALS & OBJECTIVES

Overall Objective: The Night Float team covers all of the in-house general surgery, vascular, pediatric surgery and critical care patients after hours (1900h – 0700h) Sunday through Thursday. They are responsible for admitting and stabilizing general surgery admissions and consults after hours and participating in operative surgery as necessary.

The resident team will include a Chief (5th year) and consult (3rd year) at Bellevue. The resident team will include a senior (4th year) and mid-level (2nd year) at Tisch. All residents will participate in weekly residents' conferences, monthly Grand rounds and weekly departmental M&M conferences.

Competencies: Each core competency will be assessed by nightly interactions with general surgery, vascular, pediatric surgery, and critical care faculty, and through participation in weekly resident conferences, Department of Surgery M&M conferences and monthly written faculty, resident, and ancillary staff evaluations.

1) Medical Knowledge

- Demonstrate ability to provide timely surgical assessment and operative management of the patients with acute and non-acute general surgical problems.
- Knowledge of the indications for surgical intervention in acute or elective general surgery diagnoses and the indications for operative or nonoperative management.
- Systematically evaluate, intervene, and appropriately prioritize the workup of a surgical patient
- Exhibit extensive knowledge in surgical infections, complications of acute surgical disease, and complex surgical management.
- Demonstrate familiarity with surgical literature
- Demonstrate ability to formulate and implement a diagnostic and treatment plan for critically ill patients
- Demonstrate an understanding of the pathophysiologic effect of surgical diseases

Must relate basic medical knowledge to patient care. Residents must critically evaluate and demonstrate knowledge of pertinent scientific information.

- Analyze and present complications
- Exhibit knowledge base sufficient to teach junior level residents and students
- Demonstrate ability to interpret all radiologic studies obtained in the evaluation of the general surgery patient
- Identify the indications for emergency operative procedures such as emergent vascular access, needle and tube thoracostomy, and cricothyroidotomy

2) Patient Care

- Timely evaluation of in-house general surgery patients and patients in need of surgical consultation.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences
- Discuss the management and implications of associated medical conditions as it relates to the surgical issues
- Maintain open communication with the attending physician regarding the patient status and care plan.
- Communicate effectively with patient and families regarding disease, surgical procedure, outcomes, predicted hospital stay and need for rehabilitation
- Communicate effectively with the day teams and on-call staff about patient problems and issues
- Demonstrate ability to prioritize acuity of patients and consults and involve appropriate back-up resources
- The Senior resident will be expected to demonstrate technical skills including:
 1. Demonstrates mastery in the basic exploratory laparotomy, exposures and management of common intra-abdominal pathology
 2. Demonstrates competence in complex surgical procedures and is able to assist attending staff with complex surgical procedures.
 3. Demonstrates an understanding of the benefits and limitations of operative surgical techniques.
 4. Demonstrates the ability to proceed through various steps of caring for the critically ill patient in a manner that is consistent with the flow of the operation

3) Practice Based Learning and Improvement

- Investigates and evaluates patient care practices
- Analyzes practice experience using a systematic methodology.
- Locates, appraises, and assimilates evidence from scientific studies related to their patient's diagnoses.
- Applies knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Performs practice-based improvement activities using a systematic methodology
- Uses information technology to manage information, access on-line medical information, and support his/her own education.
- Facilitates the learning of junior level residents and students.

- Demonstrates the ability to analyze personal practice outcomes to improve patient care.
- Discuss the value of an interdisciplinary approach to health care for the critically ill general surgery or trauma patient.

4) Interpersonal and Communication Skills

- Demonstrates skill and sensitivity for appropriate counseling and educating patients and their families
- Creates and sustains appropriate doctor-patient relationships with patients and families.
- Works effectively with others as a leader of the health care team and/or other professional groups.
- Effectively and promptly documents practice activities.
- Communicate effectively and courteously with teams requesting consultation about findings and plan of care
- Presents all patients and conference material in a concise, organized, chronologic, logical and knowledgeable manner.
- Utilizes input from all collaborative interactions with all personnel contributing to the surgical patient care.
- Contribute via effective teaching and example to the educational efforts of the surgical residency.
- Evaluates the performance and competence of all members of the surgical residency team.

5) Professionalism

- Demonstrates respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and on-going professional development.
- Demonstrates a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Demonstrates sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
- Exhibits professionalism through timely completion of required administrative responsibilities (evaluations, recording hours, chart documentation, medical record dictations, etc.).
- Demonstrate accountability for actions and decisions.

6) Systems-Based Practice

- Understands how patient care and other professional practices affect other health care professionals, the health care organization, and the larger society. Understand how these elements of the system affect their own practice.
- Knows how types of medical practice and delivery systems differ from one another, including methods and controlling health care costs and allocating resources.

- Practices cost-effective health care and resource allocation that does not compromise quality of care.
- Advocates for quality patient care and assist patients in dealing with system complexities.
- Partner with health care managers and health care providers to assess, coordinate, and improve health care and understands how these activities can affect system performance.
- Demonstrate knowledge of and the ability to manage a variety of healthcare services for trauma patients such as emergency room, operating room and intensive care unit.

Supervision of Residents

1. The supervising attending will provide direct supervision to the residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the residents or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
6. Direct supervision by an Attending surgeon, R5,R4,R3 and R2 morning rounds
7. Direct supervision by R5, R4, R3, and R2 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
8. Direct supervision by an Attending surgeon, R5, R4, R3, R2 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

**Department of Surgery
Surgical Oncology at Tisch Hospital
Rotation Goals and Objectives**

Summary:

The Surgical Oncology service provides the surgical resident (R4, R2 and R1) with an in-depth understanding of the multidisciplinary nature of oncologic care with a focused experience with the surgical approach to patients with cancer. The residents will understand the role that surgery plays in both curative and palliative care of the cancer patient and recognize how surgery fits into multimodality care of these patients along with chemotherapy, radiation therapy, and other biologic or immunologic therapies. There is an emphasis on neoplasm of the skin and soft tissues, breast, and endocrine system. Education in gastrointestinal tract malignancies is also part of the General Surgery rotation. These goals and objectives include clinical experience in both the outpatient and inpatient setting and are competency based. For the competency of Patient Care, the goals and objectives are specified by resident year.

Competency-Based Goals and Objectives for Surgical Oncology Service

Rotation: NYU Langone Medical Center, Tisch Hospital

Length: 4 weeks

Goals for the R1 on Surgical Oncology Service

The goals for this rotation are for the R1 to gain broad exposure to cancer patients, to perform a thorough cancer evaluation, to begin to integrate what factors go into determining the appropriate use of surgery in the oncologic patient (including when surgery is not appropriate), to start to develop an understanding of the multidisciplinary nature of cancer care, and to understand the complete care of the cancer patient (including clinical care, social support groups, palliative care, reconstructive procedures, genetic counseling).

PATIENT CARE:

Objectives for the R1 on Surgical Oncology

Patient Assessment, History and Physical

1. Perform of a complete and thorough history and physical examination as it pertains to the cancer patient.
 - a. Become adept at reviewing medical records and reports, including electronic and digital records
 - b. Become adept at obtaining family history and personal risk factor assessment
2. Integrate diagnostic laboratory and imaging studies into the patient evaluation and diagnostic process.
 - a. Develop an appreciation for the correct utilization and interpretation of diagnostic imaging and laboratory tests in the staging and post-treatment surveillance of the cancer patient.
3. Develop and identify a differential diagnosis and treatment plan for the new cancer patient, or for a new problem that develops in an established surgical oncology patient.
4. Perform review of medications taken at home versus in the hospital as part of the medication reconciliation process.
5. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families. Demonstrate sensitivity to the impact that a cancer diagnosis has on both the patient and their family members.

Documentation

6. Perform accurate, complete, legible documentation of the history, physical examination, differential diagnosis and proposed treatment plan.
 - a. Begin to demonstrate ability to stage all patients with solid tumors according to the AJCC staging manual.
7. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes, operative notes.
8. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.
 - a. Demonstrate an understanding of the benefit of health care proxies, hospice services, social work services, national and local support group services, and home care services including home hospice.

Patient Care and Management

9. Perform basic clinical care skills including phlebotomy, intravenous access, nasogastric tube placement, urinary catheterization.
10. Develop efficient and accurate methods to collect relevant data for rounds.
11. Respond to and learn to manage changes in patient status/emergencies that may occur in the non-intensive care unit cancer patient, including :
 - a. Cardiac
 - Cardiac arrhythmias
 - Myocardial infarctions
 - Hemodynamic instability
 - Electrocardiogram changes
 - b. Neurologic
 - Mental status changes
 - Knowledge of when and how to activate stroke emergency response team
 - c. Fever, Infection, Sepsis
 - Workup of fever in the postoperative and non-operative setting
 - Interpretation of culture and sensitivity results
 - Understand the antibiotic resistance profile in the hospital
 - Understand universal precautions
 - Understand the importance of hand washing and prevention of nosocomial infections
 - Basics of full barrier precautions and sterile technique
 - Understand impact of C. difficile on surgical patient
 - Recognize onset of sepsis and initiate care
 - d. Fluids and Electrolytes
 - Intravenous fluid management including replacement and maintenance
 - Recognize acid base disorders and management options
 - Electrolyte replacement
 - Enteral and parenteral nutritional support
 - e. Tumor lysis syndrome
12. Demonstrate understanding of timing of surgery, chemotherapy, hormonal therapy, and radiation therapy and the appropriate timing of each.
 - a. Adjuvant therapy
 - b. Neoadjuvant therapy
13. Participate in Practice-based learning and improvement mechanisms.
14. Obtain an understanding of Systems-based practice, particularly in the hospital setting.
 - a. Develop improved communication and transfer of information skills between housestaff and physicians assistants and nurse practitioners.

b. Develop improved team-building skills

Perioperative Care and Risk Assessment

15. Identify complications relating to preoperative, operative, postoperative, and non-operative (e.g. percutaneous ablation) interventions, including tumor lysis syndrome.
16. Recognize of how complications impact upon the treatment plan and to identify the corrective actions necessary to obtain optimal overall patient outcomes.
 - a. Recognize how surgical complications impact upon deliverance of chemotherapy and radiation therapy
 - b. Recognize how complications of chemotherapy and radiation therapy impact upon surgical intervention.
17. Perform preoperative cardiac risk assessment and venous thromboprophylaxis risk assessment.
18. Write postoperative orders, perform postoperative checks.

Operative Skills

19. Obtain the understanding of the pathophysiology and surgical anatomy of the breast, axilla, inguinal region, regional nodes of the head and neck, thyroid and parathyroid glands and neoplastic disease of the gastrointestinal tract and soft tissues.

Demonstrate an understanding of the reconstructive surgery options (including risks and benefits), especially for breast cancer patients.
20. Develop the intraoperative surgical skills necessary for effective surgical control of cancer, including the basics of sterile technique, suturing, knot tying, tissue handling, and knowledge of common surgical instrument names.
21. Develop knowledge of surgical site markings and the time out process.
22. Develop knowledge of surgical patient positioning and skin preparation.
23. Understand and develop the skill for the basics of hemostasis.
24. Develop the skills necessary to be an effective first assistant
25. Develop skills of surgical wound management
 - Infection versus inflammatory reaction
 - Abscess versus sterile fluid collection (seroma or hematoma)
 - Wound packing, Vacuum Assisted Closure dressing,
 - Recognition of wound dehiscence, evisceration
26. Develop skills in intraoperative lymphatic mapping and ultrasound techniques.

Radiographic Interpretation

27. Recognize common plain radiographic findings in surgical patients including pneumonias, pleural effusions, pneumothorax, free intraperitoneal air, small bowel obstruction.
28. Develop interpretation skills for CT scans and MRIs.
29. Develop interpretation skills for lymphoscintigraphy for sentinel node mapping and PET/CT for staging and surveillance.

Outpatient Patient Care- A minimum of one half day per week is mandatory

30. Perform an outpatient comprehensive history, physical, and evaluation of the cancer patient in an office-based setting.
31. Evaluate and manage outpatient surgical oncology patients with particular attention to the interdisciplinary nature of cancer management (medical oncology, radiation oncology, social and psychological services, genetics, palliative care, and pain management).
32. Demonstrate an understanding of when to refer to medical oncology, radiation oncology, social services, pain management, genetic counseling.

Skills Laboratory

33. Complete the formal R1 skills lab curriculum and competencies for general surgical procedures.
34. Practice the above procedures and skills using advance simulation techniques.

Education

35. Educate medical students in patient care matters and principles of surgical oncology.
36. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings.
37. Develop skills for searching the medical literature and begin to read articles critically.
 - a. Demonstrate ability to use cancer resources from the National Cancer Institute
38. Evaluate senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made

Goals for the R2 on Surgical Oncology Service

The goals for this rotation are for the R2 to broaden their exposure to cancer patients and to use the skills and education from their R1 experience for the purpose of continued improvement in cancer patient evaluation. They will demonstrate improved ability to integrate factors to appropriately judge when to use surgery in the oncologic patient (including when surgery is not appropriate), and to understand total care of the cancer patient (including clinical care, social support groups, palliative care, reconstructive procedures, genetic counseling).

PATIENT CARE:

Objectives for R2 in Surgical Oncology

Patient Assessment, History and Physical

1. Improve upon skills outlined above and developed as an R1
2. Perform a complete history and physical on complex oncologic patients.
 - a. Detailed family cancer history
 - b. Assess risk factors for cancer
3. Become more adept at lymphatic, breast and head and neck examinations.
4. Increase understanding of proper use of more sophisticated imaging techniques in patient assessment including PET/CT scans and nuclear medicine studies such as lymphoscintigraphy for lymphatic mapping.
5. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families. Demonstrate sensitivity to the impact that a cancer diagnosis has on both the patient and their family members.

Documentation

6. Improve upon the quality and efficiency of documentation as outlined for the R1.
 - a. Demonstrate greater proficiency with solid tumor staging as outlined by the AJCC Staging Manual
7. Improve upon the documentation of patient status, diagnoses, comorbidities, assessment, and care plan in the daily progress notes.
8. Dictate more accurate and succinct operative reports.
9. Improve upon the informed consent process with the increased clinical maturity obtained during the R1 year, especially with respect to end of life issues.
 - a. Demonstrate an understanding of the benefit of health care proxies, hospice services, social work services, national and local support group services, and home care services including home hospice.

Patient Care and Management

10. Improve upon the efficiency and quality of skills outlined for the R1.
11. Improve clinical care skills as outlined for the R1 plus demonstrate increasing understanding and competence in advanced skills for the critically ill surgical oncology patient, including central venous access and monitoring, arterial pressure monitoring, hemodialysis access, pulmonary artery catheterization.
12. More efficient and effective response to changes in patient status/emergencies that may occur in both the critically ill and the non-intensive care unit patient, including recognition and management of tumor lysis syndrome.
13. Identify and routinely apply measures to assure optimal patient care, including the consideration of the impact of the cancer diagnosis on both patient and their loved ones.
14. Participate in Practice-based learning and improvement mechanisms.
15. Obtain an understanding of Systems-based practice, particularly in the private hospital setting.

Perioperative Care and Risk Assessment

16. Demonstrate improvement in the recognition of perioperative complications and its impact on the treatment plan.
 - a. Recognize how surgical complications impact upon deliverance of chemotherapy and radiation therapy
 - b. Recognize how complications of chemotherapy and radiation therapy impact upon surgical
17. Demonstrate improved ability to respond to perioperative complications and propose appropriate measures.
18. Demonstrate greater independence in assessing perioperative risk.

Operative Skills

19. Demonstrate ongoing improvement in all skills outlined for PGY-1 above.
20. Improve upon understanding and technical ability for commonly performed surgical oncology operations (Total mastectomy, skin-sparing mastectomy, wide local excisions for melanoma or sarcoma, sentinel node biopsies, regional node dissections).
 - a. Demonstrate an understanding of the reconstructive surgery options (including risks and benefits), especially for breast cancer patients.
21. Demonstrate increasing proficiency with lymphatic mapping techniques, head and neck surgery, and intraoperative ultrasound.
22. Demonstrate increased basic surgical skills such as knot tying and suturing in deep cavities.
23. Develop increased understanding of retractors and appropriate exposure techniques

24. Develop skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

25. Demonstrate improvement in plain radiograph interpretation as outlined for R1.

26. Identify and interpret tumor related pathology on CT scan, MRI, and nuclear medicine studies (lymphoscintigraphy, PET/CT).

Outpatient Patient Care- A minimum of one half day per week is mandatory

27. Demonstrate improvement in outpatient history, physical, and evaluation of the surgical oncology patient.

28. Evaluate and manage outpatient surgical oncology patients with particular attention to the interdisciplinary nature of cancer management (medical oncology, radiation oncology, social and psychological services, genetics, palliative care, and pain management).

29. Demonstrate an understanding of when to refer to medical oncology, radiation oncology, social services, pain management, and genetic counseling.

Skills Laboratory

30. Complete the formal R3 skills lab curriculum and competencies for surgical oncology procedures.

31. Practice the above procedures and skills.

32. Participate in Simulation Center team-building intra-disciplinary and inter-disciplinary exercises

Education

33. Educate medical students and R1 residents in patient care matters and principles of surgical oncology.

34. Teach the R1 with respect to effective and efficient patient care techniques and data management.

35. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings and more active role in teaching rounds and conferences.

36. Searching and reading the surgical literature to expand upon patient care activities.

a. Demonstrate ability to use cancer resources from the National Cancer Institute

37. Evaluate senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.

2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.

3. The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.

4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills

5. Residents will notify the supervising attending physician in the event that:

a. A patient is transferred to the intensive care unit

b. A patient dies or an end of life decision is made

c. Critical Lab Values

d. Patient develops signs of shock

6. Direct supervision by an Attending surgeon, R5,R4,R3 and R2 morning rounds

7. Direct supervision by R5, R4, R3, and R2 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.

8. Direct supervision by an Attending surgeon, R5, R4, R3, R2 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

COMPETENCY-BASED GOALS

Medical Knowledge

At the completion of this rotation residents should:

Skin:

1. Be able to plan the evaluation and management of a patient with skin cancer.
2. Be able to name and describe the less common skin lesions.
3. Be able to describe the role of neoadjuvant and adjuvant therapy.
4. Understand the role and indications for staging tests in skin cancer.
5. Understand the implications and management of recurrent or metastatic disease.
6. Understand the prognosis of different stages of skin cancers.
7. Understand the complete skin cancer staging systems.
8. Understand the options for reconstruction, including the risks, benefits, indications, and contraindications.
9. Be able to discuss the relevant literature relating to skin cancer management (margin width, prophylactic vs. therapeutic node dissection, immunotherapy)

Soft Tissue Tumors:

1. Be able to plan the evaluation and management of a patient with a soft tissue mass.
2. Plan the evaluation and management of a patient with a sarcoma.
3. Be able to describe the role of neoadjuvant and adjuvant radiation and systemic therapy.
4. Understand the role and indications for staging tests in sarcomas.
5. Understand the implications and management of recurrent or metastatic disease.
6. Understand the prognosis of different stages of sarcoma.
7. Understand the complete sarcoma staging system.
8. Be able to discuss the relevant literature relating to sarcoma management (limb salvage, pulmonary metastasectomy, adjuvant therapy).

Patient Care

At the completion of this rotation residents should:

1. Demonstrate the ability to deliver compassionate care to all patients.
2. Become more adept at delivering information to patients' family members when appropriate.
3. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of this rotation residents should:

1. Have gained further experience in locating information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
2. Demonstrate proficiency in accessing scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
3. Be proficient at using the available technology to access patient information.
4. Maintain their ACGME web-based operative log in a timely and meticulously documented fashion.
5. Participate actively in morbidity and mortality conferences.
 - a. As M&M conference is an active Quality Assurance conference for the residents, all residents (whether presenting or not) will thoroughly read the protocol and read for each presented complication. Board-like questions will be asked at the conference.

b. Residents presenting at M&M will prepare the protocol summarizing background, events, and the complication. The resident will also review relevant evidenced-based literature regarding the case and complication and be prepared to discuss at conference.

6. Review all of their evaluations to understand their weaknesses and strengths.
 - a. In depth review at semiannual evaluations.
 - b. All evaluations available to resident in their secure file.
 - c. Each resident will receive evaluations from faculty, other residents, medical students, and hospital non-physician medical personnel.
7. Attend monthly faculty advisor meetings.
8. Review ABSITE results and if score less than 50% will complete remediation study plan.
9. Demonstrate active participation in Department's "Residency Workshops" including
 - a. Advanced Communication Skills for Surgical Practice
 - b. Admitting Mistakes: Ethical and Communication Issues
 - c. Delivering Bad News - Your Chance to Become a Master Surgeon
 - d. Working With Professionals Around You: Team Communication
 - e. Working Across Language and Cultures: The Case for Informed Consent
 - f. Self Care and the Stress of Surgical Practice
10. Self learning and technical practice in the Skills Laboratory.

Interpersonal and Communication Skills

At the completion of these rotations residents should:

1. Demonstrate an understanding of the importance of effective communication to patients, ancillary staff and colleagues.
2. Develop skills to communicate medical information to patients and their families using language appropriate for non-medical personnel and with respect and sensitivity.
3. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.
4. Demonstrate communication skills to include the delivery of "bad news" and leadership in the explanation to patients and family of treatment plans and options in a culturally sensitive compassionate manner.
5. Document accurate and appropriate information in the patient's medical record.
6. Demonstrate an understanding of appropriate communication to patients, their families, colleagues, and non-physician medical staff in the outpatient setting.
7. Demonstrate active participation in Department's "Residency Workshops" including
 - a. Advanced Communication Skills for Surgical Practice
 - b. Admitting Mistakes: Ethical and Communication Issues
 - c. Delivering Bad News - Your Chance to Become a Master Surgeon
 - d. Working With Professionals Around You: Team Communication
 - e. Working Across Language and Cultures: The Case for Informed Consent
 - f. Self Care and the Stress of Surgical Practice
8. Integrate feedback from faculty members and from their written competency-based evaluations.

Professionalism

At the completion of this rotation residents should:

1. Understand the importance of a through commitment to carrying out professional responsibilities.
2. Demonstrate adherence to ethical principals.
3. Show sensitivity to diverse patient populations.

4. Demonstrate an understanding of how to identify signs of stress and fatigue in themselves and their peers, based on the annual Departmental tutorial.
5. Successful completion of the Department's Professionalism Curriculum:
 - SESSION ONE:
 - Informed consent
 - Medical Malpractice and the Surgeon
 - Admitting Mistakes: Ethical and Communication Issues
 - SESSION TWO:
 - Depersonalization of patients
 - End of life care
 - What to do when your patient expires
 - SESSION THREE:
 - Teaching those junior you -- residents and medical students
 - Assessment and feedback
 - Team relationships
 - SESSION FOUR:
 - Dealing with the stress of surgical practice – personal/family
 - Sexual harassment
 - Cultural sensitivity
 - Professional relationships with pharmaceutical companies
 - Dealing with impaired colleagues – residents and attendings

System-Based Practice

At the completion of these rotations residents should:

1. Have successfully completed the mandatory web-based Systems-Based Practice tutorial and passed the web-based assessment.
2. Understand the importance of working effectively in the health care delivery system.
 - a. The private, third party based system at Tisch Hospital. This includes billing, coding, working with Social Work, Case Managers, Advanced Care Practitioners, Visiting Nurse Service
3. Demonstrate an understanding of the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
4. Be exposed to considerations of cost-containment and risk-benefit analysis in patient care.
5. Demonstrate an understanding of the importance of quality patient care and optimal ways to achieve it.
6. Demonstrate an understanding of when to obtain consultations from other services.
7. Be familiar with Department Quality Assurance projects such as medication reconciliation, appropriate use of antibiotics, DVT prophylaxis protocol.
8. Participate in Department's QA committee such as root cause analysis.

Transplant Surgery Rotation Goals and Objectives

Rotation: NYU Langone Medical Center, Tisch Hospital

Length: 4 week rotation

Glyn Morgan MD, Rotation Preceptor

Lewis Teperman MD, Director of Transplantation

Bruce Gelb MD

Summary:

Residents will rotate on the Transplant Service at Tisch Hospital to gain a familiarity with the diagnosis and management of end-stage liver and kidney disease, solid organ transplantation, organ procurement, immunosuppression, and the management of transplant recipients and live donors in the inpatient and outpatient setting. The residents work closely with attendings and fellows in a supervised environment.

OBJECTIVES:

The objectives of this rotation are to ensure that residents develop knowledge and skills in:

1. The performance of a thorough and complete basic evaluation including history and physical exam in adult and adolescent patients.
2. The preoperative evaluation and preparation.
3. The management of all post operative care including critical care management in high risk patients and those undergoing extensive surgical procedures requiring such care.
4. Formulation of a diagnostic and treatment plan for emergency room and inpatient consultations.
5. Introductory level operative skills.
6. Optimal patient care.
7. Professional and compassionate communication and interactive skills with patients, colleagues and families.
8. Practice-based learning and improvement.
9. Systems-based practice, particularly within the private hospital setting.

COMPETENCY-BASED GOALS

Medical Knowledge

At the completion of these rotations residents should understand:

1. The guidelines for preparing patients for organ transplantation.
2. The fundamental immunologic principles governing transplantation and immunosuppression.
3. The potential metabolic, physiologic and malignant side effects of immunosuppressants.
4. The disease process resulting in end-stage liver disease managed by liver transplantation.
5. The management of patients with end-stage liver disease and the complications related to portal hypertension (i.e. variceal bleeding, ascites, etc.).

6. The disease process resulting in end-stage renal disease.
7. The management of patients with end-stage renal disease and the complications related to renal insufficiency (i.e. hyperparathyroidism, bleeding, uremia, hyperkalemia, etc.).
8. The treatment options for patients with end-stage renal disease dialysis (i.e. hemodialysis vs. peritoneal dialysis) and transplantation.
9. The surgical issues associated with renal transplantation and be able to apply them in other settings including retroperitoneal exposure of the iliac fossa and management of surgical issues of the urologic tract.
10. The surgical issues associated with liver transplantation and be able to apply them in other settings including hepatic resections, hepatic trauma, and total vascular exclusion of the liver.

Patient Care

At the completion of these rotations residents should:

1. Evaluate potential candidates for living-related and deceased donor organ transplantation, including:
 - A. Clinical suitability
 - B. Strength of social support
 - C. Expected graft and patient survival
2. Participate in the pre- and post-operative surgical management of patients after organ transplant. Aspects of this care will include participation in the management of (but will not be limited to):
 - A. Airway management, acute respiratory failure, ventilator management
 - B. Acute and chronic renal failure
 - C. Acute and chronic liver failure
 - D. GI bleeding
 - E. Coagulopathy and blood replacement therapy
 - F. Sepsis
 - G. Shock
 - H. Post-operative nutritional support
 - I. Post-operative pain management
 - J. Cardiovascular monitoring and pharmacology
 - K. Electrolyte and acid-base monitoring and management
 - L. Multi-organ system failure
3. Assist in kidney and liver transplantation and live donor liver and kidney surgery.
4. Participate in the preoperative management of immunosuppressive drug therapy including monitoring drug levels and treating potential toxicities.
5. Participate in the evaluation and management of patients suspected of organ rejection to include:
 - A. Laboratory and radiologic testing
 - B. Administration of immunosuppressive agents
 - C. Following patients for potential acute and chronic side effects.
6. Participate in the preparation and management of multiple organ procurement in the brain dead patient.
7. Define suitability characteristics of organs for transplantation.

8. Management of postoperative surgical complications, including wound infection, anastomotic stenoses and leaks, bleeding, and lymphocele formation.
9. Participate in the management of patients with end-stage liver disease including management of ascites and other complications related to portal hypertension, including variceal bleeding.
10. Have an understanding of and be able to deliver compassionate care to all patients.
11. Gain experience in delivering information to patients' family members when appropriate.
12. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of these rotations residents should:

1. Have gained insight into how to locate information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
2. Have a working knowledge of how to access scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
3. Be adept at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of these rotations residents should:

1. Understand the importance of effective communication to patients, ancillary staff and colleagues.
2. Develop skills to communicate medical information to patients and their families.
3. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.

Professionalism

At the completion of these rotations residents should:

1. Understand the importance of a through commitment to carrying out professional responsibilities.
2. Demonstrate adherence to ethical principals.
3. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of these rotations residents should:

1. Understand the importance of working effectively in the health care delivery, particularly in the private hospital setting.
2. Understand the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
3. Be exposed to considerations of cost-containment and risk-benefit analysis in patient care, particularly in the private hospital setting.
4. Understand the importance of quality patient care and optimal ways to achieve it.

5. Understanding of when to obtain consultations from other services.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 2 residents while in the operating room and in the outpatient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 2 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
6. Direct supervision by an Attending surgeon, Transplant fellow during daily morning rounds
7. Direct supervision by Attending/Fellow during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
8. Direct supervision by an Attending surgeon, Fellow during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Department of Surgery
Goals and Objectives for Trauma Rotations

Summary:

The Trauma Service is designed to provide the residents with an in-depth knowledge of management of victims of trauma through all phases of medical care. These Goals and Objectives are designed for both the inpatient and outpatient setting. The Goals and Objectives are competency based. For the competency of Patient Care, the Goals and Objectives are specified by resident year.

Competency-Based Goals and Objectives for the Bellevue Hospital Trauma Service

PATIENT CARE

Goals for First (R1) Resident Year:

Rotation length: 4 weeks

The goals for this rotation are for the R1 resident to gain broad exposure to trauma patients and to start developing knowledge, skill, and competence in the following:

Objectives for R1 (PGY 1) in General Surgery

Patient Assessment, History and Physical

1. Outline the basic technique of evaluation and resuscitation of trauma patients using the Advanced Trauma Life Support (ATLS) protocol.
2. Perform a complete and thorough history and physical examination as it pertains to the surgical or potentially surgical trauma patient.
 - a. Become adept at reviewing medical records and reports
3. Integrate diagnostic laboratory and imaging studies into the patient evaluation and diagnostic process.
 - a. Develop an appreciation for the correct utilization and interpretation of diagnostic imaging and laboratory tests in the workup of the trauma patient.
4. Develop and identify a differential diagnosis and treatment plan for the new trauma patient, or for a new problem that develops in an established trauma patient.
5. Perform review of medications taken at home versus in the hospital as part of the medication reconciliation process.
6. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families, especially in the setting of acute trauma.

Documentation

7. Perform accurate, complete, legible documentation of the history, physical examination, differential diagnosis and proposed treatment plan.

8. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes, operative notes.
9. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.

Patient Care and Management

10. Rapidly respond to all trauma activations
11. Participate in the initial assessment and resuscitation of trauma patients as part of the trauma team
 - a. Primary assessment
 - b. Secondary survey
12. Perform basic clinical care skills including phlebotomy, intravenous access, nasogastric tube placement, urinary catheterization.
13. Develop efficient and accurate methods to collect relevant data for rounds.
14. Respond to and learn to manage changes in patient status/emergencies that may occur in the non-intensive care unit patient, including:
 - a. Cardiac
 - Cardiac arrhythmias
 - Myocardial infarctions
 - Hemodynamic instability
 - Electrocardiogram changes
 - b. Neurologic
 - Mental status changes
 - Knowledge of when and how to activate stroke emergency response team
 - c. Fever, Infection, Sepsis
 - Workup of fever in the postoperative and non-operative setting
 - Interpretation of culture and sensitivity results
 - Understand the antibiotic resistance profile in the hospital
 - Understand universal precautions
 - Understand the importance of hand washing and prevention of nosocomial infections
 - Basics of full barrier precautions and sterile technique
 - Understand impact of C. difficile on surgical patient
 - Recognize onset of sepsis and initiate care
 - d. Fluids and Electrolytes
 - Intravenous fluid management including replacement and maintenance
 - Recognize acid base disorders and management options
 - Electrolyte replacement
 - Enteral and parenteral nutritional support
 - e. Hematologic
 - Recognize and treat hemorrhagic shock
 - Recognize and treat coagulopathy and its causes
15. Identify and routinely apply quality performance measures to assure optimal patient care.
16. Participate in Practice-based learning and improvement mechanisms.

17. Obtain an understanding of Systems-based practice, particularly in the hospital setting.
 - a. Develop improved communication and transfer of information skills between housestaff and physicians assistants and nurse practitioners.
 - b. Develop improved team-building skills

Perioperative Care and Risk Assessment

18. Identify complications relating to preoperative, operative, postoperative, and non-operative interventions.
19. Recognize how complications impact upon the treatment plan and to identify the corrective actions necessary to obtain optimal overall patient outcomes.
20. Perform preoperative cardiac risk assessment and venous thromboprophylaxis risk assessment.
21. Write postoperative orders, perform postoperative checks.

Operative Skills

22. Obtain an understanding of the pathophysiology of shock and its initial management..
23. Develop the intraoperative surgical skills necessary for effective treatment of surgical pathology, including the basics of sterile technique, suturing, knot tying, tissue handling, and knowledge of common surgical instrument names.
24. Develop knowledge in the management of lacerations.
25. Develop knowledge of surgical patient positioning and skin preparation.
26. Understand and develop the skill for the basics of hemostasis.
27. Develop skills of surgical wound management
 - Infection versus inflammatory reaction
 - Abscess versus sterile fluid collection (seroma or hematoma)
 - Wound packing, Vacuum Assisted Closure dressing
 - Recognition of wound dehiscence, evisceration
 - Use of VAC dressings.
28. Develop initial skills in lower and upper endoscopy.
29. Develop skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

30. Recognize common plain radiographic findings in trauma patients including pneumonias, pleural effusions, pneumothorax, free intraperitoneal air, small bowel obstruction, fractures
31. Develop interpretation skills for CT scans and MRIs.

Outpatient Patient Care- A minimum of one half day per week is mandatory

32. Perform an outpatient comprehensive history, physical, and evaluation of the trauma surgery patient in a city hospital based setting.
33. Manage outpatient trauma surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.

Skills Laboratory

34. Complete the formal R1 skills lab curriculum and competencies for general surgical procedures.
35. Practice the above procedures and skills using advance simulation and skills enhancing techniques
36. Participate in Simulation Center team-building intra-disciplinary and inter-disciplinary exercises.

Education

37. Educate medical students in patient care matters and principles of general surgery.
38. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings.
39. Develop skills for searching the medical literature and begin to read articles critically.
40. Perform evaluations on senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents while in the emergency room, operating room, and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly immediately available in the hospital (24 hour in house trauma/critical care attending)
- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be directly immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the resident's skills and competency
- Residents will notify the supervising attending physician and senior resident in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. A patient develops signs of shock
- Direct supervision by an Attending surgeon, R5, and R3 during daily morning rounds
- Direct supervision by R5 and R3 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
- Direct supervision by an Attending surgeon, R5 and R3 during procedures until competency .is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Goals for Third (R3) Resident Year:

Rotation length: 4-6 weeks

The goals for this rotation for the R3 resident are to gain the skills and competence to serve as the trauma resident and general surgery consult under the supervision of the chief resident and faculty. They will develop skills to learn team management including taking leadership role during rounds. The critical care rotations will further elaborate on the goals and objectives for the management and understanding of the critically ill patient. The R3, after successful completion of this rotation, will further develop knowledge, skill, and competence in the following:

Objectives for R3 in General Surgery

Patient Assessment, History and Physical

1. Demonstrate improvement in skills developed as a junior resident.
2. Perform the initial assessment of trauma patients during trauma resuscitation.
3. Demonstrate ability to integrate history, physical, laboratory and imaging data to assess patient and to present a viable treatment plan(s) to the chief resident and faculty, serving in the capacity of a surgical consult.

Documentation

4. Demonstrate improvement in skills developed as a junior resident.
5. Demonstrate an active role in informed consent and documentation of discussions between other health care professionals and the team.
6. Demonstrate an active role in documenting discussions with the patient, his or her family members or medical proxy and the surgical team.

Patient Care and Management

7. Demonstrate an improvement in skills developed as a junior resident.
8. Demonstrate the ability to assume a more active role in surgical team management.
 - a. Serve as surgical consult on wards and in Emergency Department.
 - b. Respond to all trauma activations
 - c. Initiate resuscitation of trauma patients.
 - d. Formulate assessment and plan for both trauma patients and patients on the consult service and review their findings with faculty and chief resident.
 - e. Follow both trauma service and consult patients during their hospital stay.
9. Demonstrate knowledge and understanding of ventilator management, hemodynamic support, conscious sedation and pain control, and pharmaceutical intervention in the intensive care unit.
10. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families, including the morbidly obese patient.
11. Assist the junior resident and provide first response to changes in patient status.
12. Identify and routinely apply Quality Improvement measures to assure optimal patient care.
13. Participate in Practice-based learning and improvement mechanisms.
14. Obtain an understanding of Systems-based practice, particularly in the city hospital setting.

- . a. Develop improved communication and transfer of information skills between housestaff and physicians assistants and nurse practitioners.
- b . Develop improved team-building skills

Perioperative Care and Risk Assessment

- 15. Demonstrate improvement in skills developed as a junior resident.
- 16. Demonstrate ability to act as a liaison between attending staff, chief residents and the junior residents.
- 17. Educate junior residents in effective, quality perioperative care.

Operative Skills

- 18. Demonstrate improvement in skills developed as a junior resident
 - a. Improvement in leading the surgical team including briefing, debriefing, time out, specimen reconciliation.
- 19. Demonstrate understanding of surgical anatomy and technical skills necessary for more complex surgical procedures including thoracotomy, exploratory laparotomy, intestinal resection, repair of solid organs, resection of solid organs, and fasciotomies.
- 20. Demonstrate increasing proficiency with management of the open abdomen, stapling techniques and instruments, hemostasis techniques and instruments, and VAC therapy.
- 21. Demonstrate understanding of retractors and appropriate exposure techniques.
- 22. Demonstrate increased competence in endoscopic technique and diagnosis.
- 23. Demonstrate a knowledge and understanding of the pathophysiology of the disease process, the indication for surgery, alternatives to surgery, and the details of the surgical procedure.
- 24. Develop skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

- 25. Demonstrate improvement in the skills developed as a junior resident.
- 26. Demonstrate radiographic findings to junior residents and students, and during conferences.

Outpatient Patient Care- A minimum of one half day per week is mandatory

- 27. Demonstrate improvement in skills developed as a junior resident.
- 28. Manage outpatient general surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.

Skills Laboratory

- 29. Complete the formal R3 skills lab curriculum and competencies for general surgical procedures.
- 30. Practice the above procedures and skills.
- 31. Participate in Simulation Center team-building intra-disciplinary and inter-disciplinary exercises.

Education

32. Educate medical students and junior residents in patient care matters and principles of trauma surgery.
33. Teach the junior residents with respect to effective and efficient patient care techniques and data management.
34. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings, journal articles, and more active role in teaching rounds and conferences.
35. Develop knowledge to assess statistical methods and critique the surgical literature for conferences, rounds, and journal club.
36. Perform evaluations of senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 3 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 3 or be directly immediately available in the hospital (24 hour in house trauma / critical care faculty)
3. The PGY 3 resident will be able to perform certain procedures under direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be directly immediately available.
4. Supervising attending physicians will delegate portions of patient care to senior residents based on patient needs and suitable to the residents' skills and competency
5. Residents will notify the supervising attending physician and R5 in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. A patient develops signs of shock
 - d. Critical values
6. Direct supervision by Attending surgeon and R5 during daily morning rounds
 - Direct supervision by R5 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
 - Direct supervision by an Attending surgeon and R5 during procedures until competency .is documented in accordance with Departmental procedure log and scope of practice

Department of Surgery

Vascular Surgery

Rotation Goals and Objectives

Rotation: Vascular Surgery Bellevue Hospital (R1)

Length: 4 weeks

Summary:

All aspects of vascular surgery are encountered, including a rich experience in thoracic aortic aneurysms and dissections. Being a level one-trauma center in one of the biggest cities in the world, the vascular trauma experience is second to none. At Bellevue, the R1 has a unique opportunity to participate, in both the vein clinic, as well as the peripheral vascular clinic.

Goals: The R1 is expected to become familiar with vascular trauma, advanced arterial and venous disease.

Objectives:

The objectives of this rotation are for residents to develop knowledge and skills in:

1. The performance of a complete and thorough vascular examination to include history and physical examination.
2. Understanding the role of risk factors in the management decision-making process.
3. The resident will learn the pathophysiology, diagnosis and treatment of occlusive disease, including atherosclerosis, arteritis, embolus and thrombosis.
4. The resident will learn the pathophysiology, diagnosis and treatment of aneurysmal disease.
5. The resident will see patients in the outpatient setting to learn the basics of pre- and post-hospital management and to observe the long term results of vascular interventions.

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.
- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
- Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
- Direct supervision by an Attending surgeon, Vascular Fellow and R3 morning rounds

- Direct supervision by R3 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
- Direct supervision by an Attending surgeon, Vascular Fellow, R3 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Rotation: Vascular Surgery Bellevue Hospital (R3)

Length: 4 weeks

Goals: In the third year, the resident and applies the skills learned during the first two years as surgical consultant. The resident will have increased responsibility for management of critically ill patients and will see new outpatients. They are expected to enter into a teaching role for the junior residents and medical students. They prepare and present cases to the vascular conference.

OBJECTIVES

The objectives of this rotation are to for residents to develop knowledge and skills in:

1. Identify and independently diagnose acute and chronic vascular conditions.
2. Learn to dissect blood vessels, perform vascular anastomoses and manage acute vascular injury.

COMPETENCY-BASED GOALS

Medical Knowledge

On completion of the vascular surgery rotations, the resident will have achieved the following:

1. The resident will be able to obtain a detailed history, including the symptoms of various vascular disease states.
2. The resident will be able to perform a good physical examination of the patient with suspected arterial, venous or lymphatic disease
3. The resident will be able to:
 - a. Detect arterial bruits.
 - b. Palpate the pulses throughout the extremities.
 - c. Identify abdominal aortic aneurysms.
 - d. Identify the signs of arterial insufficiency of the extremities.
 - e. Understand and identify the stigmata of venous insufficiency.
 - f. Understand and identify the stigmata of venous thrombosis.
 - g. Be able to identify the patient with lymphatic disease.
 - h. Describe and suspect cause of a leg ulcer.
4. The resident will be introduced to the vascular laboratory and will understand diagnostic tests using Doppler techniques and Duplex ultrasound.
5. The resident will be able to order the appropriate examination for vascular symptoms.
6. The resident will be aware of the accuracy and specificity of these tests and will know when further testing may be required.
7. The resident will have extensive exposure to diagnostic radiology techniques.

- a. The resident will be able to name the usual blood vessels that are seen on an angiogram.
 - b. The resident will understand the pathological processes that cause the various abnormalities on the angiogram.
 - c. The resident will learn the indications for and the complications of angiography.
 - d. The resident will become familiar with the concepts and science of computed tomography and magnetic resonance imaging in the diagnosis of vascular conditions.
 - e. The resident will learn the indications and limitations of CT and MR for vascular disease.
8. Interventional radiology has assumed more importance in the treatment of vascular diseases.
- a. The resident will be introduced to techniques to perform an interventional procedure through remote site access.
 - b. The resident will understand the new technologies.
9. The resident will have responsibility for managing the patients with vascular disease in the hospital preoperatively and postoperatively.
- a. The resident will learn the management of vascular surgery patients in the Intensive Care Unit.
 - b. The resident will learn to place catheters into arteries and veins.
10. The resident will learn the basics of vascular surgery technique, including:
- a. The management of arteries and veins
 - b. The name and functions of vascular instruments
 - c. The technique of vascular suturing
 - d. The principles of vascular anastomoses
11. The resident will perform surgical procedures, including:
- Debridement of infected sites in the extremities
 - Varicose vein surgery
 - Various amputations, including toes and legs
 - Skin graft procedures
 - Vascular access procedures
12. The resident will participate in operations to treat aneurysmal and occlusive disease
13. The resident will participate actively in the educational program.
- a. The resident will make daily teaching rounds occur with the attending staff.
 - b. The resident will be expected to know the clinical details about the patients.
 - c. The resident will attend the weekly vascular conference.
 - d. The resident will read the relevant literature distributed by the vascular surgical resident.
 - e. The resident will learn about the current role of atherosclerotic research.

Patient Care

At the completion of this rotation residents should:

1. Have an understanding of and be able to deliver compassionate care to all patients.
2. Gain experience in delivering information to patients' family members when appropriate, particular in the pediatric population.
3. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of this rotation residents should:

1. Have gained insight into how to locate information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
2. Have a working knowledge of how to access scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
3. Be adept at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of this rotation residents should:

1. Understand the importance of effective communication to patients, ancillary staff and colleagues.
2. Develop skills to communicate medical information to patients and their families.
3. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.
4. Development of communication skills to include the delivery of "bad news" and leadership in the explanation to patients and family of treatment plans and options in a culturally sensitive compassionate manner.

Professionalism

At the completion of this rotation residents should:

1. Understand the importance of a through commitment to carrying out professional responsibilities.
2. Demonstrate adherence to ethical principals.
3. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of this rotation residents should:

1. Understand the importance of working effectively in the health care delivery, particularly in the private hospital setting.
2. Understand the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
3. Be exposed to considerations of cost-containment and risk-benefit analysis in patient care, particularly in the private hospital setting.
4. Understand the importance of quality patient care and optimal ways to achieve it.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 3 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 3 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 3 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
6. Direct supervision by an Attending surgeon, Vascular Fellow during daily morning rounds
7. Direct supervision by Vascular Fellow during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
8. Direct supervision by an Attending surgeon, Vascular Fellow during procedures until competency .is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Vascular Surgery

Rotation: VA Hospital (R2, R1)

Length: 4 weeks

GOALS: The VA hospital allows the R2 and R1 manage the in-patient service, over-see all consults, and participate in the out-patient clinic.

OBJECTIVES:

The objectives of this rotation are to for residents to develop knowledge and skills in the following:

1. Performance of a complete and thorough vascular examination to include history and physical examination.
2. Understanding the role of risk factors in the decision-making and management process.
3. Develop an understanding of the pathophysiology, diagnosis and treatment of venous and arterial occlusive disease, including atherosclerosis, arteritis, embolus and thrombosis.
4. Develop an understanding of the pathophysiology, diagnosis and treatment of aneurysmal disease.
5. Demonstrate skills in outpatient vascular assessment, the basics of pre- and post-hospital management, and to develop an understanding of the long term results of vascular interventions.
6. Demonstrate an understanding of the basic operative skills necessary to dissect around blood vessels and handle blood vessels in the operating room.
7. Understanding the applications and limitations of the diagnostic and therapeutic modalities utilized in the evaluation and treatment of patients with vascular diseases.
8. Demonstrate ability to perform a vascular consultation, develop a differential diagnosis, and propose a plan of action under the supervision of a senior resident and attending vascular surgeon.
9. Understanding of the role of the surgeon as patient advocate and educator in choice of, and navigation through, complex treatment plans and follow-up regimens.
10. Demonstrate a basic understanding of invasive and non-invasive vascular studies

COMPETENCY-BASED GOALS

Medical Knowledge

On completion of the vascular surgery rotations, the resident will have achieved the following:

1. The resident will be able to obtain a detailed history, including the symptoms of various vascular disease states.
2. The resident will be able to perform a good physical examination of the patient with suspected arterial, venous or lymphatic disease
3. The resident will be able to:
 - a. Detect arterial bruits.
 - b. Palpate the pulses throughout the extremities.
 - c. Identify abdominal aortic aneurysms.
 - d. Identify the signs of arterial insufficiency of the extremities.
 - e. Understand and identify the stigmata of venous insufficiency.

- f. Understand and identify the stigmata of venous thrombosis.
 - g. Be able to identify the patient with lymphatic disease.
 - h. Describe and suspect cause of a leg ulcer.
4. The resident will be introduced to the vascular laboratory and will understand diagnostic tests using Doppler techniques and Duplex ultrasound.
 5. The resident will be able to order the appropriate examination for vascular symptoms.
 6. The resident will be aware of the accuracy and specificity of these tests and will know when further testing may be required.
 7. The resident will have extensive exposure to diagnostic radiology techniques.
 - a. The resident will be able to name the usual blood vessels that are seen on an angiogram.
 - b. The resident will understand the pathological processes that cause the various abnormalities on the angiogram.
 - c. The resident will learn the indications for and the complications of angiography.
 - d. The resident will become familiar with the concepts and science of computed tomography and magnetic resonance imaging in the diagnosis of vascular conditions.
 - e. The resident will learn the indications and limitations of CT and MR for vascular disease.
 8. Interventional radiology has assumed more importance in the treatment of vascular diseases.
 - a. The resident will be introduced to techniques to perform an interventional procedure through remote site access.
 - b. The resident will understand the new technologies.
 9. The resident will have responsibility for managing the patients with vascular disease in the hospital preoperatively and postoperatively.
 - i. The resident will learn the management of vascular surgery patients in the Intensive Care Unit.
 - ii. The resident will learn to place catheters into arteries and veins.
 10. The resident will learn the basics of vascular surgery technique, including:
 - a. The management of arteries and veins
 - b. The name and functions of vascular instruments
 - c. The technique of vascular suturing
 - d. The principles of vascular anastomoses
 11. The resident will perform surgical procedures, including:
 - a. Debridement of infected sites in the extremities
 - b. Varicose vein surgery
 - c. Various amputations, including toes and legs
 - d. Skin graft procedures
 - e. Vascular access procedures
 12. The resident will participate in operations to treat aneurysmal and occlusive disease

13. The resident will participate actively in the educational program.
 - a. The resident will make daily teaching rounds occur with the attending staff.
 - b. The resident will be expected to know the clinical details about the patients.
 - c. The resident will attend the weekly vascular conference.
 - d. The resident will read the relevant literature distributed by the vascular surgical resident.
 - e. The resident will learn about the current role of atherosclerotic research.

Patient Care

At the completion of this rotation residents should:

1. Have an understanding of and be able to deliver compassionate care to all patients.
2. Gain experience in delivering information to patients' family members when appropriate, particular in the pediatric population.
3. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of this rotation residents should:

1. Have gained insight into how to locate information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
2. Have a working knowledge of how to access scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
3. Be adept at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of this rotation residents should:

1. Understand the importance of effective communication to patients, ancillary staff and colleagues.
2. Develop skills to communicate medical information to patients and their families.
3. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.
4. Development of communication skills to include the delivery of "bad news" and leadership in the explanation to patients and family of treatment plans and options in a culturally sensitive compassionate manner.

Professionalism

At the completion of this rotation residents should:

1. Understand the importance of a through commitment to carrying out professional responsibilities.
2. Demonstrate adherence to ethical principals.
3. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of this rotation residents should:

1. Understand the importance of working effectively in the health care delivery, particularly in the private hospital setting.

2. Understand the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
3. Be exposed to considerations of cost-containment and risk-benefit analysis in patient care, particularly in the private hospital setting.
4. Understand the importance of quality patient care and optimal ways to achieve

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 2, 1 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2, 1 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 2, 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
6. Direct supervision by an Attending surgeon, Vascular Fellow for morning rounds
7. Direct supervision by Vascular Fellow during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
8. Direct supervision by an Attending surgeon, Vascular Fellow during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Vascular Surgery

Rotation Goals and Objectives

Rotation: Tisch Hospital (R1, R2)

Length: 4 weeks

GOALS: Tisch Hospital allows the R2 and R1 manage the in-patient service and participate in office hours.

OBJECTIVES:

The objectives of this rotation are to for residents to develop knowledge and skills in the following:

1. Performance of a complete and thorough vascular examination to include history and physical examination.
2. Understanding the role of risk factors in the decision-making and management process.
3. Develop an understanding of the pathophysiology, diagnosis and treatment of venous and arterial occlusive disease, including atherosclerosis, arteritis, embolus and thrombosis.
4. Develop an understanding of the pathophysiology, diagnosis and treatment of aneurysmal disease.
5. Demonstrate skills in outpatient vascular assessment, the basics of pre- and post-hospital management, and to develop an understanding of the long term results of vascular interventions.
6. Demonstrate an understanding of the basic operative skills necessary to dissect around blood vessels and handle blood vessels in the operating room.
7. Understanding the applications and limitations of the diagnostic and therapeutic modalities utilized in the evaluation and treatment of patients with vascular diseases.
8. Understanding of the role of the surgeon as patient advocate and educator in choice of, and navigation through, complex treatment plans and follow-up regimens.
9. Demonstrate a basic understanding of invasive and non-invasive vascular studies.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 2, 1 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2, 1 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 2, 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock

6. Direct supervision by an Attending surgeon, Vascular Fellow and occasionally R4 morning rounds
7. Direct supervision by Vascular Fellow during afternoon rounds with immediate direct supervision available by in-house acute care attending.
8. Direct supervision by an Attending surgeon, Vascular Fellow during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Rotation: Tisch Hospital (R4)

Vascular Elective rotation as assigned

Length: 4 weeks

The vascular surgery experience during the fourth year is at Tisch Hospital for a select group of 4th year residents who want to do their elective rotation in Vascular. The resident acts as Chief Resident and works with the vascular fellow and attending surgeons in the faculty outpatient office, in the operating room, and on the ward. Supervised by the vascular attending staff, the resident assumes a leadership role with respect to patient management, perioperative care, and performing vascular consultations. The resident will be able to manage acute care problems related to these patients.

By the completion of the R4 rotation on Vascular Surgery, the resident will be able to diagnose vascular disease using history, physical examination, laboratory studies, and radiographic procedures. They will also be able to discuss interventions along with the risks and benefits of these interventions. The resident will be able to discuss treatment options from an evidenced-based approach.

OBJECTIVES:

The objectives of this rotation are to for residents to develop knowledge and skills in the following:

1. Demonstrate improvement and competence for all objectives outlined for the R1, R2, and R3.
2. Assist on major vascular reconstructions, including carotid artery endarterectomy, abdominal aortic aneurysms, and lower extremity bypass.
3. Assist on complex vascular procedures, such as thoraco-abdominal aortic aneurysm repairs and uncommon vascular reconstructions, including endovascular procedures.
4. with surgical exposure of blood vessels throughout the body
5. Demonstrate an understanding and skill with basic vascular reconstructions, both using autogenous material and grafts,
6. Demonstrate an understanding and skill with invasive studies such as angiograms.

COMPETENCY-BASED GOALS

Medical Knowledge

On completion of the vascular surgery rotations, the resident will have achieved the following:

1. The resident will be able to obtain a detailed history, including the symptoms of various vascular disease states and risk factors.
2. The resident will be able to perform a thorough physical examination of the patient with suspected arterial, venous or lymphatic disease and recognize acute versus chronic conditions.
3. The resident will be able to:
 - a. Detect arterial bruits.
 - b. Palpate the pulses throughout the extremities.
 - c. Identify abdominal aortic aneurysms.
 - d. Identify the signs of arterial insufficiency of the extremities.
 - e. Understand and identify the stigmata of venous insufficiency.

- f. Understand and identify the stigmata of venous thrombosis.
 - g. Be able to identify the patient with lymphatic disease.
 - h. Describe and determine etiology of a leg ulcer.
4. The resident will be introduced to the vascular laboratory and will understand diagnostic tests using Doppler techniques and Duplex ultrasound.
 5. The resident will be able to order the appropriate examination for vascular symptoms.
 6. The resident will be aware of the accuracy and specificity of these tests and will know when further testing may be required.
 7. The resident will have extensive exposure to diagnostic radiology techniques.
 - a. The resident will be able to name the usual blood vessels that are seen on an angiogram.
 - b. The resident will understand the pathological processes that cause the various abnormalities on the angiogram.
 - c. The resident will learn the indications for and the complications of angiography.
 - d. The resident will become familiar with the concepts and science of computed tomography and magnetic resonance imaging in the diagnosis of vascular conditions.
 - e. The resident will learn the indications and limitations of CT and MR for vascular disease.
 8. Interventional radiology has assumed more importance in the treatment of vascular diseases.
 - a. The resident will be introduced to techniques to perform an interventional procedure through remote site access.
 - b. The resident will understand the new technologies.
 9. The resident will have responsibility for managing the patients with vascular disease in the hospital preoperatively and postoperatively.
 - a. The resident will learn the management of vascular surgery patients in the Intensive Care Unit.
 - b. The resident will learn to place catheters into arteries and veins.
 10. The resident will learn the basics of vascular surgery technique, including:
 - a. The management of arteries and veins
 - b. The name and functions of vascular instruments
 - c. The technique of vascular suturing
 - d. The principles of vascular anastomoses

The resident will competently perform surgical procedures, including:

- a. Debridement of infected sites in the extremities
- b. Varicose vein surgery
- c. Various amputations, including toes and legs
- d. Skin graft procedures
- e. Vascular access procedures

COLORECTAL SURGERY ROTATION GOALS AND OBJECTIVES

Introduction:

This document provides the *outline* of the objectives for the surgical trainees rotating on the Colorectal Surgery Service so that while on this service the learning goals are clear. It is not meant to be totally inclusive of all of the necessary knowledge, but rather to serve as a *guide* so that the important concepts are clear and that it is understood that residents will be evaluated on the basis of successful completion of these learning goals.

Structure of the Colorectal Surgical Service at Tisch Hospital

The Colorectal Surgical Service at Tisch Hospital comprises five Board Certified Colon and Rectal Surgeons with practices dedicated to the care and management of patients with the full spectrum of benign and malignant condition of the colon, rectum and anus. These five surgeons will supervise the R4, R2 or R1 and oversee interactions with a physician extender (nurse practitioner) who comprises the remainder of the team. In addition to the in-patient responsibilities of the house staff, residents are expected to get outpatient experience, including colonoscopy, as outlined below

Endoscopy:

An important aspect of the educational experience on the Colorectal Surgical Service is exposure to both in-patient and out-patient colonoscopy. Both the R1 and R4 are expected to work with the surgical Attendings on the service where they will be expected to:

- Understand how patients and physicians use the out-patient endoscopy centers as an adjunct to both the in-patient health care facilities and out-patient care.
- Become familiar with the various pre-procedure bowel preparations
- Demonstrate knowledge, judgment and skills for colonoscopy, specifically:
 - Familiarity with the use of the colonoscope and endoscopy tower (light and power source, monitor, air and water sources)
 - Ability to manipulate the colonoscope in a retrograde fashion (ie colonoscope withdrawal) while maintaining adequate view for evaluation of the colonic lumen and mucosa
 - A basic ability to manipulate the colonoscope in a prograde fashion while maintaining adequate view for evaluation of the colonic lumen and mucosa
 - Familiarity with the various options for polyp removal and retrieval
 - Familiarity with various therapeutic options to control colonic bleeding

Colonoscopy is taught throughout the rotation and occurs in the following settings:

1. Tisch Hospital endoscopy suite
2. NYU Langone Miller Practice

Outpatient Responsibilities:

An important part of the Colorectal Surgical Service is the out-patient experience. Residents will be required to see patients in conjunction with the core faculty in their respective offices. The offices are located in the main Tisch Hospital (Drs. Bernstein and Hirsch) and at 251 East 33rd Street, 2nd Floor (Drs. Brandeis, Harlin and Harris).

During these office hours both the R1 and R4 will be expected to:

- Participate in the evaluation and management of new patients with benign and malignant conditions of the colon, rectum and anus.
- Participate in the pre-operative planning and management of any patients requiring either ambulatory or in-patient surgery.
- Participate in the out-patient post-operative management of patients who have undergone surgery.

- Gain familiarity with as well as assist in the performance of routine, office-based anorectal surgical procedures.
- Gain familiarity with the diagnostic Anorectal Physiology tests, specifically, anorectal manometry, pudendal nerve terminal motor latency testing and endoanal sonography.
 - Both the R1 and R4 are expected to learn the proper role of the physiology lab and which tests are appropriate for which patients.

Overall Educational Goals & Objectives for the Colorectal Surgery Rotation

In addition to the Goals and Objectives commensurate with their level of training as outlined for the General Surgical Services, the residents rotating on the Colorectal Surgical Service will achieve the following with respect to the care of the colon and rectal surgical patients.

I. Medical Knowledge:

- Demonstrate ability to formulate and implement a diagnostic and treatment plan for benign and malignant diseases of the colon, rectum and anus.
- Understanding of surgical pathophysiology, pharmacology, physiology, and interpretation of scientific data in diagnosing and managing the patient with colorectal disease.
- Workup and determination of the clinical stage of the colon, rectal and anal cancers according to AJCC criteria.
- Favored modality of treatment according to the primary site and extent (stage) of neoplastic disease.
- Demonstrate an understanding of the roles of surgery, chemotherapy, and radiation therapy as curative, adjuvant or palliative measures in the total management of the colon, rectal and anal cancer patient.
- Demonstrate an understanding of the roles of surgery and pharmacology in the total management of patients with inflammatory bowel disease
- Understand Advanced Laparoscopic Surgery concepts – ports, pneumoperitoneum, scopes, magnification; general limitations, general indicators, general techniques, general risks.
- Understand commonly undertaken minimally invasive surgery techniques pertinent to diseases of the colon and rectum and IBD-related conditions affecting the large and small bowel.
- Understand preoperative concerns unique to minimally invasive (laparoscopic) surgery: cardiac, pulmonary, previous operations.
- Understand postoperative concerns, especially unique to laparoscopic surgery: pulmonary, cardiac, pain, potential complications, especially related to, pneumo-peritoneum insufflations, and specific operations.
- Demonstrate familiarity with surgical literature and extensive areas of basic surgical disease in abdominal surgery, alimentary tract and digestive systems, and laparoscopic surgery.
- Understand concepts of Inflammatory Bowel Disease, basic medical management and surgical options/pitfalls.
- Analyze and present complications at weekly M&M Conference as needed.
- Exhibit knowledge base sufficient to teach junior level residents and students on the service.
- Demonstrate surgical competence by the use of surgical knowledge and skill to achieve a performance that produces appropriate and anticipated outcomes.
- Demonstrate the capacity to integrate surgical continuity of care principles into the total care plan for all surgical patients.
- Through leadership and teaching, demonstrate understanding of the significance of the natural history of surgical disease as related to diseases of the colon, rectum and anus, the consequence of surgical care (both positive and negative), and the influence of continuity of care upon surgical outcomes.
- Exhibit the capability to integrate surgical continuity of care principles into the total care plan for all surgical patients.

II. Patient Care:

Compassionate Patient Care:

- Demonstrate caring and respectful behaviors when interacting with patients and/or their families.
- Incorporate the patient preferences in making decisions about diagnostic and therapeutic interventions.

Appropriate Patient Care:

- Oversee the gathering of essential and accurate information about patients.
- Evaluate patients with complex surgical conditions and presents a differential diagnosis.
- Demonstrate ability to manage ambulatory colorectal disease patients on an outpatient basis.
- Apply clinical screening for malignancies of the colon, rectum and anus.
- Recognize typical presentations and clinical manifestations for different types of neoplasms of the colon, rectum and anus.
- Stage neoplasm's of the colon, rectum and anus, both clinically and pathologically, including the tumor, nodes and metastasis system.
- Relate tumor staging and prognosis.
- Identify margins of resection and how this relates to local recurrence.
- Compare laparoscopic versus open procedures for each case.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- Develop and carries out patient management plans.
- Demonstrate knowledge of the indications and contraindications for various medications used in the preparation and performance of procedures.
- Coordinate the overall care of patients for the team of residents and students.

Technical Skills in Patient Care:

- Demonstrate knowledge, psychomotor skills and judgment related to his/her role in the performance of operative surgical procedures.
- Arrive in the OR prepared for the cognitive components of his/her role in individual operative surgical procedures.
- Apply post-treatment screening/surveillance for malignancies of the colon, rectum and anus.
- Discuss the rationale of specific techniques and procedures involved in the surgical management of both benign and malignant conditions of the colon, rectum and anus.
- Demonstrate the ability to proceed through various steps of operative procedures in a manner that is consistent with the flow of the operation.
- Demonstrates the ability to make appropriate and timely decisions with respect to the operative procedure.
- Demonstrate manual dexterity appropriate for level of training
- Demonstrate an understanding of the benefits and limitations of operative surgical techniques.

III. Practice-Based Learning and Improvement:

Investigates And Evaluates Patient Care Practices:

- Analyze practice experience using a systematic methodology.
- Obtain and use information about their population of patients and the larger population from which patients are drawn.

Appraises and Assimilates Scientific Evidence Relevant To Patient Care:

- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Perform practice-based improvement activities using a systematic methodology.

- Use information technology to manage information, access on-line medical information; and support his/her own education.
- Facilitate the learning of junior level residents.
- Exhibit and recognize the importance of lifelong learning in surgical practice.

Improves Patient Care Practices:

- Demonstrate the ability to analyze personal practice outcomes to improve patient care.
- Perform practice-based improvement activities using a systematic methodology.
- Uses information technology to manage information, access on-line medical information; and support his/her own education.
- Facilitates the learning of junior level residents

IV. Interpersonal and Communication Skills:

- Demonstrate skill and sensitivity for appropriate counseling and educating patients and their families in a variety of clinical situations
- Create and sustains therapeutic and ethically sound relationships with patients and families
- Work effectively with others as a leader of the health care team and/or other professional groups.
- Effectively and promptly documents practice activities. Creates and sustains therapeutic and ethically sound relationships with patients and families especially in patients with morbid obesity
- Demonstrate an understanding of the roles of other non-medical professional group and disciplines in the total care of the patient with benign and malignant conditions of the colon, rectum and anus.
- Presents all patients and conference material in a concise, organized, chronologic, logical and knowledgeable manner.
- Utilize input from all collaborative interactions with all personnel contributing to the surgical patient care
- Exhibit surgical team leadership.
- Contribute via effective teaching and example to the educational efforts of the surgical residency.

V. Professionalism:

- Demonstrate respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and on-going professional development.
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
- Exhibits professionalism through timely completion of required administrative responsibilities (evaluations, recording hours, chart documentation, medical record dictations, etc.).
- Maintain positive relationships.
- Demonstrate accountability for actions and decisions.

VI. Systems-Based Practice:

Awareness and Responsiveness to the Health Care System:

- Understand how patient care and other professional practices affect other health care professionals, the health care organization, and the larger society.
- Understand how these elements of the system affect their own practice.
- Know how types of medical practice and delivery systems differ from one another, including methods and controlling health care costs and allocating resources.
- Incorporate the knowledge of ethical, legal, economic, and/or social factors into the activities of the entire surgical team for all components of surgical care.

Utilization of System Resources:

- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.

- Partner with health care managers and health care providers to assess, coordinate, and improve health care and understands how these activities can affect system performance.

Colorectal Surgery Service – Core Competencies

Overview:

The curriculum for the Colorectal Surgery Rotation is a blueprint for learning and competency achievement.

Residents rotating on the Colorectal Surgery Service will gain and demonstrate competence in each of the six core competencies as established by the ACGME's outcome project (Approved by ACGME 9/28/99). The acquisition of competence in each of these domains occurs throughout the entire resident education process as outlined in the General Surgery Program's Goals and Objectives.

PATIENT CARE OVERVIEW

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

1. Patient Care Learning Activities which provide experience in this competency development include:
 - a. Inpatient and outpatient patient care experiences
 - b. Operative patient care experiences
 - c. Operative log completion
 - d. Case review at M&M conference
 - e. Case discussion at resident conferences
 - f. Bedside teaching
 - g. Ward rounds
 - h. Operating room instruction

2. Residents are expected to:
 - a. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
 - b. Gather essential and accurate information about their patients
 - c. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment (R4s)
 - d. Develop (R4s) and carry out patient management plans (R4s & R1s)
 - e. Counsel and educate patients and their families
 - f. Use information technology to support patient care decisions and patient education
 - g. Work with health care professionals, including those from other disciplines, to provide patient-focused care

Resident Assessment includes observation of performance in these areas:

- a. Medical Interviewing
- b. Physical Examination
- c. Procedural Skills
- d. Clinical Judgment
- e. Ongoing Care

PATIENT CARE COMPETENCIES BY RESIDENT TRAINING LEVEL

Goals for First/Second (R1/R2) Resident Year:

Rotation length: 4 weeks

The goals for this rotation are for the R1 resident to gain broad exposure to patients with benign and malignant conditions of the colon, rectum and anus and to start developing knowledge, skill, and competence in the following:

Objectives for R1/R2 (PGY 1/2) in Colorectal Surgery

Patient Assessment, History and Physical

1. Perform of a complete and thorough history and physical examination as it pertains to the patient with colorectal conditions.
 - a. Become adept at reviewing medical records and reports, including electronic and digital records
2. Integrate diagnostic laboratory and imaging studies into the patient evaluation and diagnostic process.
 - a. Develop an appreciation for the correct utilization and interpretation of diagnostic imaging and laboratory tests in the workup of the surgical patient.
3. Develop and identify a differential diagnosis and treatment plan for the new patient, or for a new problem that develops in an established patient.
4. Perform review of medications taken at home versus in the hospital as part of the medication reconciliation process.
5. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families, including the morbidly obese and acutely ill patients.

Documentation

6. Perform accurate, complete, legible documentation of the history, physical examination, differential diagnosis and proposed treatment plan.
7. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes, operative notes.
8. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.

Patient Care and Management

9. Perform basic clinical care skills including phlebotomy, intravenous access, nasogastric tube placement, urinary catheterization.
 - a. Become familiar with basic management of stoma care (both ileostomy and colostomy care and management).
10. Develop efficient and accurate methods to collect relevant data for rounds.
11. Respond to and learn to manage changes in patient status/emergencies that may occur in the non-intensive care unit patient, including:
 - a. Cardiac
 - Cardiac arrhythmias
 - Myocardial infarctions
 - Hemodynamic instability
 - Electrocardiogram changes
 - b. Neurologic
 - Mental status changes
 - Knowledge of when and how to activate stroke emergency response team
 - c. Fever, Infection, Sepsis
 - Workup of fever in the postoperative and non-operative setting
 - Interpretation of culture and sensitivity results
 - Understand the antibiotic resistance profile in the hospital
 - Understand universal precautions
 - Understand the importance of hand washing and prevention of nosocomial infections
 - Basics of full barrier precautions and sterile technique

- Understand impact of C. difficile on surgical patient
- Recognize onset of sepsis and initiate care
- d. Fluids and Electrolytes
 - Intravenous fluid management including replacement and maintenance
 - Recognize acid base disorders and management options
 - Electrolyte replacement
 - Recognize and manage the fluid and electrolyte shifts in a patient with an ileostomy
 - Enteral and parenteral nutritional support
- 12. Identify and routinely apply quality measures to assure optimal patient care.
- 13. Participate in Practice-based learning and improvement mechanisms.
- 14. Obtain an understanding of Systems-based practice, particularly in the hospital setting.
 - a. Develop improved communication and transfer of information skills between house staff and physicians assistants and nurse practitioners.
 - b. Develop improved team-building skills

Perioperative Care and Risk Assessment

- 15. Identify complications relating to preoperative, operative, postoperative, and non-operative interventions.
- 16. Recognize of how complications impact upon the treatment plan and to identify the corrective actions necessary to obtain optimal overall patient outcomes.
- 17. Perform preoperative cardiac risk assessment and venous thromboprophylaxis risk assessment.
- 18. Write postoperative orders, perform postoperative checks.

Operative Skills

- 19. Obtain an understanding of the pathophysiology and surgical anatomy of the anus and rectum as it pertains to conditions such as hemorrhoids, fissures, fistulas and abscesses. Obtain an understanding of the pathophysiology and anatomy of the colon and small bowel as it pertains to neoplastic, inflammatory, and infectious disorders of the gastrointestinal tract.
- 20. Develop the intraoperative surgical skills necessary for effective treatment of surgical pathology, including the basics of sterile technique, suturing, knot tying, tissue handling, and knowledge of common surgical instrument names.
- 21. Develop knowledge of surgical site markings and the time out process.
- 22. Develop knowledge of surgical patient positioning and skin preparation.
- 23. Understand and develop the skill for the basics of hemostasis.
- 24. Develop the skills necessary to be an effective first assistant
- 25. Develop skills of surgical wound management
 - Infection versus inflammatory reaction
 - Abscess versus sterile fluid collection (seroma or hematoma)
 - Wound packing, Vacuum Assisted Closure dressing
 - Recognition of wound dehiscence, evisceration
- 26. Develop initial skills in colonoscopy.
- 27. Develop skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

- 28. Recognize common plain radiographic findings in surgical patients including pneumonias, pleural effusions, pneumothorax, free intraperitoneal air, small bowel obstruction.
- 29. Develop interpretation skills for CT scans and MRIs.

Outpatient Patient Care- A minimum of one half day per week is mandatory

- 30. Perform an outpatient comprehensive history, physical, and evaluation of the colorectal surgical patient in an office-based setting.
- 31. Manage outpatient colorectal surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.

Education

32. Educate medical students in patient care matters and principles specific to colorectal surgery
33. Develop skills for searching the medical literature and begin to read articles critically.
34. Perform evaluations on senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.
- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
- Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
- Direct supervision by an Attending surgeon and R4 morning rounds
- Direct supervision by R5 during afternoon rounds with immediate direct supervision available by attending surgeon.
- Direct supervision by an attending surgeon and R5 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Goals for Third (R3) Resident Year:

Rotation length: 4 weeks

The primary goal for this rotation is for the R3 resident to gain skills and competence in mastering the skills to run a sub-specialty surgical service under the supervision of a Chief Surgical Resident and an Attending surgeon. In addition, the R3 will gain the skills and competence of managing colorectal surgical patients in an outpatient setting, including pre-operative and post-operative management. At the completion of the rotation the R3 will be ready to assume full responsibility of all aspects of patient care on a colorectal surgical service under the supervision of an attending surgeon. The R3, after successful completion of this rotation, will further develop knowledge, skill, and competence in the following:

Objectives for R3 in Colorectal Surgery

Patient Assessment, History and Physical

1. Supervise and instruct lower level residents and students in the integration of history, physical, laboratory and imaging data in order to assess patients with colorectal conditions and present treatment plans to the faculty.

Documentation

2. Demonstrate a leadership role in documentation, especially when there is a change in patient status or major change in treatment plan or prognosis.
3. Demonstrate a leadership role in informed consent and documentation of discussions between other health care professionals and the team.
4. Demonstrate a leadership role in documenting discussions with the patient, his or her family members or medical proxy and the surgical team.
5. Demonstrate the ability to oversee the appropriate daily progress note, admission and discharge notes, procedure dictations, and medicine reconciliation as performed by the junior house staff.

Patient Care and Management

6. Establish responsibility for the running of the colorectal surgery service under the direct supervision of a Chief Resident and an attending surgeon.
 - a. Formulate assessment and plans for all patients and review with the Chief resident and faculty.
7. Demonstrate knowledge and understanding of ventilator management, hemodynamic support, conscious sedation and pain control, and pharmaceutical intervention in the intensive care unit as pertains to the colorectal surgical patient.
8. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families.
9. Assist the junior resident and consult resident with all aspects of patient care and evaluations.
10. Identify and routinely apply quality measures to assure optimal patient care.
11. Participate in Practice-based learning and improvement mechanisms.
12. Obtain an understanding of Systems-based practice, particularly in the private hospital setting.
 - a. Develop continued improvement in communication and transfer of information skills between house staff and physicians assistants and nurse practitioners.
 - b. Develop continued improved team-building skills

Perioperative Care and Risk Assessment

13. Demonstrate the ability to oversee perioperative care and assessments made by more junior housestaff.
14. Educate junior residents and consults in effective, quality perioperative care.

Operative Skills

15. Demonstrate improvement in skills developed as a more junior resident.
16. Demonstrate the skill to first assist or act as the operating surgeon under the direct supervision of the surgical attending.
17. Demonstrate more in depth understanding of surgical anatomy and technical skills necessary for more complex surgical procedures of the anorectum including advancement flaps, management of rectovaginal fistulas, sphincteroplasties and trans-anal excisions of rectal lesions.
18. Demonstrate more in depth understanding of surgical anatomy and technical skills necessary for more complex abdominal surgical procedures of the colon and small bowel including those related to malignancy and inflammatory bowel diseases, and the appropriate use of advanced laparoscopic procedures.
19. Demonstrate proficiency with advanced laparoscopic equipment, stapling techniques and instruments, hemostasis techniques and instruments. 19. Demonstrate understanding of retractors and appropriate exposure techniques.
20. Demonstrate competence in the use of the colonoscope and understanding of its diagnostic and therapeutic roles.
21. Demonstrate an in depth knowledge and understanding of the pathophysiology of the disease process, the indication for surgery, alternatives to surgery, and the details of the surgical procedure.
22. Develop improved skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

23. Demonstrate radiographic findings to junior residents and students, and during conferences.
24. Demonstrate an understanding of how to best utilize the imaging results to optimize patient care.

Outpatient Patient Care- A minimum of one half day per week is mandatory

25. Demonstrate the ability to assume a more senior role in the evaluation and management of outpatient colorectal surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.
26. Learn coding, billing, and outpatient systems.

Education

27. Educate medical students and junior residents in patient care matters and principles of colorectal surgery.
28. Teach the junior residents with respect to effective and efficient patient care techniques and data management.
29. Help to prepare conferences and journal clubs and take an active role in teaching at these conferences.

30. Develop knowledge to assess statistical methods and critique the surgical literature for conferences, rounds, and journal club.
31. Integrate the evidence-based literature to clinical practice.
32. Demonstrate ability to evaluate junior residents in writing and to evaluate the faculty, the rotation, and the program in an anonymous fashion.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 3 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 3 or be directly available in the hospital or by telephone 24 hours daily.
3. PGY 3 Residents will serve as supervisors to junior residents
4. The PGY 3 resident will be able to perform certain procedures under indirect supervision of an attending physician; with the attending physician immediately available by phone or other electronic device, or on the premises. This excludes any invasive procedures beyond the scope of what can be safely performed at the patient's bedside. Anything beyond this will require direct attending supervision.
5. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
6. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
7. Direct supervision by an Attending surgeon during daily morning rounds
8. immediate direct supervision available by attending surgeon on afternoon rounds
9. Direct supervision by an Attending surgeon until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available

Goals for Fourth (R5) Resident Year:

Rotation length: 4 weeks

The primary goal for this rotation is for the R5 resident to gain skills and competence in the running of a sub-specialty surgical service under the supervision of an attending surgeon. At the completion of the rotation the R5 will be ready to assume full responsibility of all aspects of patient care on a colorectal surgical service under the supervision of an attending surgeon. The R5, after successful completion of this rotation, will further develop knowledge, skill, and competence in the following:

Objectives for R5 in Colorectal Surgery

Patient Assessment, History and Physical

1. Supervise and instruct lower level residents and students in the integration of history, physical, laboratory and imaging data in order to assess patients with colorectal conditions and present treatment plans to the faculty.

Documentation

2. Demonstrate a leadership role in documentation, especially when there is a change in patient status or major change in treatment plan or prognosis.
3. Demonstrate a leadership role in informed consent and documentation of discussions between other health care professionals and the team.
4. Demonstrate a leadership role in documenting discussions with the patient, his or her family members or medical proxy and the surgical team.
5. Demonstrate the ability to oversee the appropriate daily progress note, admission and discharge notes, procedure dictations, and medicine reconciliation as performed by the junior house staff.

Patient Care and Management

6. Establish complete responsibility for the running of the colorectal surgery service under the direct supervision of an attending surgeon.
 - a. Formulate assessment and plans for all patients and review with faculty.
7. Demonstrate knowledge and understanding of ventilator management, hemodynamic support, conscious sedation and pain control, and pharmaceutical intervention in the intensive care unit as pertains to the colorectal surgical patient.
8. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families.
9. Assist the junior resident and consult resident with all aspects of patient care and evaluations.
10. Identify and routinely apply quality measures to assure optimal patient care.
11. Participate in Practice-based learning and improvement mechanisms.
12. Obtain an understanding of Systems-based practice, particularly in the private hospital setting.
 - a. Develop continued improvement in communication and transfer of information skills between house staff and physicians assistants and nurse practitioners.
 - b. Develop continued improved team-building skills

Perioperative Care and Risk Assessment

13. Demonstrate the ability to oversee perioperative care and assessments made by more junior housestaff.
14. Educate junior residents and consults in effective, quality perioperative care.

Operative Skills

15. Demonstrate improvement in skills developed as a more junior resident.
16. Demonstrate the skill to first assist or act as the operating surgeon under the direct supervision of the surgical attending.
17. Demonstrate more in depth understanding of surgical anatomy and technical skills necessary for more complex surgical procedures of the anorectum including advancement flaps, management of rectovaginal fistulas, sphincteroplasties and trans-anal excisions of rectal lesions.
18. Demonstrate more in depth understanding of surgical anatomy and technical skills necessary for more complex abdominal surgical procedures of the colon and small bowel including those related to malignancy and inflammatory bowel diseases, and the appropriate use of advanced laparoscopic procedures.
19. Demonstrate proficiency with advanced laparoscopic equipment, stapling techniques and instruments, hemostasis techniques and instruments. 19. Demonstrate understanding of retractors and appropriate exposure techniques.
20. Demonstrate competence in the use of the colonoscope and understanding of its diagnostic and therapeutic roles.
21. Demonstrate an in depth knowledge and understanding of the pathophysiology of the disease process, the indication for surgery, alternatives to surgery, and the details of the surgical procedure.
22. Develop improved skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

23. Demonstrate radiographic findings to junior residents and students, and during conferences.
24. Demonstrate an understanding of how to best utilize the imaging results to optimize patient care.

Outpatient Patient Care- A minimum of one half day per week is mandatory

25. Demonstrate the ability to assume a more senior role in the evaluation and management of outpatient colorectal surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.
26. Learn coding, billing, and outpatient systems.

Education

27. Educate medical students and junior residents in patient care matters and principles of colorectal surgery.
28. Teach the junior residents with respect to effective and efficient patient care techniques and data management.
29. Help to prepare conferences and journal clubs and take an active role in teaching at these conferences.

30. Develop knowledge to assess statistical methods and critique the surgical literature for conferences, rounds, and journal club.
31. Integrate the evidence-based literature to clinical practice.
32. Demonstrate ability to evaluate junior residents in writing and to evaluate the faculty, the rotation, and the program in an anonymous fashion.

Supervision of Residents

10. The supervising attending will provide direct supervision to the PGY 5 residents while in the operating room and in the out-patient setting.
11. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 5 or be directly available in the hospital or by telephone 24 hours daily.
12. PGY 5 Residents will serve as supervisors to junior residents
13. The PGY 5 resident will be able to perform certain procedures under indirect supervision of an attending physician; with the attending physician immediately available by phone or other electronic device, or on the premises. This excludes any invasive procedures beyond the scope of what can be safely performed at the patient's bedside. Anything beyond this will require direct attending supervision.
14. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
15. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
16. Direct supervision by an Attending surgeon during daily morning rounds
17. immediate direct supervision available by attending surgeon on afternoon rounds
18. Direct supervision by an Attending surgeon until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Medical Knowledge Learning Activities which provide experience in this competency development include:

- a. Resident conferences
- b. Monthly Surgical Grand Rounds
- c. Presentations at Morbidity & Mortality Conferences (R3s & R5s)
- d. Daily Ward Rounds
- e. Educational experiences in clinic, hospital, operating room
- f. Regularly scheduled weekly/monthly conferences (departmental and/or service specialized conferences)

Residents are expected to:

- a. Demonstrate an investigatory and analytic thinking approach to clinical situations
- b. Know and apply the basic and clinically supportive sciences, which are appropriate to their level of training.

Resident Assessment includes observation of performance in these areas:

- a. Daily Attending Rounds
- b. Daily Ward Rounds
- c. Written evaluation by faculty

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Residents are expected to:

- a. Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- b. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems (R3s & R5s)
- c. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness (R4s & R5s)
- d. Use information technology to manage information, access on-line medical information; and support their own education
- e. Facilitate the learning of students and other health care professionals with which they interact on the service.

Practice-Based Learning and Improvement Learning Activities which provide experience in this competency development include:

- a. Case review at weekly M&M Conference
- b. Case discussion at resident conferences
- c. Medical student education

Resident Assessment includes observation of performance in these areas:

- a. Faculty evaluations
- b. Presentations at M&M conference, (R3s & R5s) Colorectal Surgery Rounds
- c. Knowledge of study designs, statistical methods.
- d. Analysis of own practices-self evaluations
- e. Data gathering and feedback
- f. Use of information technology
- g. Student education

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

Interpersonal and Communication Skills Learning Activities which provide experience in this competency development include:

- a. Patient care experiences in outpatient settings and in-hospital
- b. Grand Rounds and M&M presentations (R3s & R5s)
- c. Ward Rounds presentations
- d. Observed Structured Clinical Exams
- e. Teaching interactions with student learners; analysis of student feedback on teaching

Residents are expected to:

- a. Create and sustain a therapeutic and ethically sound relationship with patients
- b. Show compassion for patients and their families
- c. Provide Counseling, education, and informed consent instructions to patients at the level appropriate with their training
- d. Listens to patients, and other members of the health care team
- e. Patient inclusion in treatment decisions
- f. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- g. Work effectively with others as a member or leader of a health care team or other professional group

Resident Assessment includes observation of performance in these areas:

- a. Faculty evaluation
- b. Ward Rounds feedback
- c. M&M presentation evaluation
- d. Multi-source evaluations by residents, nurses and mid level practitioners
- e. Patient surveys

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Professionalism Learning Activities which provide experience in this competency development, include:

- a. Surgical faculty and other role modeling
- b. Completing medical records, evaluations and certifications in a timely fashion
- c. Professional dress and timeliness to conferences

Residents are expected to:

- a. Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- b. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- c. Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

Residents Assessment includes observation of performance in these areas:

- a. Regard for welfare of others
- b. Adheres to a code of moral and ethical values
- c. Respectful of patients and their families
- d. Respectful of other members of the health care team
- e. Provides prompt consultations upon request
- f. Sensitive to patients' cultural backgrounds
- g. Accountable for own actions
- h. Reliable
- i. Punctual

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Systems-Based Practice Learning Activities which provide experience in this competency development include:

- a. Case review at M&M Conference
- b. Planning discharge of complicated patients using home health, nursing homes
- c. Coordinating patients' care

Residents are expected to:

- a. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- b. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- c. Practice cost-effective health care and resource allocation that does not compromise quality of care
- d. Advocate for quality patient care and assist patients in dealing with system complexities
- e. Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Resident Assessment includes observation of performance in these areas:

- a. Provides cost-effective care
- b. Successfully facilitates patient care through the in-patient system
- c. Advocates for patients within the health care system
- d. Refers patients to appropriate practitioners and agencies
- e. Accesses assistance within the health care system for coordination and management of ongoing care
- f. Discharges patients in a timely and appropriate manner

Department of Surgery

Endocrine Surgery

Rotation Goals and Objectives

Summary:

The Endocrine Surgery service provides a focused, in depth experience in the management of patients with endocrine tumors. There is an emphasis on patients with thyroid cancer, parathyroid tumors, and adrenal tumors, as well as patients with benign thyroid conditions. Residents (R4, R2, and R1) will learn the multidisciplinary care these patients require for evaluation and treatment, and will recognize the role that surgery plays in the management of their disease. Education in the adjuvant treatment and postoperative screening of thyroid cancer patients will also be emphasized. Residents will gain clinical experience in the inpatient and outpatient settings. These goals and objectives are competency based and for the competency of Patient Care, the goals and objectives are specified by resident year.

Competency-Based Goals and Objectives for Endocrine Surgery Service

Rotation: NYU Langone Medical Center, Tisch Hospital

Length: 2 weeks (4-6 weeks/resident/year)

Goals for the R1 on Endocrine Surgery Service

The goals on this rotation are for the R1 to gain broad exposure to Endocrine Surgery patients, to begin to learn how to perform an evaluation of patients with Endocrine Surgical diseases including an assessment of relevant risk factors, to start to develop an understanding of the multidisciplinary nature of Endocrine Surgical diseases, and to understand the perioperative and postoperative care of the Endocrine Surgery patient.

R1 Summary: Residents at this level will participate as first and second assistants on a variety of surgical procedures for benign and malignant conditions of the thyroid, parathyroid, and adrenal glands. They will provide care for these patients postoperatively. They will also participate in the endocrine surgery outpatient clinics under attending supervision.

PATIENT CARE

Objectives for the R1 on Endocrine Surgery

Patient Assessment, History and Physical

Thyroid

1. Develop an algorithm that includes pertinent history, examination findings, and diagnostic evaluation of:
 - a. A palpable thyroid nodule
 - b. A nonpalpable nodule discovered on ultrasound performed for nonthyroid pathology
 - c. Well-differentiated thyroid cancer
2. Describe the risk factors for well-differentiated thyroid cancer
3. Outline algorithms for the evaluation and treatment of hyperthyroidism due to Graves' disease, toxic nodule, medications, and pregnancy.
4. Describe the clinical presentation of thyroid storm and outline the treatment of thyroid storm
5. Outline an algorithm for the evaluation and management of nontoxic multinodular goiter
6. Outline the pathophysiology of multinodular goiter, Graves' disease, and thyroid cancer
7. Obtain a focused history, perform an examination, and institute the diagnostic evaluation of a patient with:
 - a. A thyroid nodule
 - b. Goiter
 - c. Hyperthyroidism
8. Palpate and describe a thyroid nodule
9. Palpate and describe a goiter
10. Identify exophthalmos

Parathyroid

1. Obtain a focused history, perform an examination, and institute the diagnostic evaluation of a patient with hypercalcemia
2. Develop an algorithm that includes pertinent history, examination finding, and initial diagnostic evaluation of:
 - a. Asymptomatic primary hyperparathyroidism including appropriate follow up to include diagnostic evaluation, frequency of testing, and anticipated outcomes.
 - b. Symptomatic primary hyperparathyroidism
3. Outline an algorithm for the preoperative localization of parathyroid adenoma in patients with primary hyperparathyroidism.
4. Outline the evaluation and treatment of life-threatening hypercalcemia

Adrenal

1. Describe the evaluation and treatment of an adrenal incidentaloma.
2. Perform a thorough physical examination and be familiar with signs of hormone excess. (hirsutism, striae, acne, facial changes, clitoral hypertrophy, etc) .

3. Identify the etiologies, common signs and symptoms, and clinical presentations of Cushing's syndrome.
4. Describe the diagnostic algorithm for primary hyperaldosteronism.
5. Describe the treatment and outcome for primary hyperaldosteronism in patients treated with adenoma vs. bilateral adrenal hyperplasia.
6. Describe the signs, symptoms, and evaluation of primary hyperaldosteronism.
7. Describe the physiology, clinical presentation, treatment, and preoperative preparation of pheochromocytoma.
8. Outline the diagnostic pathway for pheochromocytoma and review of the treatment modalities and recommendations.
9. Be familiar with medications that can alter interpretation of catecholamines (i.e. antidepressants, Tylenol, etc)
10. Describe the general attributes of adrenocortical carcinoma.
11. Outline the diagnostic evaluation and treatment of adrenocortical carcinoma.

Radiographic Interpretation

1. Recognize common radiographic findings in Endocrine Surgical patients including thyroid nodules, parathyroid adenomas and adrenal masses.
2. Develop interpretation skills for US, CT scans and MRIs.
3. Interpret a Sestamibi scan
4. Locate the adrenal glands on a CT scan

Perioperative Care and Risk Assessment

1. Perform preoperative cardiac risk assessment and venous thromboprophylaxis risk assessment.
2. Describe the protocol for perioperative steroid use in a patient taking exogenous steroids.

Operative Skills

Thyroid

1. Demonstrate normal thyroid anatomy in the operating room, including the thyroid gland, its vascular supply and venous drainage, the parathyroid glands, recurrent laryngeal nerves, strap muscles, and platysma.
2. Describe the operative approaches to thyroid pathology
3. Perform the initial steps in thyroid surgery, including
 - a. Patient positioning and marking
 - b. Skin incision and raising subplatysmal flaps
 - c. Opening strap muscles
 - d. Close strap muscles, platysma, and skin

Parathyroid

1. Demonstrate normal parathyroid anatomy in the operating room, including typical gland locations, blood supply, and relationship to the recurrent laryngeal nerves and other adjacent structures.

2. Outline an algorithm for intraoperative confirmation of successful parathyroidectomy during full neck exploration and minimally invasive parathyroidectomy including the role of intraoperative PTH monitoring and its correlation with postoperative eucalcemia.
3. Perform the following steps in a parathyroidectomy (for both bilateral exploration and minimally invasive procedures):
 - a. Patient positioning and marking
 - b. Skin incision and raising subplatysmal flaps
 - c. Opening strap muscles
 - d. Close strap muscles, platysma, and skin

Adrenal

1. Identify adrenal anatomy, blood supply, and surrounding structures at the time of adrenalectomy or other operation.

Patient Care and Management

1. Recognize, respond to and learn to manage changes in patient status/emergencies that may occur after thyroidectomy and parathyroidectomy, including :
 - a. Hematoma
 - b. Hypocalcemia
 - c. Unilateral and bilateral recurrent laryngeal nerve injury
2. Identify complications of adrenalectomy, including adrenal insufficiency and the diagnosis, treatment, and causes.

Documentation

1. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes.
2. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.

Outpatient Patient Care- A minimum of one half day per week is mandatory

Thyroid

1. Describe the outpatient management of the following postoperative conditions:
 - a. Thyroid hormone replacement
 - b. Postoperative hypocalcemia
 - c. Postoperative voice changes
2. Perform an outpatient comprehensive history, physical, and evaluation of the Endocrine Surgery patient in an office-based setting.

Parathyroid

1. Describe the recognition, evaluation, and management of the following postoperative complications:
 - a. Hematoma
 - b. Hypocalcemia
 - c. Voice changes

2. Outline outpatient follow up after parathyroidectomy

Adrenal

1. Identify complications of adrenalectomy, including adrenal insufficiency and the diagnosis, treatment, and causes.

Education

1. Educate medical students in patient care matters and principles of Endocrine Surgery.
2. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings and national guidelines.
3. Develop skills for searching the medical literature and begin to read articles critically.

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.
- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
- Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
- d. Patient develops signs of shock
 - Direct supervision by an Attending surgeon, R5,R4,R3 and R2 morning rounds
 - Direct supervision by R5, R4, R3, and R2 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.

Direct supervision by an Attending surgeon, R5, R4, R3, R2 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available

Goals for the R2 on Endocrine Surgery Service

The goals for this rotation are for the R2 to gain broad exposure to Endocrine Surgery patients, to learn how to perform an evaluation of patients with Endocrine Surgical diseases including an assessment of relevant risk factors, to begin to integrate what factors go into determining the appropriate use of surgery (including when surgery is not appropriate), to start to develop an understanding of the multidisciplinary nature of Endocrine Surgical diseases, and to understand the complete care of the Endocrine Surgery patient (including perioperative and postoperative care, indications for and administration of adjuvant treatments, genetic counseling when appropriate).

R2 Summary: Residents at this level will participate as first assistant on a variety of surgical procedures for benign and malignant conditions of the thyroid, parathyroid, and adrenal glands. They will provide care for these patients postoperatively. They will also participate in the endocrine surgery outpatient clinics under attending supervision. Outpatient care of endocrine surgery patients includes preoperative evaluation as well as postoperative management, including long term follow-up and monitoring of thyroid cancer patients.

PATIENT CARE

Objectives for the R2 on Endocrine Surgery

Patient Assessment, History and Physical

Thyroid

11. Develop an algorithm that includes pertinent history, examination findings, and diagnostic evaluation of:
 - a. A palpable thyroid nodule
 - b. A nonpalpable nodule discovered on ultrasound performed for nonthyroid pathology
 - c. Well-differentiated thyroid cancer
 - d. Medullary thyroid cancer
 - e. Anaplastic thyroid cancer
12. Describe the risk factors for well-differentiated thyroid cancer, medullary thyroid cancer, and anaplastic thyroid cancer
13. Outline algorithms for the evaluation and treatment of hyperthyroidism due to Graves' disease, toxic nodule, medications, and pregnancy.
14. Describe the clinical presentation of thyroid storm and outline the treatment of thyroid storm
15. Outline an algorithm for the evaluation and management of nontoxic multinodular goiter, including substernal goiter with and without airway involvement
16. Outline the pathophysiology of multinodular goiter, Graves' disease, and thyroid cancer
17. Obtain a focused history, perform an examination, and institute the diagnostic evaluation of a patient with:
 - a. A thyroid nodule
 - b. Goiter
 - c. Hyperthyroidism
18. Palpate and describe a thyroid nodule
19. Palpate and describe a goiter
20. Identify exophthalmos

Parathyroid

5. Obtain a focused history, perform an examination, and institute the diagnostic evaluation of a patient with hypercalcemia

6. Develop an algorithm that includes pertinent history, examination finding, and initial diagnostic evaluation of:
 - a. Asymptomatic primary hyperparathyroidism including appropriate follow up to include diagnostic evaluation, frequency of testing, and anticipated outcomes. Describe which patients are appropriate candidates for nonoperative management
 - b. Symptomatic primary hyperparathyroidism
7. Outline an algorithm for the preoperative localization of parathyroid adenoma in patients with primary hyperparathyroidism. Discuss the rationale and accuracy of the various localizing strategies and tests
8. Outline a diagnostic and treatment pathway for patients with non-MN familial hyperparathyroidism
9. Outline indication for and interpretation of results of bone density testing
10. Outline the evaluation and treatment of life-threatening hypercalcemia

Adrenal

12. Describe the evaluation and treatment of an adrenal incidentaloma.
13. Perform a thorough physical examination and be familiar with signs of hormone excess. (hirsutism, striae, acne, facial changes, clitoral hypertrophy, etc) .
14. Identify the etiologies, common signs and symptoms, and clinical presentations of Cushing's syndrome.
15. Outline the diagnostic evaluation of hypercortisolism.
16. Outline the diagnostic pathway of ACTH dependent vs. ACTH independent Cushing's syndrome, including the role of the low and high dose dexamethasone suppression test. Understand normal ranges and those expected for suppression of cortisol and be familiar with the utility and role of salivary, venous and urinary cortisol assessments.
17. Distinguish bilateral hyperplasia vs. unilateral disease in Cushing's syndrome and primary hyperaldosteronism.
18. Describe the diagnostic algorithm for primary hyperaldosteronism.
19. Describe the treatment and outcome for primary hyperaldosteronism in patients treated with adenoma vs. bilateral adrenal hyperplasia.
20. Describe the signs, symptoms, and evaluation of primary hyperaldosteronism.
21. Differentiate between primary and secondary hyperaldosteronism.
22. Describe the physiology, clinical presentation, treatment, and preoperative preparation of pheochromocytoma.
23. Outline the diagnostic pathway for pheochromocytoma and review of the treatment modalities and recommendations.
24. Be familiar with medications that can alter interpretation of catecholamines (i.e. antidepressants, Tylenol, etc)
25. Describe the general attributes of adrenocortical carcinoma.
26. Outline the diagnostic evaluation and treatment of adrenocortical carcinoma.
27. Explain the etiology, diagnosis, and treatment of adrenal cystic disease.
28. Explain the role of fine needle aspiration biopsy in the evaluation of adrenal tumors.
29. Outline the etiologies, clinical presentation, evaluation and management of adrenal insufficiency.

Radiographic Interpretation

5. Recognize common radiographic findings in Endocrine Surgical patients including thyroid nodules, parathyroid adenomas and adrenal masses.
6. Develop interpretation skills for US, CT scans and MRIs.
7. Interpret a Sestamibi scan
8. Locate the adrenal glands on a CT scan
9. Describe the localization studies available for adrenal tumors, including CT scanning, MIBG, PET scanning, and MRI.
10. Understand functioning imaging modalities for pheochromocytoma and adrenal hyperplasia (i.e., MIBG or NP 59 scanning)
11. Understand technique involved with adrenal vein sampling; role of ACTH stimulation and cortisol assessment to document accuracy of catheter location.

Perioperative Care and Risk Assessment

3. Perform preoperative cardiac risk assessment and venous thromboprophylaxis risk assessment.
4. Describe the protocol for perioperative steroid use in a patient taking exogenous steroids.
5. Understand algorithm and dosing of preoperative preparation/blockade for pheochromocytoma

Operative Skills

Thyroid

4. Demonstrate normal thyroid anatomy in the operating room, including the thyroid gland, its vascular supply and venous drainage, the parathyroid glands, recurrent laryngeal nerves, strap muscles, and platysma.
5. Describe the normal variants in recurrent laryngeal nerve anatomy including frequency.
6. Describe the operative approaches to thyroid pathology
7. Perform the initial steps in thyroid surgery, including
 - a. Patient positioning and marking
 - b. Skin incision and raising subplatysmal flaps
 - c. Opening strap muscles
 - d. Close strap muscles, platysma, and skin

Parathyroid

4. Demonstrate normal parathyroid anatomy in the operating room, including typical gland locations, blood supply, and relationship to the recurrent laryngeal nerves and other adjacent structures.
5. Demonstrate in the operating room typical locations for ectopic parathyroid glands
6. Outline an algorithm for intraoperative confirmation of successful parathyroidectomy during full neck exploration and minimally invasive parathyroidectomy including the role of intraoperative PTH monitoring and its correlation with postoperative eucalcemia.
7. Describe the technique of cryopreservation and its role in the treatment of patients with multigland disease or during reoperative parathyroid surgery

8. Perform the following steps in a parathyroidectomy (for both bilateral exploration and minimally invasive procedures):
 - a. Patient positioning and marking
 - b. Skin incision and raising subplatysmal flaps
 - c. Opening strap muscles
 - d. Close strap muscles, platysma, and skin

Adrenal

2. Describe operative approaches for adrenal surgery, including the laparoscopic trans- and extraperitoneal approaches and anterior, lateral and posterior open approaches.
3. Identify both adrenal glands in a cadaver or in the operating room.
4. Identify adrenal anatomy, blood supply, and surrounding structures at the time of adrenalectomy or other operation.
5. Demonstrate operative exposure (open or laparoscopic; human, cadaver, or animal) of either adrenal gland.

Patient Care and Management

3. Recognize, respond to and learn to manage changes in patient status/emergencies that may occur after thyroidectomy and parathyroidectomy, including :
 - a. Hematoma
 - b. Hypocalcemia
 - c. Unilateral and bilateral recurrent laryngeal nerve injury
4. Identify complications of adrenalectomy, including adrenal insufficiency and the diagnosis, treatment, and causes.

Documentation

3. Outline the staging and prognosis of thyroid cancer
4. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes.
5. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.

Outpatient Patient Care- A minimum of one half day per week is mandatory

Thyroid

3. Describe the outpatient management of the following postoperative conditions:
 - a. Thyroid hormone replacement
 - b. Postoperative hypocalcemia
 - c. Postoperative voice changes
4. Perform an outpatient comprehensive history, physical, and evaluation of the Endocrine Surgery patient in an office-based setting.

Parathyroid

3. Describe the recognition, evaluation, and management of the following postoperative complications:

- a. Hematoma
 - b. Hypocalcemia
 - c. Voice changes
4. Outline outpatient follow up after parathyroidectomy

Adrenal

2. Identify complications of adrenalectomy, including adrenal insufficiency and the diagnosis, treatment, and causes.

Education

4. Educate medical students in patient care matters and principles of Endocrine Surgery.
5. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings and national guidelines.
6. Develop skills for searching the medical literature and begin to read articles critically.

Supervision of Residents

Faculty supervision of the R2 will be in the following capacity:

1. The supervising attending will provide direct supervision to the R2 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the R2 or be directly available in the hospital or by telephone 24 hours daily.
3. The R2 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising, the attending physician will be immediately available. Such procedures are limited to minor procedures at the bedside, including (but not limited to) staple removal, phlebotomy, removal of drains. This excludes any invasive procedure beyond the scope of what can be safely performed at a patient's bedside. Anything beyond this will require direct attending supervision.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient develops any significant change in status, such as hematoma, hypocalcemia, signs of unilateral or bilateral recurrent laryngeal nerve injury following thyroidectomy or parathyroidectomy, or adrenal insufficiency following adrenalectomy.
 - b. A patient is transferred to the intensive care unit
 - a. A patient dies or an end of life decision is made

Goals for the R4 on Endocrine Surgery Service

The goals for this rotation are for the R4 to gain in depth exposure to Endocrine Surgery patients, to perform a complete evaluation of patients with Endocrine Surgical diseases including an assessment of relevant risk factors, to integrate which factors go into determining the appropriate use of surgery (including when surgery is not appropriate), to develop a detailed understanding of the multidisciplinary nature of Endocrine Surgical diseases, and to understand the complete care of the Endocrine Surgery patient (including perioperative and postoperative

care, indications for and administration of adjuvant treatments, genetic counseling when appropriate).

R4 Summary: Residents at this level will participate as first assistant or surgeon (with attending supervision) on a variety of surgical procedures for benign and malignant conditions of the thyroid, parathyroid, and adrenal glands. They will provide care for these patients postoperatively. They will also participate in the endocrine surgery outpatient clinics under attending supervision. Outpatient care of endocrine surgery patients includes preoperative evaluation as well as postoperative management, including long term follow-up and monitoring of thyroid cancer patients.

PATIENT CARE

Objectives for the R4 on Endocrine Surgery

The objective of the Endocrine Surgery rotation for R4 residents is to develop knowledge and skills, **in addition to those listed above for R1/R2 residents**, in the evaluation and treatment of patients with diseases of the thyroid, parathyroid, and adrenal glands including:

Patient Assessment, History and Physical

Thyroid

1. The complete evaluation and management of patients with thyroid cancer (papillary, follicular, medullary, poorly differentiated, and anaplastic) including:
Preoperative evaluation and accurate interpretation of radiographic studies (Neck Ultrasound, CT, MRI, PET, Radioactive Iodine Scans)
2. The complete evaluation and management of nontoxic multinodular goiter and substernal goiter
3. The complete evaluation and management of toxic multinodular goiter, Graves' and thyroiditis
4. Perform a fine needle aspiration of thyroid nodule
5. The interpretation of thyroid FNA and the complete evaluation and management of patients with indeterminate FNA

Parathyroid

1. The complete evaluation and management of patients with parathyroid disease including
 - a. Preoperative evaluation including radiographic studies
 - b. Operative approaches
 - c. Extent of resection
 - d. Postoperative treatment, surveillance, and monitoring
2. The complete evaluation and management of recurrent or persistent hyperparathyroidism, including imaging studies and selective venous sampling
3. The treatment pathway for MEN 1 and 2A patients, including the order in which the different manifestations should be treated

Adrenal

1. Identify the distinguishing characteristics of extraadrenal pheochromocytomas.

2. Describe the evaluation and treatment of multiple endocrine neoplasia type 2 syndrome in a patient with adrenal lesions.
3. Describe the diagnosis and treatment of paragangliomas.

Radiographic Interpretation

1. Performance and interpretation of head and neck ultrasonography including thyroid and cervical lymph node imaging.
2. Performance and interpretation of head and neck ultrasonography, demonstrating the thyroid gland, adjacent structures and a parathyroid adenoma or hyperplasia.

Perioperative Care and Risk Assessment

1. Assessment of vocal cord function by flexible transnasal endoscopy

Operative Skills

Thyroid

1. Performance of the critical steps of thyroid lobectomy including
 - a. Identification of recurrent laryngeal nerve
 - b. Identification of parathyroid glands
 - c. Ligation of superior pole vessels
 - d. Ligation of inferior thyroid artery branches
2. Mobilization of thyroid lobe
3. Approaches for and complications associated with reoperative thyroid surgery
4. Management of intraoperative recurrent nerve injury
5. Locally invasive thyroid cancer
 - a. Tracheal invasion
 - b. Esophageal invasion

Parathyroid

1. Understanding the different techniques of focused parathyroidectomy including:
 - a. Mini incision open
 - b. Radioguided
2. Regional anesthesia for minimally invasive parathyroidectomy
3. Performance of parathyroidectomy (both bilateral and minimally invasive) including
 - a. Intraoperative identification and resection of adenoma
 - b. Intraoperative identification of normal parathyroid glands
 - c. Intraoperative identification of hyperplasia
 - d. Parathyroid biopsy
4. Reimplantation of a parathyroid gland
5. Participation in or performance of re-exploration for persistent or recurrent hyperparathyroidism.

Adrenal

1. Review all the surgical options/approaches for adrenalectomy and the indications for each.

2. Identify the steps for a safe and successful right and left laparoscopic transabdominal adrenalectomy. Be familiar with operative technique (positioning, steps of the operation)
3. Perform an adrenalectomy (open or laparoscopic), including patient positioning, dissection, resection, and postoperative care.
4. Describe the surgical approaches to pheochromocytoma.
5. Describe the intraoperative management of patients with pheochromocytoma during surgery regarding anesthetic management, surgical technique, and pre and postoperative care.
6. Understand indications and technique of subtotal adrenalectomy
7. Have an understanding of intraoperative medical management of adrenergic crisis.

Patient Care and Management

1. Recognize, respond to and manage changes in patient status/emergencies that may occur, including :
 - a. Hematoma
 - b. Hypocalcemia
2. Be familiar with common complications following adrenalectomy and ways to avoid them.
3. Be comfortable with maintenance or physiologic dosing of steroids and flornidol following bilateral adrenalectomy. Be comfortable with conversion of steroid supplementation.(ex: Dexamethasone, Solumedrol, hydrocortisone)

Documentation

1. Outline the staging and prognosis of thyroid cancer
2. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes.
3. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.

Outpatient Patient Care- A minimum of one half day per week is mandatory

Thyroid

1. Management of incidental finding of cancer in resected specimen
2. Metastatic/recurrent thyroid cancer
3. Management of large thyroid remnant in patient with thyroid cancer
4. Postoperative treatment, surveillance and monitoring

Parathyroid

1. Outline the prevention, recognition, and management of hungry bone syndrome after parathyroidectomy

Adrenal

1. Describe the treatment options for a patient with malignant pheochromocytoma.

Education

1. Educate medical students in patient care matters and principles of Endocrine Surgery.
2. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings and National guidelines.
3. Develop skills for searching the medical literature and begin to read articles critically.

Supervision of Residents

Faculty supervision of the R4 will be in the following capacity:

1. The supervising attending will provide direct supervision to the R4 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the R4 or be directly available in the hospital or by telephone 24 hours daily.
3. R4 Residents will serve as supervisors to junior residents
4. The R4 resident will be able to perform certain procedures under indirect supervision of an attending physician; with the attending physician immediately available by phone or other electronic device, or on the premises. This excludes any invasive procedures beyond the scope of what can be safely performed at the patient's bedside. Particular bedside procedures may be performed by the R4 with Indirect Supervision (24 hour accessible attending physician by phone or pager and/or attending physician on premises). Such procedures are limited to minor procedures at the bedside, including (but not limited to) incision and drainages, phlebotomy, removal of drains. This excludes any invasive procedure beyond the scope of what can be safely performed at a patient's bedside. Anything beyond this will require direct attending supervision.
5. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
6. Residents will notify the supervising attending physician in the event that:
 - a. A patient develops any significant change in status, such as hematoma, hypocalcemia, signs of unilateral or bilateral recurrent laryngeal nerve injury following thyroidectomy or parathyroidectomy, or adrenal insufficiency following adrenalectomy.
 - b. A patient is transferred to the intensive care unit
 - c. A patient dies or an end of life decision is made

MEDICAL KNOWLEDGE

Thyroid

At the completion of this rotation all residents should be able to:

1. Describe normal thyroid embryogenesis and descent.
2. Outline the normal thyroid hormone synthetic pathway including iodine metabolism and feedback mechanisms.
3. Describe the impact of specific medication on the thyroid hormone synthetic pathway and thyroid function.
4. Describe the impact of aging on the thyroid hormone synthetic pathway and thyroid function.

5. Outline appropriate thyroid function testing for the following clinical scenarios, including interpretation of predicted test results:
 - a. Thyroid nodule
 - b. Goiter
 - c. Hyperthyroidism
 - d. Hypothyroidism

Parathyroid

At the completion of this rotation all residents should be able to:

1. Describe the normal parathyroid embryogenesis and descent. Describe how the affects ectopic gland location
2. Outline the normal calcium metabolic pathway including vitamin D metabolism, parathyroid hormone production and regulation, and Calcitonin production and regulation
3. Describe the impact of specific medication and medical condition on serum calcium and calcium metabolism
4. Describe the impact of aging on calcium metabolism
5. Outline the appropriate evaluation for the following clinical scenarios, including:
 - a. Primary hyperparathyroidism
 - b. Secondary hyperparathyroidism
 - c. Tertiary hyperparathyroidism
 - d. Hypercalcemia associate with malignancy
 - e. Hypercalcemia associated with medications

Adrenal

At the completion of this rotation all residents should be able to:

1. Describe the embryology, histology, and physiology of the adrenal gland, distinguishing differences in the cortex and medulla.
2. Describe the anatomy of the adrenal gland, including the arterial supply, venous drainage and relationship to adjacent structures.
3. Outline the biosynthesis and physiologic effects of glucocorticoids, mineralocorticoids, and adrenal sex steroids.
4. Outline the catecholamine synthetic pathway.
5. Describe congenital adrenal hyperplasia.

Familial Endocrinopathies

Familial endocrinopathies are rare entities; however they have important screening and treatment implications. Because of their rarity only Medical Knowledge objectives are incorporated in this section of the curriculum.

Multiple Endocrine Neoplasia Syndromes

1. Describe the components of each of the following multiple endocrine neoplasia (MEN) syndromes, their mode of inheritance, and the frequency of expression of each component:
 - a. MEN type 1

- b. MEN type 2A
 - c. MEN type 2B
- 2. Outline the diagnostic approach for each of the MEN syndromes.
- 3. Describe the treatment, including timing of operative approach, for each component of the following syndromes:
 - a. MEN type 1
 - b. MEN type 2A
 - c. MEN type 2B
- 4. Outline recommended genetic testing for patients suspected of having one of the MEN syndromes.
- 5. Outline the recommended screening for kindred of patients with the different MEN syndromes.
- 6. Outline the recommended follow up of patients with the different MEN syndromes.
- 7. Describe the prognosis for each of the MEN syndromes.

Familial Medullary Thyroid Cancer

1. Describe the mode of inheritance of familial medullary thyroid cancer (FMTC).
2. Outline the diagnostic evaluation, including genetic testing, of FMTC.
3. Outline the recommended treatment, including the role of prophylactic thyroidectomy, for FMTC.
4. Outline the recommended screening for kindred of patients with the different MEN syndromes.
5. Outline the recommended follow up of patients with FMTC.
6. Describe the prognosis for FMTC.
7. Compare and contrast the evaluation and management of FMTC with sporadic medullary thyroid cancer.

Familial Papillary Thyroid Cancer

1. Describe the diagnostic criteria for familial papillary thyroid cancer (FPTC).
2. Describe the mode of inheritance of FPTC.
3. Outline recommended screening for FPTC.
4. Outline the recommended treatment of FPTC.
5. Outline the recommended follow up of patients with FPTC.
6. Describe the prognosis for FPTC.
7. Compare and contrast the evaluation and management of FPTC with sporadic papillary thyroid cancer.

Familial non-MEN Hyperparathyroidism

1. Describe the diagnostic criteria for familial non-MEN hyperparathyroidism (FHPTH).
2. Describe the mode of inheritance of FHPTH.
3. Outline recommended screening for FHPTH.
4. Compare and contrast the evaluation and management of FHPTH with sporadic primary hyperparathyroidism.

PRACTICE-BASED LEARNING AND IMPROVEMENT

At the completion of this rotation all residents should:

11. Have gained further experience in locating information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
 - a. National management guidelines such as those published by the American Thyroid Association and American Association of Endocrine Surgeons should be specifically emphasized.
12. Demonstrate proficiency in accessing scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
13. Be proficient at using the available technology to access patient information.

INTERPERSONAL AND COMMUNICATION SKILLS

At the completion of these rotations all residents should:

1. Demonstrate effective communication to patients, ancillary staff and colleagues, particularly medical Endocrinologists and Nuclear Medicine Physicians.
2. Improve skills to communicate medical information to Endocrine Surgery patients and their families.
3. Improve skills to communicate with co-workers and colleagues to allow for optimum patient care.

PROFESSIONALISM

At the completion of this rotation residents should:

1. Demonstrate a thorough commitment to carrying out professional responsibilities.
2. Demonstrate adherence to ethical principles.
3. Show sensitivity to diverse Endocrine Surgery patient populations.

SYSTEM-BASED PRACTICE

At the completion of these rotations residents should:

1. Show the ability to work effectively in the health care delivery setting, particularly in the private hospital setting, where there are multiple referring physicians.
2. Demonstrate the ability to coordinate Endocrine Surgery patient care within the health care system, particularly coordination with many different referring Endocrinologists and primary physicians, each with specific treatment preferences.
3. Gain a more advanced understanding of cost-containment and risk-benefit analysis in Endocrine Surgery patient care, particularly in the private hospital setting.
4. Improve understanding of quality patient care and optimal ways to achieve it.
5. Demonstrate an advanced understanding of when to utilize consultations from other services to provide an interdisciplinary management of patients.

Department of Surgery

Goals and Objectives for General Surgery Rotations

Summary:

The General Surgery Services are designed to provide the residents with an in-depth knowledge of pre-operative, operative, postoperative, and non-operative care for patients with diseases of the alimentary tract, abdominal wall, and soft tissues. These Goals and Objectives are designed for both the inpatient and outpatient setting. These rotations are also designed to gain technical skills and competence in endoscopic procedures. The Goals and Objectives are competency based. For the competency of Patient Care, the Goals and Objectives are specified by resident year.

Competency-Based Goals and Objectives for Bellevue Hospital, Tisch Hospital and VA Hospital General Surgery

PATIENT CARE

Goals for First (R1) Resident Year:
Rotation length: 4 weeks

The goals for this rotation are for the R1 resident to gain broad exposure to general surgical patients and to start developing knowledge, skill, and competence in the following:

Objectives for R1 (PGY 1) in General Surgery

Patient Assessment, History and Physical

1. Perform of a complete and thorough history and physical examination as it pertains to the surgical or potentially surgical patient.
 - a. Become adept at reviewing medical records and reports, including electronic and digital records
2. Integrate diagnostic laboratory and imaging studies into the patient evaluation and diagnostic process.
 - a. Develop an appreciation for the correct utilization and interpretation of diagnostic imaging and laboratory tests in the workup of the surgical patient.
3. Develop and identify a differential diagnosis and treatment plan for the new surgical patient, or for a new problem that develops in an established patient.
4. Perform review of medications taken at home versus in the hospital as part of the medication reconciliation process.
5. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families, including the morbidly obese and acutely ill patients.

Documentation

6. Perform accurate, complete, legible documentation of the history, physical examination, differential diagnosis and proposed treatment plan.
7. Develop effective medical communication skills and documentation, including the writing of daily progress notes that reflect the SOAP or SBAR acronyms, admission notes, discharge notes, operative notes.
8. Effectively utilize and implement the principles of informed consent and consideration of patient rights, including advanced directives, DNR, and HIPAA rules.

Patient Care and Management

9. Perform basic clinical care skills including phlebotomy, intravenous access, nasogastric tube placement, urinary catheterization.
10. Develop efficient and accurate methods to collect relevant data for rounds.
11. Respond to and learn to manage changes in patient status/emergencies that may occur in the non-intensive care unit patient, including:
 - a. Cardiac
 - Cardiac arrhythmias
 - Myocardial infarctions
 - Hemodynamic instability
 - Electrocardiogram changes
 - b. Neurologic
 - Mental status changes
 - Knowledge of when and how to activate stroke emergency response team
 - c. Fever, Infection, Sepsis
 - Workup of fever in the postoperative and non-operative setting
 - Interpretation of culture and sensitivity results
 - Understand the antibiotic resistance profile in the hospital
 - Understand universal precautions
 - Understand the importance of hand washing and prevention of nosocomial infections
 - Basics of full barrier precautions and sterile technique
 - Understand impact of C. difficile on surgical patient
 - Recognize onset of sepsis and initiate care
 - d. Fluids and Electrolytes
 - Intravenous fluid management including replacement and maintenance
 - Recognize acid base disorders and management options
 - Electrolyte replacement
 - Enteral and parenteral nutritional support
12. Identify and routinely apply quality measures to assure optimal patient care.
13. Participate in Practice-based learning and improvement mechanisms.
14. Obtain an understanding of Systems-based practice, particularly in the hospital setting.
 - a. Develop improved communication and transfer of information skills between housestaff and physicians assistants and nurse practitioners.
 - b. Develop improved team-building skills

Perioperative Care and Risk Assessment

15. Identify complications relating to preoperative, operative, postoperative, and non-operative interventions.
16. Recognize of how complications impact upon the treatment plan and to identify the corrective actions necessary to obtain optimal overall patient outcomes.
17. Perform preoperative cardiac risk assessment and venous thromboprophylaxis risk assessment.
18. Write postoperative orders, perform postoperative checks.

Operative Skills

19. Obtain an understanding of the pathophysiology and surgical anatomy of abdominal wall hernias, biliary tract disease, and neoplastic, inflammatory, and infectious disorders of the gastrointestinal tract and soft tissues.
20. Develop the intraoperative surgical skills necessary for effective treatment of surgical pathology, including the basics of sterile technique, suturing, knot tying, tissue handling, and knowledge of common surgical instrument names.
21. Develop knowledge of surgical site markings and the time out process.
22. Develop knowledge of surgical patient positioning and skin preparation.
23. Understand and develop the skill for the basics of hemostasis.
24. Develop the skills necessary to be an effective first assistant
25. Develop skills of surgical wound management
 - Infection versus inflammatory reaction
 - Abscess versus sterile fluid collection (seroma or hematoma)
 - Wound packing, Vacuum Assisted Closure dressing
 - Recognition of wound dehiscence, evisceration
26. Develop initial skills in lower and upper endoscopy.
27. Develop skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

28. Recognize common plain radiographic findings in surgical patients including pneumonias, pleural effusions, pneumothorax, free intraperitoneal air, small bowel obstruction.
29. Develop interpretation skills for CT scans and MRIs.

Outpatient Patient Care- A minimum of one half day per week is mandatory

30. Perform an outpatient comprehensive history, physical, and evaluation of the general surgery patient in an office-based setting.
31. Manage outpatient general surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.

Skills Laboratory

32. Complete the formal R1 skills lab curriculum and competencies for general surgical procedures.
33. Practice the above procedures and skills using advance simulation techniques.

Education

34. Educate medical students in patient care matters and principles of general surgery.
35. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings.
36. Develop skills for searching the medical literature and begin to read articles critically.
37. Perform evaluations on senior residents, faculty, the rotation and the program in an anonymous fashion.
38. Participate in Simulation Center team-building intra-disciplinary and inter-disciplinary exercises

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.
- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
- Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
- Direct supervision by an Attending surgeon, R5,R4,R3 and R2 morning rounds
- Direct supervision by R5, R4, R3, and R2 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
- Direct supervision by an Attending surgeon, R5, R4, R3, R2 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Goals for Second (R2) Resident Year:

Rotation length: 4-6 weeks.

The goals for this rotation for the R2 resident is to broaden their exposure to general surgical problems and pathology and to apply their education as an R1 for the purpose of continued improvement and more advanced responsibility in patient management. The critical care rotations will further elaborate on the goals and objectives for the management and understanding of the critically ill patient. The R2, after successful completion of this rotation, will further develop knowledge, skill, and competence in the following:

Objectives for R2 in General Surgery

Patient Assessment, History and Physical

1. Improve upon skills outlined above and developed as an R1
2. Perform history and physical on critically ill patients.
3. Perform more detailed and in depth rectal, pelvic, and head and neck examinations.
4. Increase knowledge of proper use of more sophisticated imaging techniques in patient assessment including PET/CT scans and nuclear medicine.

Documentation

5. Demonstrate an improvement in the quality and efficiency of documentation as outlined for the R1.
6. Demonstrate and improvement in the documentation of patient status, diagnoses, comorbidities, assessment, and care plan in the daily progress notes.
7. Dictate more accurate and succinct operative reports.
8. Demonstrate an improvement in the informed consent process with the increased clinical maturity obtained during the R1 year.

Patient Care and Management

9. Demonstrate an improvement in the efficiency and quality of skills outlined for the R1.
10. Demonstrate an improvement of clinical care skills as outlined for the R1 plus demonstrate increasing understanding and competence in advanced skills for the critically ill patient, including central venous access and monitoring, arterial pressure monitoring, hemodialysis access, pulmonary artery catheterization.
11. Demonstrate a more efficient and effective response to changes in patient status/emergencies that may occur in both the critically ill and the non-intensive care unit patient.
12. Identify and routinely apply quality measures to assure optimal patient care.
13. Participate in Practice-based learning and improvement mechanisms.
14. Obtain an understanding of Systems-based practice, particularly in the hospital setting.
 - a. Develop improved communication and transfer of information skills between housestaff and physicians assistants and nurse practitioners.
 - b. Develop improved team-building skills

Perioperative Care and Risk Assessment

15. Demonstrate improvement in the recognition of perioperative complications and its impact on the treatment plan.
16. Demonstrate improved ability to respond to perioperative complications and propose appropriate measures.
17. Demonstrate greater independence in assessing perioperative risk.

Operative Skills

18. Demonstrate ongoing improvement in all skills outlined for PGY-1 above.
19. Improve upon understanding and technical ability for commonly performed surgical operations (hernia repair, hemorrhoidectomy, cholecystectomy, laparotomy).

20. Demonstrate increasing proficiency with laparoscopic equipment, stapling techniques and instruments, and intraoperative ultrasound.
21. Demonstrate increased basic surgical skills such as knot tying and suturing in deep cavities.
22. Develop increased understanding of retractors and appropriate exposure techniques.
23. Demonstrate improvement in endoscopic technique and diagnosis.
24. Develop skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

25. Demonstrate improvement in plain radiograph interpretation as outlined for R1.
26. Identify and interpret surgical pathology on CT scan, MRI, and nuclear medicine studies.

Outpatient Patient Care- A minimum of one half day per week is mandatory

27. Demonstrate improvement in outpatient history, physical, and evaluation of the general surgery patient.
28. Demonstrate an improvement in the management of outpatient general surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.

Skills Laboratory

29. Complete the formal R2 skills lab curriculum and competencies for general surgical procedures.
30. Practice the above procedures and skills.
31. Participate in Simulation Center team-building intra-disciplinary and inter-disciplinary exercises

Education

32. Educate medical students and R1 residents in patient care matters and principles of general surgery.
33. Teach the R1 with respect to effective and efficient patient care techniques and data management.
34. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings and more active role in teaching rounds and conferences.
35. Demonstrate ability to effectively search and read the surgical literature to expand upon patient care activities.
36. Perform evaluations of senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

9. The supervising attending will provide direct supervision to the PGY 2 residents while in the operating room and in the out-patient setting.
10. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2 or be directly available in the hospital or by telephone 24 hours daily.

11. The PGY 2 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
12. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
13. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
14. Direct supervision by an Attending surgeon, R5, R4, and R3 during daily morning rounds
15. Direct supervision by R5, R4 and R3 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
16. Direct supervision by an Attending surgeon, R5, R4, and R3 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Goals for Third (R3) Resident Year:

Rotation length: 4-6 weeks

The goals for this rotation for the R3 resident are to gain the skills and competence to serve as the general surgery consult under the supervision of the chief resident and faculty. They will develop skills to learn team management including taking leadership role during rounds. The critical care rotations will further elaborate on the goals and objectives for the management and understanding of the critically ill patient. The R3, after successful completion of this rotation, will further develop knowledge, skill, and competence in the following:

Objectives for R3 in General Surgery

Patient Assessment, History and Physical

1. Demonstrate improvement in skills developed as a junior resident.
2. Demonstrate ability to integrate history, physical, laboratory and imaging data to assess patient and to present a viable treatment plan(s) to the chief resident and faculty, serving in the capacity of a surgical consult.

Documentation

3. Demonstrate improvement in skills developed as a junior resident.
4. Demonstrate an active role in informed consent and documentation of discussions between other health care professionals and the team.
5. Demonstrate an active role in documenting discussions with the patient, his or her family members or medical proxy and the surgical team.

Patient Care and Management

6. Demonstrate an improvement in skills developed as a junior resident.

7. Demonstrate the ability to assume a more active role in surgical team management.
 - a. Serve as surgical consult on wards and in Emergency Department.
 - b. Formulate assessment and plan for consults and review with faculty and chief resident.
 - c. Follow consult patients during their hospital stay.
8. Demonstrate knowledge and understanding of ventilator management, hemodynamic support, conscious sedation and pain control, and pharmaceutical intervention in the intensive care unit.
9. Demonstrate professional and compassionate communication and interactive skills with patients, colleagues, and families, including the morbidly obese patient.
10. Assist the junior resident and provide first response to changes in patient status.
11. Identify and routinely apply quality measures to assure optimal patient care.
12. Participate in Practice-based learning and improvement mechanisms.
13. Obtain an understanding of Systems-based practice, particularly in the private hospital setting.
 - a. Develop improved communication and transfer of information skills between housestaff and physicians assistants and nurse practitioners.
 - b. Develop improved team-building skills

Perioperative Care and Risk Assessment

14. Demonstrate improvement in skills developed as a junior resident.
15. Demonstrate ability to act as a liaison between attending staff, chief residents and the junior residents.
16. Educate junior residents in effective, quality perioperative care.

Operative Skills

17. Demonstrate improvement in skills developed as a junior resident.
18. Demonstrate understanding of surgical anatomy and technical skills necessary for more complex surgical procedures including hemicolectomy, exploratory laparotomy, and advanced laparoscopic procedures.
19. Demonstrate increasing proficiency with advanced laparoscopic equipment, stapling techniques and instruments, hemostasis techniques and instruments, and intraoperative ultrasound.
20. Demonstrate understanding of retractors and appropriate exposure techniques.
21. Demonstrate increased competence in endoscopic technique and diagnosis.
22. Demonstrate a knowledge and understanding of the pathophysiology of the disease process, the indication for surgery, alternatives to surgery, and the details of the surgical procedure.
23. Develop improved skills in briefing and debriefing the entire operative team, carrying out the time out, and performing surgical specimen reconciliation

Radiographic Interpretation

24. Demonstrate improvement in the skills developed as a junior resident.
25. Demonstrate radiographic findings to junior residents and students, and during conferences.

Outpatient Patient Care- A minimum of one half day per week is mandatory

26. Demonstrate improvement in skills developed as a junior resident.
27. Manage outpatient general surgical patients, including referrals to and interaction with other medical specialties, development of care plans, and the appropriate utilization of diagnostic imaging, laboratory, or physiologic studies.
28. Learn basics of coding, billing, and outpatient systems.

Skills Laboratory

29. Complete the formal R3 skills lab curriculum and competencies for general surgical procedures.
30. Practice the above procedures and skills.
31. Participate in Simulation Center team-building intra-disciplinary and inter-disciplinary exercises

Education

32. Educate medical students and junior residents in patient care matters and principles of general surgery.
33. Teach the junior residents with respect to effective and efficient patient care techniques and data management.
34. Maintain personal study as outlined in Medical Knowledge competency below, including core curriculum textbook readings, journal articles, and more active role in teaching rounds and conferences.
35. Develop knowledge to assess statistical methods and critique the surgical literature for conferences, rounds, and journal club.
36. Perform evaluations of senior residents, faculty, the rotation and the program in an anonymous fashion.

Supervision of Residents

9. The supervising attending will provide direct supervision to the PGY 3 residents while in the operating room and in the out-patient setting.
10. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 3 or be directly available in the hospital or by telephone 24 hours daily.
11. The PGY 3 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
12. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
13. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
14. Direct supervision by an Attending surgeon, R5, and R4 during daily morning rounds
15. Direct supervision by R5 and R4 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.

16. Direct supervision by an Attending surgeon, R5 and R4 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Goals for Fourth (R4) Resident Year:

Rotation length: 4-8 weeks

The primary goal for this rotation is for the R4 resident to gain skills and competence in the running of a surgical service under the supervision of an attending surgeon. At the completion of the R4 year and R4 general surgery rotations, the resident will be ready to assume full responsibility of all aspects of patient care on a general surgery service under the supervision of an attending surgeon. The R4, after successful completion of this rotation, will further develop knowledge, skill, and competence in the following:

MEDICAL KNOWLEDGE

All scheduled conferences are protected time from clinical duties.

1. Demonstrate active medical learning through Departmental, Divisional, and Service conferences.
 - a. All residents will attend the mandatory Morbidity and Mortality (M&M) conference every Thursday at 7:00am.
 - b. As M&M conference is an active Quality Improvement conference for the residents, all residents (whether presenting or not) will thoroughly read the protocol and read for each presented complication. Board-like questions will be asked at the conference.
 - c. Residents presenting at M&M will prepare the protocol summarizing background, events, and the complication. The resident will also review relevant evidenced-based literature regarding the case and complication and be prepared to discuss at conference.
2. Demonstrate self learning and participation in the mandatory Core Basic Science and Clinical Curriculum based on the SCORE curriculum every Wednesday 7:00am.
 - a. Residents will read the chapter prior to the conference.
 - b. Residents will take the weekly quiz based on the readings and lecture for that week.
3. Demonstrate commitment to learning by attending the monthly Grand Rounds.
4. Demonstrate commitment to learning by participating in and presenting at each site-specific conference.
5. Demonstrate commitment to learning by participating in and presenting at Patient Safety conference held 6-7 times a year
6. Display active participation on teaching attending rounds 2 days per week with the designated attending.
7. Maintain weekly assignments in the SCORE curriculum while reading and preparing for specific cases, patients, and conferences.
8. Demonstrate commitment to self learning by all categorical and Plastics-designated residents taking the annual ABSITE examination.
 - a. Residents are expected to achieve a score of no less than 75%.

- b. Residents achieving below 50% will be placed on an academic plan of remediation and self-study.
- 9. Demonstrate a commitment to education by teaching medical students and junior residents at a level appropriate for their level of training.
- 10. Show ability to explain and discuss, in the operating room, the specifics of a particular case, the surgical anatomy, the pathophysiology, and the steps of the operation.
- 11. Demonstrate commitment to self learning by attending and completing the Skills Lab curriculum by class year.
- 12. Demonstrate skill and efficiency at utilizing internet based and library-based literature searches and effectively utilize web-based medical educational resources.

PRACTICE-BASED LEARNING and IMPROVEMENT

At the completion of these rotations residents should:

1. Demonstrate insight into how to locate information (written, electronic, and assistance from senior residents and faculty) relevant to a particular patient's clinical situation and to be able to apply that information to patient care.
2. Demonstrate competence in using the available information technology to access patient records and obtain related educational information.
3. Maintain their ACGME web-based operative log in a timely and meticulously documented fashion.
4. Participate actively in morbidity and mortality conferences.
 - a. As M&M conference is an active Quality Improvement conference for the residents, all residents (whether presenting or not) will thoroughly read the protocol and read for each presented complication. Board-like questions will be asked at the conference.
 - b. Residents presenting at M&M will prepare the protocol summarizing background, events, and the complication. The resident will also review relevant evidenced-based literature regarding the case and be prepared to discuss at conference.
5. Identify and understand their strengths and weaknesses by reviewing their evaluations on a routine basis.
 - a. In depth review at semiannual evaluations.
 - b. All evaluations available to resident at any time in their secure file.
 - c. Each resident will receive evaluations from faculty, other residents, medical students, and hospital non-physician medical personnel.
6. Attend and contribute to monthly faculty advisor meetings.
7. Review ABSITE results and if score less than 50% will complete remediation study plan.
8. Demonstrate active participation in Department's "Residency Workshops" including
 - a. Advanced Communication Skills for Surgical Practice
 - b. Admitting Mistakes: Ethical and Communication Issues
 - c. Delivering Bad News - Your Chance to Become a Master Surgeon
 - d. Working With Professionals Around You: Team Communication
 - e. Working Across Language and Cultures: The Case for Informed Consent
 - f. Self Care and the Stress of Surgical Practice
9. Demonstrate self-learning and technical practice in the Skills Laboratory.

10. Demonstrate active involvement in the Resident-initiated morbidity and mortality conference and quality improvement conferences.

INTERPERSONAL and COMMUNICATION SKILLS

At the completion of these rotations residents should:

9. Demonstrate an understanding of the importance of effective communication to patients, ancillary staff and colleagues.
10. Develop skills to communicate medical information to patients and their families using language appropriate for non-medical personnel and with respect and sensitivity.
11. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.
12. Demonstrate communication skills including the delivery of “bad news”, and the explanation of treatment plans and options to patients and family members in a culturally sensitive compassionate manner.
13. Document accurate and appropriate information in the patient’s medical record.
14. Demonstrate an understanding of appropriate communication to patients, their families, colleagues, and non-physician medical staff in the outpatient setting.
15. Demonstrate active participation in Department’s “Residency Workshops” including
 - a. Advanced Communication Skills for Surgical Practice
 - b. Admitting Mistakes: Ethical and Communication Issues
 - c. Delivering Bad News - Your Chance to Become a Master Surgeon
 - d. Working With Professionals Around You: Team Communication
 - e. Working Across Language and Cultures: The Case for Informed Consent
 - f. Self Care and the Stress of Surgical Practice
16. Integrate feedback from faculty members and from their written competency-based evaluations.

Professionalism

At the completion of these rotations residents should:

6. Demonstrate a commitment to carrying out professional responsibilities.
7. Demonstrate adherence to ethical principals.
8. Show sensitivity to diverse patient populations.
9. Demonstrate an understanding of how to identify signs of stress and fatigue in themselves and their peers, based on the annual Departmental tutorial.
10. Demonstrate professional competence by successfully completing the Surgery Department’s Professionalism Curriculum:

SESSION ONE:

Informed consent
Medical Malpractice and the Surgeon
Admitting Mistakes: Ethical and Communication Issues

SESSION TWO:

Depersonalization of patients
End of life care
What to do when your patient expires

SESSION THREE:

Teaching those junior you -- residents and medical students
Assessment and feedback
Team relationships

SESSION FOUR:

Dealing with the stress of surgical practice – personal/family
Sexual harassment
Cultural sensitivity
Professional relationships with pharmaceutical companies
Dealing with impaired colleagues – residents and attendings

System-Based Practice

At the completion of these rotations residents should:

9. Demonstrate knowledge of this competency by successfully completing the mandatory web-based Systems-Based Practice tutorial and passed the web-based assessment.
10. Demonstrate an understanding of the importance of working effectively in the health care delivery system.
 - a. The private, third party based system at Tisch Hospital. This includes billing, coding, working with Social Work, Case Managers, Advanced Care Practitioners, and Visiting Nurse Service.
 - b. The public hospital system at Bellevue Hospital including working with the Medicaid system, patient advocate, patient navigators, translation services, and social work.
 - c. The Veterans Hospital system including social work and government services.
11. Demonstrate an understanding of the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
12. Demonstrate an understanding of the issues of cost-containment and risk-benefit analysis in patient care.
13. Demonstrate an understanding of the importance of quality patient care and optimal ways to achieve it.
14. Demonstrate an understanding of when to obtain consultations from other services.
15. Participate actively in Departmental Quality Improvement projects such as medication reconciliation, appropriate use of antibiotics, DVT prophylaxis protocol.
16. Participate in Department's QI committee such as root cause analysis.
17. Demonstrate active involvement in resident-initiated root cause analysis, morbidity and mortality conference, QI meetings, team-building exercises, and sign-out projects.

ICU/TRACC

Rotation Goals and Objectives

Rotation: Bellevue Hospital TRACC (R3) Length: 4 weeks

Summary:

The main goal of this rotation is to provide the R3 Resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients in the intensive care setting.

Goals:

The objectives of these rotations are for residents to develop knowledge and skills in:

1. The performance of a thorough and complete evaluation including comprehensive history and physical exam in surgical critical care patients.
2. The preoperative evaluation and cardiovascular preparation of patients.
3. The management of all post operative patients including critical care management in high risk patients and others undergoing extensive surgical procedures requiring such care.
4. Procedural skills appropriate for level including percutaneous tracheostomy, Swan Ganz catheters, bronchoscopy, compartment pressure monitoring, intubation, and difficult venous and arterial access.
5. Professional and compassionate communication and interactive skills with patients, colleagues and families.
6. Practice-based learning and improvement.
7. Systems-based practice particularly within the public hospital setting.

COMPETENCY BASED Objectives

1. Patient Care

The R3 will develop skills in providing patient care that is compassionate and effective for the treatment of critical care patients. At the end of the rotation, the R3 will be knowledgeable in and be able to perform:

Critical Care and Management of Shock

- Differentiate types of shock (hemorrhagic, cardiogenic, septic, neurologic) and initiate appropriate therapies
- Insert invasive catheters and obtain hemodynamic data; interpret data and initiate therapy based on results
- Recognize clinic presentation of acute airway and breathing issues and initiate plan of action (e.g. pneumothorax/chest tube)
- Recognize the indications for blood component therapy and initiate therapy
- Recognize a transfusion reaction and initiate appropriate response
- Institute measures to prevent upper GI bleeding in critically ill patients

Coagulation and Anticoagulation

- Choose the appropriate tests for diagnosis of a coagulopathy, and have a working

knowledge of factor analysis

- Apply effective preventive measures for DVT and PE
- Initiate and monitor therapeutic anticoagulation and its complications
- Diagnose and manage acute deep venous thrombosis
- Acutely manage a patient with a suspected acute pulmonary embolus

Applied Cardiac Physiology

- Recognize rhythm disturbances or myocardial ischemia on EKG
- Assess and formulate a differential diagnosis and initiate therapy for hypotension
- Know and apply appropriate treatment for supraventricular tachycardia
- Recognize and treat congestive failure and acute pulmonary edema
- Manage hypertension in a surgical patient. Understand multidrug therapy and the toxic and side effects of antihypertensive drugs.

Applied Renal Physiology

- Understand pathophysiology of the acute kidney injury; the differentiation of prerenal, renal obstructive types of renal failure; and the general concepts of prevention and treatment of AKI
- Recognize and treat complex electrolyte disturbances
- Understand complex fluid replacement and balance

Applied Pulmonary Physiology

- Know the manifestations – clinical and laboratory testing – of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management
- Recognize bronchoconstrictive disorders and their perioperative management

Applied Nutrition

- Learn to manage complex nutritional needs of a critically ill patient
- Learn to recognize refeeding syndrome

Procedural Skills

- Develop skills including percutaneous tracheostomy, Swan Ganz catheters, bronchoscopy, compartment pressure monitoring, CPR, VAC change, chest tubes, and difficult venous and arterial access.
- Obtain oropharyngeal control of airway, provide Ambu ventilation and perform orotracheal intubation

2. Medical Knowledge

The R3 will demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. At the end of the rotation, the R3 will be knowledgeable in:

- Understand and utilize complex principles of mechanical ventilation
- Recognize the indications for blood component therapy and initiate therapy
- Recognize a transfusion reaction and initiate management
- Recognize rhythm disturbances, myocardial ischemia on EKG

- Assess, formulate a differential diagnosis and initiate therapy for hypotension
- Know and apply appropriate treatment for complex arrhythmias
- Know the pathophysiology of the development of acute kidney injury; the differentiation of prerenal, renal obstructive types of renal failure; and the general concepts of prevention and treatment of AKI
- Know the manifestations – clinical and by laboratory testing – of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management
- Recognize and treat complex electrolyte disturbances
- Cite current literature

3. Practice-Based Learning and Improvement

The R3 will begin to attain the ability to investigate and evaluate his/her care of patients, to appraise and assimilate scientific evidence and to continuously improve patient care. R3 residents will:

- Self-monitor to identify strengths and weaknesses and set goals for learning
- Incorporate feedback from peers, faculty, patients and ancillary staff for self-improvement
- Use information technology in patient care
- Analyze practice and implement improvements
- Maintain an updated Procedure log book which documents procedures which he/she may perform independently or for which he/she requires supervision

4. Interpersonal and Communication Skills

R3 residents must begin to demonstrate interpersonal and communication skills that facilitate the flow of information between patients, their families and health professionals. R3 residents will:

- Communicate effectively with patients and families across all socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals and health agencies
- Work effectively in a health care team
- Act as a consultant
- Maintain comprehensive, timely and legible medical records

5. Professionalism

The R3 resident will begin to demonstrate a commitment for carrying out professional responsibilities and an adherence to ethical principles by showing:

- Compassion, integrity and respect to others not withstanding race, religion, age, gender or disabilities
- Responsiveness to patient needs that supersedes self-interest and respects the patient's privacy and autonomy
- Accountability to patients, society and the profession

6. **Systems-Based Practice**

The R3 resident must begin to demonstrate an awareness of and responsiveness to the larger context and system of health care by having the ability to call upon appropriate resources in the system to optimize health care. The resident will:

- Work effectively in various settings and systems
- Coordinate patient care within the health care system considering costs and risk-benefit analysis
- Advocate for quality care within interprofessional teams to enhance safety and improve quality
- Identify system errors and formulate solutions
- Be familiar with ethical, socioeconomic and medicolegal issues

7. **Supervision of Residents**

17. The supervising attending will provide direct supervision to the PGY 3 residents while in the operating room and in the out-patient setting.
18. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 3 or be directly available in the hospital or by telephone 24 hours daily.
19. The PGY 3 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
20. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
21. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
22. Direct supervision by an Attending surgeon, senior anesthesia resident during daily morning rounds
23. Direct supervision by anesthesia resident during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
24. Direct supervision by an Attending surgeon, anesthesia resident during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Rotation: TRACC/ SICU Bellevue Hospital (R1)

Length: 4 weeks

Summary:

The main goal of this rotation is to provide the R1 Resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients in the intensive care setting.

GOALS:

The objectives of these rotations are for residents to develop knowledge and skills in:

1. The performance of a thorough and complete basic evaluation including history and physical exam in surgical critical care patients.
2. Preoperative evaluation and preparation.
3. The management of all post operative care including critical care management in high risk patients and those undergoing extensive surgical procedures requiring such care.
4. Appropriate for level procedural skills.
5. Optimal patient care.
6. Professional and compassionate communication and interactive skills with patients, colleagues and families.
7. Practice-based learning and improvement.
8. Systems-based practice, particularly within the public hospital setting.

COMPETENCY BASED GOALS

1. Patient Care

The R1 will begin to learn to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health. At the end of the rotation, the R1 will be knowledgeable in and be able to perform:

Critical Care and Management of Shock

- Differentiate types of shock (hemorrhagic, cardiogenic, septic, neurologic) and initiate appropriate therapy
- Insert central venous and arterial catheters and obtain hemodynamic data; interpret data and initiate therapy
- Recognize clinic presentation of a pneumothorax and insert chest tube
- Recognize the indications for blood component therapy and initiate therapy
- Institute measures to prevent upper GI bleeding in critically ill patients

Coagulation and Anticoagulation

- Choose the appropriate tests for diagnosis of a coagulopathy, and have a basic knowledge of factor analysis
- Apply effective preventive measures for DVT and PE
- Initiate and monitor therapeutic anticoagulation and its complications
- Diagnose and manage acute deep venous thrombosis
- Provide a differential diagnosis and manage a patient with a suspected acute pulmonary embolus

Applied Cardiac Physiology

- Recognize rhythm disturbances, myocardial ischemia on EKG
- Assess, formulate a differential diagnosis and initiate therapy for hypotension
- Know and apply appropriate treatment for supraventricular tachycardia
- Diagnose and treat congestive failure and acute pulmonary edema
- Manage hypertension in a surgical patient. Understand multidrug therapy and the toxic and side effects of antihypertensive drugs.

Applied Renal Physiology

- Know the pathophysiology of the development of acute kidney injury; the differentiation of prerenal, renal obstructive types of renal failure; and the general concepts of prevention and treatment of AKI
- Recognize and treat simple electrolyte disturbances
- Understand appropriate fluid replacement and balance

Applied Pulmonary Physiology

- Know the manifestations – clinical and by laboratory testing – of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management
- Recognize bronchoconstrictive disorders and their perioperative management

Applied Nutrition

- Learn to manage the nutritional needs of a critically ill patient
- Placement of nasogastric tube and Dobhoff feeding tube

Surgical Skills

- Develop surgical skills in CPR, CVC placement, arterial catheter placement, and chest tube placement
- Perform first or second assistant in bedside bronchoscopy, pulmonary lavage, and tracheostomy
- Obtain oropharyngeal control of airway, provide Ambu ventilation and perform orotracheal intubation

2. Medical Knowledge

The R1 will begin to demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. At the end of the rotation, the R1 will be knowledgeable in:

- Understand and utilize basic principles of mechanical ventilation
- Recognize clinic presentation of a pneumothorax
- Recognize the indications for blood component therapy and initiate therapy
- Recognize a transfusion reaction and initiate management
- Recognize rhythm disturbances, myocardial ischemia on EKG
- Assess, formulate a differential diagnosis and initiate therapy for hypotension
- Know and apply appropriate treatment for supraventricular tachycardia
- Know the pathophysiology of the development of acute kidney injury; the differentiation of prerenal, renal obstructive types of renal failure; and the general concepts of prevention and treatment of AKI
- Know the manifestations – clinical and by laboratory testing – of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management
- Recognize and treat simple electrolyte disturbances

3. Practice-Based Learning and Improvement

The R1 will begin to attain the ability to investigate and evaluate his/her care of patients, to appraise and assimilate scientific evidence and to continuously improve patient care. R1 residents will:

- Self-monitor to identify strengths and weaknesses and set goals for learning
- Incorporate feedback from peers, faculty, patients and ancillary staff for self-improvement
- Use information technology in patient care
- Analyze practice and implement improvements
- Maintain an updated Procedure log book which documents procedures

4. Interpersonal and Communication Skills

R1 residents must begin to demonstrate interpersonal and communication skills that facilitate the flow of information between patients, their families and health professionals.

R1 residents will:

- Communicate effectively with patients and families across all socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals and health agencies
- Work effectively in a health care team
- Maintain comprehensive, timely and legible medical records

5. Professionalism

The R1 resident will begin to demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles by showing:

- Compassion, integrity and respect to others not withstanding race, religion, age, gender or disabilities
- Responsiveness to patient needs that supersedes self-interest and respects the patient's privacy and autonomy
- Accountability to patients, society and the profession

6. Systems-Based Practice

The R1 resident must begin to demonstrate an awareness of and responsiveness to the larger context and system of health care by having the ability to call upon appropriate resources in the system to optimize health care. The resident will:

- Work effectively in various settings and systems
- Advocate for quality care within interprofessional teams to enhance safety and improve quality
- Identify system errors and formulate solutions
- Be familiar with ethical, socioeconomic and medicolegal issues

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents while in the operating room and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either

directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.

- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
- Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
- Direct supervision by an Attending surgeon, R3 morning rounds
- Direct supervision by R3 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
- Direct supervision by an Attending surgeon, R3 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Tisch ICU
Rotation Goals and Objectives
Rotation: Tisch Hospital (R2)
Length: 4 weeks

ROTATION GOALS:

The goal of this rotation is to provide a training environment for surgical R2 and other service's rotating residents to acquire skills in the comprehensive management of surgical patients with life-threatening critical illness. Residents will become knowledgeable in assessment and support of high risk surgical patients, care of patients with organ failure, sepsis and shock.

ROTATION OBJECTIVES:

The objectives of this rotation are for residents to develop knowledge and skills in:

1. The performance of a thorough and complete basic evaluation including history and physical exam in surgical critical care patients.
2. The preoperative evaluation of critically ill patients going to the OR
3. The management of all post operative care including critical care management in high risk patients and those undergoing extensive surgical procedures requiring such care.
4. Formulation of a diagnostic and treatment plan for emergency room and inpatient consultations.
5. Introductory level operative skills.
6. Optimal patient care.
7. Professional and compassionate communication and interactive skills with patients, colleagues and families.
8. Practice-based learning and improvement.
9. Systems-based practice, particularly within the private hospital setting.

COMPETENCY BASED GOALS AND OBJECTIVES

1. Patient Care

The resident will participate in the daily management of critically ill patients in postoperative and nonoperative settings in the ICU. The R2 and rotators will begin to learn to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health. At the end of the rotation, the R2 will be knowledgeable in and be able to:

- Be able to accurately and independently perform a history and physical examination (by physiologic system) on the critically ill patient and write clear and concise notes reflecting the findings
- Be able to render an accurate assessment of the patient based on those findings
- Be able to accurately and succinctly verbally present those findings and that assessment

- Be skilled in bedside procedures including:
 - Arterial access
 - Nasogastric tube placement
 - Dobhof tube placement
 - Foley catheter placement
- Be able to successfully perform the following procedures with supervision:
 - Intubation
 - Orotracheal
 - Nasotracheal
 - Bronchoscopy with bronchoalveolar lavage
 - Central venous catheter insertion
 - Insert central venous and arterial catheters and obtain hemodynamic data; interpret data and initiate therapy:
 - Subclavian approach
 - Internal jugular approach
 - Femoral approach
 - Pulmonary artery catheter insertion
 - Tube thoracostomy placement
 - Pleurocentesis
 - Pericardiocentesis
 - Cricothyroidotomy
 - Tracheostomy
- Recognize and treat patients with multiple organ failure, sepsis, and shock
 - Differentiate the four classic types of shock (hypovolemic/hemorrhagic, cardiogenic, distributive/septic/neurologic/obstructive) and initiate appropriate therapy
- Recognize the indications for blood component therapy and initiate therapy
- Recognize a transfusion reaction and initiate management
- Institute measures to prevent upper GI bleeding in critically ill patients
- Be knowledgeable regarding nutritional support of critically ill patients
- Be a member of the multidisciplinary treatment team
- Be knowledgeable regarding pharmacologic agents used for critically ill patients, including paralytic agents, analgesics, sedation, antibiotics, hemodynamic agents, antiarrhythmics, and others
- Be able to follow ACLS protocol

Coagulation and Anticoagulation

- Choose the appropriate tests for diagnosis of a coagulopathy, and have a working knowledge of factor analysis
- Apply effective preventive measures for DVT and PE
- Initiate and monitor therapeutic anticoagulation and its complications
- Diagnose and manage acute deep venous thrombosis
- Acutely manage a patient with a suspected acute pulmonary embolus, and provide a differential diagnosis

- Acutely manage a patient with a suspected acute Heparin Induced Thrombocytopenia (HIT), and provide a differential diagnosis

Applied Cardiac Physiology

- Recognize rhythm disturbances, myocardial ischemia on EKG
- Assess, formulate a differential diagnosis and initiate therapy for hypotension
- Know and apply appropriate treatment for supraventricular tachycardia
- Treat congestive failure and acute pulmonary edema
- Manage hypertension in a surgical patient. Understand multidrug therapy and the toxic and side effects of antihypertensive drugs.

Applied Renal Physiology

- Know the pathophysiology of the development of acute renal failure; the differentiation of prerenal, renal obstructive types of renal failure; and the general concepts of prevention and treatment of ARF
- Recognize and treat simple electrolyte disturbances
- Understand appropriate fluid replacement and balance

Applied Pulmonary Physiology

- Know the manifestations – clinical and by laboratory testing – of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management
- Recognize bronchoconstrictive disorders and their perioperative management
- Follow best practices in prevention and treatment of acute lung injury and the adult respiratory distress syndrome (ARDS).

Applied Nutrition

- Learn to manage the nutritional needs of a critically ill patient
- Placement of nasogastric tube and Dobhoff feeding tube

Surgical Skills

- Develop surgical skills in CPR, CVC placement, arterial catheter placement, and chest tube placement
- Perform first assistant in bedside bronchoscopy, pulmonary lavage, and tracheotomy
- Obtain oropharyngeal control of airway, provide Ambu ventilation and perform orotracheal intubation

2. Medical Knowledge and Procedural Skills

Shock and Resuscitation

The resident will be able to:

- Accurately define the components of the following forms of shock:
 - Hypovolemic/Hemorrhagic
 - Cardiogenic
 - Distributive (including septic, neurogenic, anaphylactic, endocrine)
 - Obstructive (massive PE, air embolus, tamponade, tension pneumothorax)

Correctly delineate the etiology of each form of shock

- Accurately summarize the clinical presentation of each form of shock
- Correctly describe the hemodynamic parameters associated with each type of shock
- Demonstrate an algorithm for the diagnosis and management of each form of shock
- Accurately explain tissue oxygen demand. In doing so, the resident should be able to calculate:
 - Calculate oxygen delivery
 - Calculate oxygen consumption
 - Calculate the cardiac output
 - Correctly and succinctly describe the role of each of the following in normal coagulation:
 - Blood vessel
 - Platelets
 - Fibrin cascade
- Accurately discuss disseminated intravascular coagulopathy
- List the following etiologies of thrombocytopenia:
 - Failure of production
 - Accelerated destruction
 - Dilution
- Correctly relate the pathophysiology and treatment of thrombocytopenia:
 - Hemophilia A
 - Von Willebrand's disease
 - Idiopathic thrombocytopenia purpura (ITP)
 - Thrombotic thrombocytopenic purpura (TTP)
- Correctly describe potential effects of misapplication of heparin and coumadin
- Accurately describe the effects on coagulation of advanced liver disease
- Correctly describe the effect of abnormal concentration of the following factors on coagulation:
 - Protein C
 - Protein S
 - Lupus circulating anticoagulant
- Accurately describe the pathophysiology, including the mechanism of cardiac arrest, for each of the following:
 - Acute myocardial infarction
 - Acute dysrhythmia
 - Congestive heart failure
 - Pulmonary embolus
 - Tension pneumothorax
 - Substance abuse
 - Hypothermia
 - Hemorrhagic shock
- List the indications for, contraindications to and potential complications from administration of the following drugs:
 - Lidocaine
 - Bretylium

- Digoxin
- Diltiazem
- Procainamide
- Labetalol
- Esmolol
- Adenosine
- Correctly and briefly summarize the indications for and appropriate techniques for:
 - Cardioversion
 - Defibrillation
- Correctly describe the signs and symptoms of acute airway obstruction and its initial management
- Accurately describe the physiological impact of mechanically assisted ventilation on the cardiovascular and respiratory systems
- Correctly describe the indications for ventilatory support
- Correctly describe the parameters used in initially prescribing ventilatory support
- Correctly list indications for, contraindications to, the technique of and the potential complications of performing each of the following:
 - Central venous catheter placement
 - Pulmonary artery catheter placement
 - Peripheral arterial line placement
 - Tube thoracostomy placement
 - Peripheral vein cutdown
 - Pericardiocentesis
 - Thoracentesis
 - Endotracheal intubation
 - Oral
 - Nasal
- Correctly list the clinical and laboratory indications for transfusion of the following blood products:
 - Packed red cells
 - Fresh frozen plasma
 - Platelets
 - Cryoprecipitate
 - Whole blood
 - Recombinant factor VII
- Accurately list the potential complications of administration of each of the products listed above
- Correctly delineate the indications for administration of each of the following products in resuscitation:
 - Desmopressin acetate (DDAVP)
 - Hespan and similar products
 - Albumin
- Correctly describe the indications, protocols, and contraindications for administration of each of the following:
 - Dopamine

- Dobutamine
- Phenylephrine
- Epinephrine
- Norepinephrine
- Milrinone
- Be thoroughly conversant with ACLS protocol

Body as a Whole

The resident should be able to:

- Correctly describe the normal physiologic response of the respiratory, cardiovascular, renal, and endocrine systems to:
 - Sepsis
 - Surgical stress
- Accurately describe the rationale and indications for the following prophylactic measures that are routinely utilized in critical care
 - Gastrointestinal bleeding prophylaxis
 - Pulmonary morbidity prophylaxis such as incentive spirometry
 - Venous thromboembolic event prophylaxis
 - Aseptic technique
 - Universal precautions
 - Skin care protocols
- Correctly differentiate utilization of antibiotics for the following conditions:
 - Prophylaxis
 - Empiric therapy
 - Directed therapy
- Accurately describe the pharmacotherapeutics of the following drugs used for support and treatment of critically ill patients, with emphasis on mode of action, physiologic effects, spectrum of effects duration of action, appropriate dosing, means of metabolism and/or excretion, complications and cost:
 - Vasopressor
 - Vasodilators
 - Inotropic agents
 - Antibiotics
 - Antifungals
 - Diuretics
 - Bronchodilators
 - Antihypertensives
 - Antidysrhythmics
- Correctly describe the indications, selection of formulations, cost and route of administration of nutritional support that is:
 - Parenteral
 - Enteral
- List the complications of parenteral nutritional support and the means to prevent these complications

- Correctly describe the signs and symptoms in the nutritionally supported critically ill patient that are associated with perturbations in the serum concentration of each of the following :
 - Glucose
 - Potassium
 - Chloride
 - Sodium
 - Phosphate
 - Magnesium
 - Trace metals/elements
 - Vitamins
- Accurately describe a method for estimating protein and calorie requirements
- Accurately describe a method for determining the adequacy of nutritional support using laboratory methods
- Accurately delineate the following in the setting of postoperative fever
 - Causes
 - Empiric diagnostic modalities
 - Empiric therapy
 - Specific therapy

Respiratory System

The resident should be able to:

- Correctly describe the physiology of normal respiration
- Accurately relate the indications and commonly acceptable values for initiation of mechanical ventilatory support
- Correctly describe the assessment of the following:
 - Airway
 - Lung parenchymal characteristics
- Accurately describe utilization of the following pulmonary parameters:
 - Tidal volume
 - Positive end expiratory pressure (PEEP)
 - Auto PEEP
 - Compliance
 - Static
 - Dynamic
 - Functional residual capacity
 - Airway pressure
- Correctly list indications for and commonly accepted objective parameters for weaning from mechanical ventilation
- Accurately describe the specific pathology involved in ventilation-perfusion deficits
- Accurately describe, compare and contrast:
 - Modes of mechanical ventilation
 - Triggering mechanisms
- Accurately describe the pathophysiology of acute lung injury

- Correctly describe the effects and prevention of the following on the patient with long term ventilator dependence:
 - Ventilator acquired pneumonia
 - Acute renal failure
 - Cardiac failure
 - Malnutrition
 - Restitution of body stores
 - Systemic inflammatory response syndrome (SIRS)
 - Sepsis
- Correctly describe the role for and parameters of each of the following in the patient with long term ventilator dependence:
 - Skin care
 - Psychological support for the patient and family
 - Physical therapy
- Accurately delineate approaches to treatment of the following complex problems in the patient with mechanical ventilation:
 - Areas of differing compliance
 - Bronchopleural fistula
 - Bronchoesophageal fistula
 - Borderline cardiac reserve
- Accurately describe the indications for mechanisms of, contraindications to and potential complications of the following drugs that are used to improve respiratory function:
 - Bronchodilators
 - Membrane stabilizing agents
 - Diuretics
 - Venodilators
 - Analgesics and sedative
 - Paralytics
 - Mucolytics

Cardiovascular System

The resident should be able to:

- Accurately describe normal circulatory physiology
- Accurately describe the effects on circulation of:
 - Preload
 - Afterload
 - Myocardial contractility
- Accurately describe the information that can be obtained with their use and whether that information is directly measured, indirectly measured or calculated:
 - Arterial catheters
 - Central venous catheters
 - Pulmonary artery catheters
- Accurately describe the relative accuracy of values obtained from hemodynamic monitoring devices in:

- Patients with severe pulmonary insufficiency who have low compliances or high PEEP
- Patients with severe valvular insufficiency or stenosis
- The various shock states
- Accurately summarize the effects of appropriate volume and drug therapies to manipulate the cardiovascular system in the following patients:
 - Hypovolemic hypotensive patient
 - Hypotensive euvoletic patient
 - Hypotensive hypervolemic patient
 - Hypotensive oliguric patient
 - Hypotensive hypervolemic oliguric patient
 - Hypovolemic oliguric patient
 - Hypotensive, oliguric hypoxic patient

Renal System

The resident should be able to:

- List the acid-base and electrolyte abnormalities common in critically-ill patients
- Define, identify and classify the major categories of acid-base disturbances including:
 - Metabolic acidosis
 - Metabolic alkalosis
 - Respiratory acidosis
 - Respiratory alkalosis
- Correctly cite common clinical scenarios for their appearance of each of the acid/base disturbances listed above
- Correctly describe the identification and correction of the following complex renal and acid-base problems:
 - The hyperchloremic, metabolically-acidotic patient
 - The hypochloremic, metabolically- alkalotic patient
 - The stuporous, dehydrated, hypernatremic patient
 - The patient with central diabetes insipidus
 - The hyponatremic, volume overloaded patient with carbon dioxide retention
- Accurately describe the physiologic principles of and define specific management aspects for the following complex acid-base problems:
 - Renal tubular acidosis
 - Type I
 - Type II
 - High output loss states from the gastrointestinal tract in a patient with poor cardiac function
 - Management of volume excess states associated with eunatremia
 - Management of volume excess states associated with hyponatremia
- Accurately summarize the utilization of each of the following, including indications, mechanism, contraindications and potential complications:
 - Continuous veno-venous hemofiltration (CVVH)
 - Continuous veno-venous hemodialysis (CVVHD)
 - Dialysis

- Peritoneal
- Hemodialysis

Endocrine System

The resident should be able to:

- Accurately describe the identification of (signs, symptoms and laboratory values) and therapy for the following endocrine-related problems associated with critical care:
 - Hypothyroidism/hyperthyroidism
 - Hyperparathyroidism
 - Hypoparathyroidism
 - Adrenal cortical excess
 - Cushing's disease
 - Cushing's syndrome
 - Adrenal cortical deficiency states (Addison's disease)

Neurology System

The resident should be able to:

- Accurately describe the initial evaluation, ongoing evaluation, acute monitoring and long-term management of commonly occurring neurologic problems in the ICU setting:
 - Seizures
 - Coma
 - Hemorrhagic stroke
 - Thromboembolic stroke
 - Elevated intracranial pressure

3. Practice-Based Learning and Improvement

The resident should:

- Maintain a detailed log of procedures and operative cases in which (s)he participates including:
 - Diagnosis
 - Procedure performed
 - Postoperative course of the patient including any complications sustained and an analysis of the origin(s) of each complication
- Maintain a portfolio of rotation related literature searches
- Maintain a portfolio of rotation related formal presentations including presentation of complications (Morbidity and Mortality Conference)

The R2 will begin to attain the ability to investigate and evaluate his/her care of patients, to appraise and assimilate scientific evidence and to continuously improve patient care. R2 residents will:

- Self-monitor to identify strengths and weaknesses and set goals for learning
- Incorporate feedback from peers, faculty, patients and ancillary staff for self-improvement

- Use information technology in patient care
- Analyze practice and implement improvements

4. Interpersonal and Communication Skills

R2 residents must begin to demonstrate interpersonal and communication skills that facilitate the flow of information between patients, their families and health professionals. R2 residents will:

- Clearly, accurately and succinctly present pertinent information to faculty regarding patients new to the service including newly admitted patients and patients for whom the service has been consulted
- Clearly, accurately and respectfully communicate with nurses and other hospital employees
- Clearly, accurately and respectfully communicate with referring and consulting physicians, including fellow residents
- Clearly, accurately and respectfully communicate with patients and appropriate members of their families identified disease processes (including complications), the expected courses, operative findings and operative procedures
- Maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, orders, operative notes and discharge summaries
- Clearly and accurately teach junior residents and medical students about the procedures performed on this rotation when qualified to do so by hospital and program policy

5. Professionalism

The R2 resident will begin to demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. The resident:

- Must be honest with all individuals at all times in conveying issues of patient care
- Should place the needs of the patient above the needs or desires of self. Be responsive to patient needs superseding self-interest and respecting the patient's privacy and autonomy.
- Should maintain high ethical behavior in all professional activities
- Must demonstrate commitment to continuity of care through carrying out her/his own personal responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in her/his stead
- Should, at any time while engaged in patient care, be properly and professionally attired including adherence to any extant dress code
- Should while engaged in patient care, be properly and professionally groomed
- Should demonstrate sensitivity to issues of age, race, gender and religion with patients, families and all members of the health care team
- Should at all time treat patients, families and all members of the health care team with respect

- Should reliably be present in pre-arranged places and at pre-arranged times except when the resident is actively engaged in the treatment of a surgical or medical emergency. Under such circumstances, the resident should provide timely notification to the appropriate individual(s) of her/his inability to engage in the pre-arranged activity
- Is accountable to patients, society and the profession

6. Systems-Based Practice

The R2 resident must begin to demonstrate an awareness of and responsiveness to the larger context and system of health care by having the ability to call upon appropriate resources in the system to optimize health care. The resident will:

- Appropriately utilize in a timely and cost efficient manor ancillary services including:
 - Social Work
 - Discharge Planning
 - Physical Therapy
 - Occupational Therapy
 - Respiratory Therapy
 - Nutrition Services
 - Enterostomal Therapy
 - Pharmacists
 - Physician Extenders including Physicians' Assistants and Nurse Practitioners
- Appropriately utilize consultations from other surgical and medical specialties in a timely and cost efficient manor to facilitate and enhance patient care
- Summarize the financial costs, the risks and the benefits of all proposed diagnostic studies and therapeutic interventions
- Determine and convey to the appropriate individuals the instruments and other materials necessary for all procedures in order to minimize waste of resources
- Offer sound justification for all diagnostic tests (including laboratory studies) ordered by her/him
- Work effectively in various settings and systems
- Coordinate patient care within the health care system considering costs and risk-benefit analysis
- Advocate for quality care within interprofessional teams to enhance safety and improve quality
- Identify system errors and formulate solutions
- Be familiar with ethical, socioeconomic and medicolegal issues

The resident should be able to:

- Delineate the criteria for predicting preoperatively the patient's need for critical care, including:
 - Pre-existing disease states
 - Cardiac
 - Pulmonary
 - Renal
 - Operation-specific requirements for postoperative intensive care management

- Accurately define the roles and the relationships of the following who manage patients in the SICU:
 - Physicians
 - Nurses
 - Administrators
- Able to list the resources available to assist the physician in dealing with the following moral and ethical problems encountered in the ICU:
 - The need for organ donation and the identification of potential donors
 - Decisions about whom to resuscitate and to what degree
 - Care for the mentally incapacitated or incompetent patient
 - Dealing with a difficult family
 - Futility of care
 - Identifying and interacting with alternate religious/cultural beliefs including
 - Protocols
 - Social workers
 - Patient advocate/ombudsman
 - State laws
 - Ethics Committee

Description of the Supervision of Residents per the ACGME requirement:

1. In-house 24/7 NYU Faculty Board Certified in Critical Care Medicine will provide direct supervision to the PGY 2 residents during their Tisch Surgical ICU Rotation during all rounds and procedures.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 2 resident will not perform any procedures without the direct supervision of an attending physician; Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills.
5. Residents will notify the supervising attending physician in the event that a patient dies or an end of life decision is made

Intensivist Attending Faculty at NYU Tisch rotate on a weekly basis allowing the faculty sufficient time to evaluate and assess the residents' skill levels, capabilities and need for improvement. Feedback is given during the rotation on a daily basis and at the conclusion of the faculty's rotation with the resident. At the end of the formal 4 week rotation, a written evaluation is submitted via the New Innovations Evaluation System by each faculty supervising the R2 detailing the resident's performance in all six areas of competency; 1) Patient Care, 2) Medical Knowledge and Procedural Skills, 3) Practice based Learning, 4) Interpersonal and Communication Skills, 5) Professionalism, and 6) System Based Practice.

NIGHT FLOAT
Tisch Hospital and Bellevue Hospital Center
JUNIOR RESIDENT
GOALS & OBJECTIVES

Overall Goals: The Night Float team covers all of the in-house general surgery, vascular, pediatric surgery and critical care patients after hours (1900h – 0700h) Sunday through Thursday. They are responsible for admitting and stabilizing general surgery admissions and consults after hours and participating in operative surgery as necessary.

The resident team will include a Chief (5th year) and consult (3rd year) at Bellevue. The resident team will include a senior (4th year) and mid-level (2nd year) at Tisch.

All residents will participate in weekly residents' conferences, monthly Grand rounds and weekly departmental M&M conferences.

Competencies: Each core competency will be assessed by nightly interactions with general surgery, vascular, pediatric surgery, and critical care faculty, and through participation in weekly resident conferences, Department of Surgery M&M conferences and monthly written faculty, resident, and ancillary staff evaluations.

Specific Objectives:

1) Medical Knowledge

- Demonstrate ability to provide timely surgical assessment and operative management of the patients with acute and non-acute general surgical problems.
- Knowledge of the indications for surgical intervention in acute or elective general surgery diagnoses and the indications for operative or nonoperative management
- Demonstrate familiarity with surgical literature
- Demonstrate basic critical care management
- Demonstrate an understanding of the pathophysiologic effect of surgical diseases
- Must relate basic medical knowledge to patient care. Residents must critically evaluate and demonstrate knowledge of pertinent scientific information.
- Analyze and present complications
- Exhibit knowledge base sufficient to teach PGY2 residents and students
- Identify the indications for emergency operative procedures such as emergent vascular access, needle and tube thoracostomy, and cricothyroidotomy.
- Demonstrate ability to appropriately order, read and interpret the results of most all radiologic studies obtained during the evaluation of a patient.

2) Patient Care

- Timely evaluation of in-house general surgery patients and patients in need of surgical consultation.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences
- Discuss the management and implications of associated medical conditions as it relates the surgical disease
- Maintain open communication with the senior resident and/or the attending physician regarding the patient status and care plan.
- Demonstrate early ability to communicate effectively with patient and families regarding diagnosis and surgical procedures, injuries and outcomes.
- Communicate effectively with the day teams and on-call staff about patient problems and issues
- The Junior resident will be expected to demonstrate technical skills including:
 1. Demonstrates the ability to proceed through various steps of caring for the surgical patient and/or critically ill patient in a manner that is consistent with the flow of the operation
 2. Performs preliminary assessment and is able to formulate treatment plan based on findings.
 3. Demonstrates competence in basic surgical skills like suturing, wound management, vascular access techniques and tube thoracostomy
 4. Develops ability to make appropriate and timely decisions in regards to operative interventions
 5. Demonstrates manual dexterity appropriate to his/her level of training.
 6. Demonstrates an understanding of the benefits and limitations of operative surgical techniques.
 7. Demonstrates surgical knowledge and early training in general surgical laparotomy, exposures and management of common general surgical pathology

3) Practice Based Learning and Improvement

- Investigates and evaluates patient care practices
- Analyzes practice experience using a systematic methodology.
- Locates, appraises, and assimilates evidence from scientific studies related to patients' diseases
- Applies knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Performs practice-based improvement activities using a systematic methodology
- Uses information technology to manage information, access on-line medical information; and support his/her own education.
- Facilitates the learning of junior residents and students.
- Demonstrates the ability to analyze personal practice outcomes to improve patient care.
- Discuss the value of an interdisciplinary approach to health care for the critically ill general surgery and trauma patient.

4) Interpersonal and Communication Skills

- Demonstrates skill and sensitivity for appropriate counseling and educating patients and their families in a variety of clinical situations.
- Creates and sustains appropriate doctor-patient relationships with patients and families.
- Works effectively with others as a member of the health care team and/or other professional groups.
- Effectively and promptly documents practice activities.
- Communicate effectively and courteously with teams requesting consultation about findings and plan of care
- Presents all patients and conference material in a concise, organized, chronologic, logical and knowledgeable manner.
- Utilizes input from all collaborative interactions with all personnel contributing to the surgical patient care.
- Works effectively as a team member
- Contributes via effective teaching and example to the educational efforts of the surgical residency.

5) Professionalism

- Demonstrates respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and on-going professional development.
- Demonstrates a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Demonstrates sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
- Exhibits professionalism through timely completion of required administrative responsibilities (evaluations, recording hours, chart documentation, medical record dictations, etc.).
- Maintains positive relationships with other healthcare providers
- Demonstrate accountability for actions and decisions.

6) Systems-Based Practice

- Understands how patient care and other professional practices affect other health care professionals, the health care organization, and the larger society. Understand how these elements of the system affect their own practice.
- Knows how types of medical practice and delivery systems differ from one another, including methods and controlling health care costs and allocating resources.
- Utilization of system resources
- Practices cost-effective health care and resource allocation that does not compromise quality of care for the trauma and general surgery patient and/or critically ill.

- Advocates for quality patient care and assist patients in dealing with system complexities.
- Partner with health care managers and health care providers to assess, coordinate, and improve health care and understands how these activities can affect system performance.
- Demonstrate knowledge of disaster management, including the role of triage
- Demonstrate knowledge of a variety of healthcare services for trauma patients such as emergency room, operating room, intensive care unit, and rehabilitation.
- Demonstrate ability to identify system error in the overall care of the trauma patient
- Develops and understanding of how the hospital environment functions differently in night versus daytime hours and how to accomplish optimal patient care during both.

Supervision of Residents

17. The supervising attending will provide direct supervision to the PGY 2 residents while in the operating room and in the out-patient setting.
18. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2 or be directly available in the hospital or by telephone 24 hours daily.
19. The PGY 2 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
20. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
21. :
22. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
23. Direct supervision by an Attending surgeon, R5, R4, and R3 during daily morning rounds
24. Direct supervision by R5, R4 and R3 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
25. Direct supervision by an Attending surgeon, R5, R4, and R3 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Department of Surgery
Minimally Invasive Surgery
Rotation Goals and Objectives

Goals

The Minimally Invasive Surgery service provides the surgical resident (R4 and R1) an opportunity to learn in-depth knowledge of obesity as a disease and the surgical treatment of it. This includes clinical experience in both the outpatient and inpatient setting. In addition, the residents will learn minimally invasive surgical techniques, particularly in the more challenging population of the morbidly obese. Furthermore, management of some complex foregut and general surgery patients is also a large part of this rotation—both in and out of the operating room. These laparoscopic skills will be utilized in both bariatric and non-bariatric surgical cases.

Rotation: NYU Langone Medical Center, Tisch Hospital (R1)

Length: 4 weeks

OBJECTIVES:

The objectives of the rotation is for residents to develop knowledge and skills:

10. To understand the health effects of morbid obesity and the role of bariatric surgery in their treatment.
11. To appreciate the surgical risks that the morbidly obese patient carries and how to optimize their care.
12. To experience continuity of care for preoperative and postoperative bariatric patients.
13. To recognize and diagnose post-operative side-effects and complications of bariatric surgery
14. To observe surgeon–patient interactions, whether at initial evaluation, in obtaining informed consent, or in handling postoperative difficulties. Concerns of and interaction with family and friends add to these interactions.
15. To understand the technical utility of laparoscopic technology as it pertains to general surgery.
16. To provide optimal patient care.
17. To exhibit professional and compassionate communication with patients, colleagues and families especially towards the morbidly obese patients.
18. To experience practice-based learning and improvement.
19. To experience systems-based practice, particularly within the private hospital setting.

COMPETENCY-BASED GOALS

Medical Knowledge

At the completion of these rotations residents should:

1. Obtain the basic understanding of the pathophysiology of obesity.
2. Assess the impact that morbid obesity has on medical co-morbidities, psychological and emotional state and economics.

3. Exhibit the ability to conduct an independent assessment of the patient in the pre-operative phase by performing a comprehensive history and physical examination of the morbidly obese patient. Since morbid obesity causes a multitude of co-morbid conditions, the resident will achieve an understanding of the medical complexity that the morbidly obese patient poses.
4. Learn the basic indications for bariatric surgery and the different surgical options available.
5. Learn the basics of laparoscopy, including the use and physiologic impact of carbon dioxide insufflation, laparoscopic visualization, and angled laparoscopes.
6. Learn how to place trocars safely, use laparoscopic instruments, manipulate an angled laparoscope, first assist and trouble shoot.
7. Become familiar with peri-operative and long-term surgical complications and nutritional/metabolic complications.

Patient Care

At the completion of these rotations residents should:

1. Have an understanding of and be able to deliver compassionate care to all patients.
2. Gain experience in delivering information to patients' family members when appropriate, particular in the pediatric population.
3. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of these rotations residents should:

11. Have gained insight into how to locate information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
12. Have a working knowledge of how to access scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
13. Be adept at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of these rotations residents should:

17. Understand the importance of effective communication to patients, ancillary staff and colleagues.
18. Develop skills to communicate medical information to patients and their families.
19. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.

Professionalism

At the completion of these rotations residents should:

11. Understand the importance of a through commitment to carrying out professional responsibilities.
12. Demonstrate adherence to ethical principals.
13. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of these rotations residents should:

18. Understand the importance of working effectively in the health care delivery, particularly in the private hospital setting.
19. Understand the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
20. Be exposed to considerations of cost-containment and risk-benefit analysis in patient care, particularly in the private hospital setting.
21. Understand the importance of quality patient care and optimal ways to achieve it.
22. Understanding of when to obtain consultations from other services.

Supervision of Residents

- The supervising attending will provide direct supervision to the PGY 1 residents and medical students while in the operating room and in the out-patient setting.
- While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 1 or be directly available in the hospital or by telephone 24 hours daily.
- The PGY 1 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
- Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
- Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
- Direct supervision by an Attending surgeon, R5,R4,R3 and R2 morning rounds
- Direct supervision by R5, R4, R3, and R2 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
- Direct supervision by an Attending surgeon, R5, R4, R3, R2 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Rotation: NYU Langone Medical Center, Tisch Hospital (R4)

Length: 4-6 weeks

OBJECTIVES:

The objectives of rotation is for residents to develop knowledge and skills:

1. To understand the health effects of morbid obesity and the role of bariatric surgery in their treatment.
2. To appreciate the surgical risks that the morbidly obese patient carries and how to optimize their care.
3. To experience continuity of care for preoperative and postoperative bariatric patients.

4. To recognize and diagnose post-operative side-effects and complications of bariatric surgery
5. To observe surgeon–patient interactions, whether at initial evaluation, in obtaining informed consent, or in handling postoperative difficulties. Concerns of and interaction with family and friends add to these interactions.
6. To understand the technical utility of laparoscopic technology as it pertains to general surgery.
7. To provide optimal patient care.
8. To exhibit professional and compassionate communication with patients, colleagues and families especially towards the morbidly obese patients.
9. To experience practice-based learning and improvement.
10. To experience systems-based practice, particularly within the private hospital setting.

COMPETENCY-BASED GOALS

Medical Knowledge

At the completion of this rotation:

1. The senior resident will learn how to evaluate the bariatric surgical patient who may come into the emergency room with surgical or nutritional complications. The will be able to diagnose problems and appropriately provide treatment options.
2. The resident should have a foundation in the essentials of laparoscopic surgery and be familiar with the equipment, instrumentation, and system trouble-shooting.
3. The resident will be familiar with the literature related to bariatric surgery, as well as to the nature of the major weight loss surgery operations on both a scientific and technical level.
4. The resident will have a general understanding of laparoscopic surgery as it pertains to general surgery. This involves the management of general surgical issues in terms of diagnosis and treatment. This also involves general surgery follow up care and the identification of complications.
5. The resident will learn how to access the subcutaneous reservoir port of the gastric band and how to manage it in various clinical situations.

Skills

At the completion of this rotation residents should:

1. Know the use and physiologic impact of carbon dioxide insufflation, laparoscopic visualization, and angled laparoscopes.
2. Place trocars safely, use laparoscopic instruments, manipulate an angled laparoscope, first assist and trouble shoot.
3. Know advanced laparoscopic techniques including two-handed tissue manipulation and intracorporeal suturing/knot-tying.

Patient Care

At the completion of this rotation residents should:

1. Demonstrate the ability to deliver compassionate care to all patients.
2. Become more adept at delivering information to patients' family members when appropriate.

3. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of this rotation residents should:

14. Have gained further experience in locating information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
15. Demonstrate proficiency in accessing scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
16. Be proficient at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of these rotations residents should:

4. Demonstrate effective communication to patients, ancillary staff and colleagues.
5. Improve skills to communicate medical information to patients and their families.
6. Improve skills to communicate with co-workers and colleagues to allow for optimum patient care.

Professionalism

At the completion of this rotation residents should:

4. Demonstrate a thorough commitment to carrying out professional responsibilities.
5. Demonstrate adherence to ethical principals.
6. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of these rotations residents should:

6. Show the ability to work effectively in the health care delivery setting, particularly in the private hospital setting.
7. Demonstrate the ability to coordinate patient care within the health care system
8. Gain a more advanced understanding of cost-containment and risk-benefit analysis in patient care particularly in the private hospital setting.
9. Improve understanding of quality patient care and optimal ways to achieve it.
10. Demonstrate an advanced understanding of when to utilize consultations from other services to provide an interdisciplinary management of patients.

Supervision of Residents

Faculty supervision of the R4 will be in the following capacity:

1. The supervising attending will provide direct supervision to the PGY 4 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 4 or be directly available in the hospital or by telephone 24 hours daily.
3. PGY 4 Residents will serve as supervisors to junior residents and medical students
4. The PGY 4 resident will be able to perform certain procedures under indirect supervision of an attending physician; with the attending physician immediately available by phone or other electronic device, or on the premises. This excludes any invasive procedures beyond the scope of what can be safely performed at the patient's bedside. Particular bedside procedures may be performed by the R4 with Indirect Supervision (24 hour

accessible attending physician by phone or pager and/or attending physician on premises). Such procedures are limited to minor procedures at the bedside, including (but not limited to) incision and drainages, phlebotomy, removal of drains, and accessing subcutaneous ports in laparoscopic adjustable gastric bands. This excludes any invasive procedure beyond the scope of what can be safely performed at a patient's bedside. Anything beyond this will require direct attending supervision. Access to the subcutaneous port in an adjustable gastric band can be performed on the wards or in the emergency room by an R4 with indirect supervision—an attending physician on premises or available by telephone/page. Anything beyond this will require direct attending supervision.

5. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
6. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made

Pediatric Surgery

Rotation Goals and Objectives

Rotation: NYU Langone Medical Center, Tisch and Bellevue Hospital (R2)

Length: 4 weeks

Summary: The Pediatric Surgical service consists of all pediatric surgical cases at both Tisch Hospital and Bellevue Hospital. This includes patients from the neonatal period to approximately 18-19 years of age. Representative cases include those from general abdominal pediatric surgery as well as thoracic, head and neck and urology.

OBJECTIVES:

The objectives of these rotations are to for residents to develop knowledge and skills in:

20. The performance of a thorough and complete basic evaluation including history and physical exam in pediatric patients.
21. The preoperative evaluation and preparation.
22. The management of all post operative care for pediatric patients.
23. Formulation of a diagnostic and treatment plan for emergency room and inpatient consultations.
24. Optimal patient care.
25. Professional and compassionate communication and interactive skills with patients, colleagues and families.
26. Practice-based learning and improvement.
27. Systems-based practice, particularly within the private hospital setting.

COMPETENCY-BASED GOALS

Medical Knowledge

At the completion of these rotations residents should:

1. Exposure to all phases of pediatric surgery including congenital neonatal problems, pediatric tumor disease as well as general pediatric surgery.
2. Introductory level operative skills and familiarity with common pediatric surgical procedures such as pediatric umbilical and inguinal hernia repair and circumcision

Patient Care

At the completion of these rotations residents should:

4. Have an understanding of and be able to deliver compassionate care to pediatric patients.
5. Gain experience in delivering information to patients' family members when appropriate, particular in the pediatric population.
6. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of these rotations residents should:

14. Have gained insight into how to locate information relevant to a particular patient's clinical situation and be able to apply that information to patient care.

15. Have a working knowledge of how to access scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
16. Be adept at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of these rotations residents should:

20. Understand the importance of effective communication to patients, ancillary staff and colleagues.
21. Develop skills to communicate medical information to parents and family members of a pediatric patient.
22. Develop skills to communicate with co-workers and colleagues to allow for optimum patient care.

Professionalism

At the completion of these rotations residents should:

14. Understand the importance of a through commitment to carrying out professional responsibilities.
15. Demonstrate adherence to ethical principals.
16. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of these rotations residents should:

23. Understand the importance of working effectively in the health care delivery, particularly in the private hospital setting.
24. Understand the importance of coordination of patient care within the health care system and demonstrate a working knowledge of this.
25. Be exposed to considerations of cost-containment and risk-benefit analysis in patient care, particularly in the private hospital setting.
26. Understand the importance of quality patient care and optimal ways to achieve it.
27. Understanding of when to obtain consultations from other services.

Supervision of Residents

1. The supervising attending will provide direct supervision to the PGY 2 residents while in the operating room and in the out-patient setting.
2. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 2 or be directly available in the hospital or by telephone 24 hours daily.
3. The PGY 2 resident will not perform any procedures without the direct supervision of an attending physician; or if a senior resident is supervising the attending physician will be immediately available.
4. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
5. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values

- d. Patient develops signs of shock
6. Direct supervision by an Attending surgeon, R5, R4, and R3 during daily morning rounds
7. Direct supervision by R5, R4 and R3 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending.
8. Direct supervision by an Attending surgeon, R5, R4, and R3 during procedures until competency is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available.

Rotation: NYU Langone Medical Center, Tisch and Bellevue Hospital (R4)

Length: 4-6 weeks

Summary:

OBJECTIVES:

The objectives of this rotation are to for residents to develop knowledge and skills in:

1. The preoperative evaluation and preparation of pediatric patients
2. Improved management of all post operative care including critical care management in pediatric patients.
3. The formulation of a diagnostic and treatment plan for more complex emergency room and inpatient consultations.
4. Intermediate level operative skills in peds and adolescent laparoscopic surgery.
5. Optimal patient care.
6. Professional and compassionate communication and interactive skills with patients, colleagues and families.
7. Practice-based learning and improvement.
8. Systems-based practice, particularly within the private hospital setting.
9. Teaching of junior residents and medical students.

COMPETENCY-BASED GOALS

Medical Knowledge

At the completion of this rotation residents should:

1. Effective evaluation and management of pediatric patients with more complex pediatric surgical operative procedures.
2. Knowledge of common pediatric surgical conditions such as pyloric stenosis and intussusception.
3. Manage pediatric patients with commons surgical congenital anomalies such as Hirschsprung's disease, imperforate anus, esophageal atresia, malrotation and abdominal wall defects.

Skills

At the completion of this rotation residents should:

1. Be able to formulate treatment for complex pediatric diseases such as skin and soft tissue tumors, vascular malformations and urologic diseases to name a few.

Patient Care

At the completion of this rotation residents should:

4. Demonstrate the ability to deliver compassionate care to all patients.
5. Become more adept at delivering information to patients' family members when appropriate, particular in the pediatric population.
6. Be able to use knowledge and skills learned to enhance care of patients.

Practice-Based Learning and Improvement

At the completion of this rotation residents should:

17. Have gained further experience in locating information relevant to a particular patient's clinical situation and be able to apply that information to patient care.
18. Demonstrate proficiency in accessing scientific information relevant to a particular patient and be able to assimilate that information and apply to it patient care.
19. Be proficient at using the available technology to access patient information.

Interpersonal and Communication Skills

At the completion of these rotations residents should:

7. Demonstrate effective communication to patients, ancillary staff and colleagues.
8. Improve skills to communicate medical information to families of pediatric patients.
9. Improve skills to communicate with co-workers and colleagues to allow for optimum patient care.

Professionalism

At the completion of this rotation residents should:

7. Demonstrate a thorough commitment to carrying out professional responsibilities.
8. Demonstrate adherence to ethical principals.
9. Show sensitivity to diverse patient populations.

System-Based Practice

At the completion of these rotations residents should:

11. Show the ability to work effectively in the health care delivery setting, particularly in the private hospital setting.
12. Demonstrate the ability to coordinate patient care within the health care system
13. Gain a more advanced understanding of cost-containment and risk-benefit analysis in patient care particularly in the private hospital setting.
14. Improve understanding of quality patient care and optimal ways to achieve it.
15. Demonstrate an advanced understanding of when to utilize consultations from other services to provide an interdisciplinary management of patients.

Supervision of Residents

19. The supervising attending will provide direct supervision to the PGY 4 residents while in the operating room and in the out-patient setting.
20. While helping to manage the care of inpatients, an attending physician will either directly supervise the PGY 4 or be directly available in the hospital or by telephone 24 hours daily.

21. PGY 4 Residents will serve as supervisors to junior residents
22. The PGY 4 resident will be able to perform certain procedures under indirect supervision of an attending physician; with the attending physician immediately available by phone or other electronic device, or on the premises. This excludes any invasive procedures beyond the scope of what can be safely performed at the patient's bedside. Anything beyond this will require direct attending supervision.
23. Supervising attending physicians will delegate portions of patient care to residents based on patient needs and suitable to the residents' skills
24. Residents will notify the supervising attending physician in the event that:
 - a. A patient is transferred to the intensive care unit
 - b. A patient dies or an end of life decision is made
 - c. Critical Lab Values
 - d. Patient develops signs of shock
25. Direct supervision by an Attending surgeon, R4 during daily morning rounds
26. Direct supervision by R4 during afternoon rounds with immediate direct supervision available by in-house trauma/acute care attending
27. Direct supervision by an Attending surgeon, R4 during procedures until competency .is documented in accordance with Departmental procedure log and scope of practice; Subsequent supervision will be with attending supervision immediately available

Policies

All GME Policies can be found at www.ATNYULMC.org under the **Ellucid** Application. Links have been provided for each policy list hereafter as applicable.

Advancement Policy

Vascular Surgery

Criteria for Advancement within and Graduation from the Training Program

Advancement from Year 1 to Year 2 requires:

1. Successful completion of all scheduled rotations and the individual rotation requirements with evaluations of 3 or greater in all competencies. Advancement with lesser grades is at the discretion of the Program Director and the Clinical Competency Committee, typically based upon demonstrated improvement, and / or ongoing compliance with a remediation or probation plan.
2. Up-to-date procedure log showing satisfactory progress in procedural experience and competence. This includes certification of procedural competence indicated by the filing of the appropriately signed documents.
3. Completion of the online Sleep and Fatigue Module.
4. Completion of the Institutional Review Board HIPAA and Human Subjects Research (CITI) on line modules.
5. Conference attendance of at least 75% or demonstration of a satisfactory alternative didactic substitute (e.g. on line review of missed seminars). See Policy on conference attendance.
6. Completion of an appropriate and designated number of surgical cases in the designated year, as determined by ACGME requirements and the Program Director and Clinical Competency Committee.
7. Completion of the GME NI Advancement Checklist.
8. Achievement of at least Level 2 in the ACGME / ABS Vascular Surgery Milestones Project in at least 75% of Milestone categories.
9. Unanimous support among the Program Director, Associate Program Director, and members of the Clinical Competency Committee that the trainee is at an appropriate level to move into Year 2.

Advancement from Year 2 to Year 3 requires:

1. Successful completion of all scheduled rotations and the individual rotation requirements with evaluations of 3 or greater in all competencies. Advancement with lesser grades is at the discretion of the Program Director and the Clinical Competency Committee, typically based upon demonstrated improvement, and / or ongoing compliance with a remediation or probation plan.
2. Up-to-date procedure log showing satisfactory progress in procedural experience and competence. This includes certification of procedural competence indicated by the filing of the appropriately signed documents.
3. Completion of the online Sleep and Fatigue Module.
4. Completion of the Institutional Review Board HIPAA and Human Subjects Research (CITI) on line modules.
5. Conference attendance of at least 75% of demonstration of a satisfactory alternative didactic substitute (e.g. on line review of missed seminars). See Policy on conference attendance.

6. Completion of an appropriate and designated number of surgical cases in the designated year, as determined by ACGME requirements and the Program Director and Clinical Competency Committee. This would typically be represented by 250 cases at the end of Year 2.
7. Completion of the GME NI Advancement Checklist.
8. Achievement of at least Level 3 in the ACGME / ABS Vascular Surgery Milestones Project in at least 75% of Milestone categories.
9. Unanimous support among the Program Director, Associate Program Director, and members of the Clinical Competency Committee that the trainee is at an appropriate level to move into Year 3.

Advancement from Year 3 to Year 4 requires:

1. Successful completion of all scheduled rotations and the individual rotation requirements with evaluations of 3 or greater in all competencies. Advancement with lesser grades is at the discretion of the Program Director and the Clinical Competency Committee, typically based upon demonstrated improvement, and / or ongoing compliance with a remediation or probation plan.
2. Up-to-date procedure log showing satisfactory progress in procedural experience and competence. This includes certification of procedural competence indicated by the filing of the appropriately signed documents.
3. Completion of the online Sleep and Fatigue Module.
4. Completion of the Institutional Review Board HIPAA and Human Subjects Research (CITI) on line modules.
5. Conference attendance of at least 75% of demonstration of a satisfactory alternative didactic substitute (e.g. on line review of missed seminars). See Policy on conference attendance.
6. Completion of an appropriate and designated number of surgical cases in the designated year, as determined by ACGME requirements and the Program Director and Clinical Competency Committee.
7. Completion of the GME NI Advancement Checklist.
8. Completion of Skills Lab Modules for Year 3.
9. Achievement of at least Level 3 in the ACGME / ABS Vascular Surgery Milestones Project in at least 90% of Milestone categories.
10. Unanimous support among the Program Director, Associate Program Director, and members of the Clinical Competency Committee that the trainee is at an appropriate level to move into Year 4.

Advancement from Year 4 to Year 5 requires:

1. Successful completion of all scheduled rotations and the individual rotation requirements with evaluations of 3 or greater in all competencies. Advancement with

lesser grades is at the discretion of the Program Director and the Clinical Competency Committee, typically based upon demonstrated improvement, and / or ongoing compliance with a remediation or probation plan.

2. Up-to-date procedure log showing satisfactory progress in procedural experience and competence. This includes certification of procedural competence indicated by the filing of the appropriately signed documents.
3. Completion of the online Sleep and Fatigue Module.
4. Completion of the Institutional Review Board HIPAA and Human Subjects Research (CITI) on line modules.
5. Conference attendance of at least 75% of demonstration of a satisfactory alternative didactic substitute (e.g. on line review of missed seminars). See Policy on conference attendance.
6. Completion of an appropriate and designated number of surgical cases in the designated year, as determined by ACGME requirements and the Program Director and Clinical Competency Committee.
7. Completion of Skills Lab Modules for Year 4.
8. Completion of the GME NI Advancement Checklist.
9. Achievement of at least Level 4 in the ACGME / ABS Vascular Surgery Milestones Project in at least 75% of Milestone categories.
10. Unanimous support among the Program Director, Associate Program Director, and members of the Clinical Competency Committee that the trainee is at an appropriate level to move into Year 4.

Graduation from the Program requires:

1. Successful completion of all schedule rotations with evaluations of 3 or greater in all competencies. Graduation with lesser grades is at the discretion of the Program Director and the Clinical Competency Committee, typically based upon demonstrated improvement, and / or ongoing compliance with a remediation or probation plan.
2. Complete and accurate procedure log to substantiate future credentialing.
3. Achievement of appropriate designated numbers of surgical procedures, as required by the ACGME.
4. Completion or satisfactory progress demonstrated in a meaningful research effort.
5. Current and complete portfolio and CV on file.
6. Completion / fulfillment of all “de-credentialing” requirements with the several hospitals, and signoff by the Office of Graduate Medical Education. This includes return of all keys, lab coats, pagers, etc. The Program requires that graduating trainees also leave contact information for future communications.
7. Completion of GME NI Termination Checklist.
8. The graduate should be making appropriate plans to achieve Board Certification in the area of Vascular Surgery
9. Achievement of at least Level 4 in the ACGME / ABS Vascular Surgery Milestones Project in at least 90% of Milestone categories.
10. Unanimous support among the Program Director, Associate Program Director, and members of the Clinical Competency Committee that the trainee is at an appropriate level to graduate.

BLS/ACLS/PALS/NRP/ATLS training Policy

<https://nyumc.ellucid.com/documents/view/2447>

Case Log Policy & Procedure

Vascular Surgery Case Log Policy

Vascular Surgery residents are required to enter their cases using the ACGME resident case log system. The Defined categories and requirements are listed below. Residents review their case load during their semi-annual reviews with the Associate Program Director.

Cases can be logged by going to this link: <https://apps.acgme.org/connect/login>

Defined Categories-

- Endovascular Diagnostic = 100
- Endovascular Therapeutic = 80
- Endovascular Aneurysm Repair = 20
- Abdominal = 30
- Cerebrovascular = 25
- Peripheral = 45
- Complex = 10

Residents in an integrated program should perform a minimum of 500 operations, to include 250 major vascular reconstructive procedures

Operative experience in excess of 1500 total cases must be justified by the program director

Resident Role to take credit for cases is as follows:

SC = Surgeon Chief Year (only cases credited as surgeon during 12 months of Chief Year)

SJ = Surgeon Junior Years (all cases credited as surgeon prior to Chief Year)

TA = Teaching Assistant (more senior resident working with junior resident who takes credit as surgeon)

FA = First Assistant (any instance in which a resident assists at an operation with another surgeon---an attending or more senior resident---responsible for the operation)

Procedure Log

Residents are also required to log in their procedures such as central lines in New Innovations. **Residents have to show proficiency in a number of procedures as part of their scope of practice by PGY level.**

Procedures are logged in New Innovations. Progressive responsibility and independence occurs with increasing numbers of procedures under initially Direct Supervision. In particular, rotations in the Intensive Care Unit typically involve large numbers of inpatient procedures, including central venous catheter insertion, ultrasound guidance for central venous catheter insertion, indwelling arterial line insertion, pulmonary artery catheter insertion. Competence is assessed directly by Core and Vascular Surgery Faculty.

Chief Resident or Fellow Policy

<https://nyumc.ellucid.com/documents/view/2474>

Concerns and Complaints Policy

The NYU School of Medicine Vascular Surgery Program is committed to maintaining an environment that is supportive and conducive to learning. As such, open communication with our residents is of utmost importance. In the event that an individual would like to discuss or report a concern or complaint, there are numerous opportunities for residents to do so, either directly or anonymously.

Residents have a professionalism session dedicated to “Admitting Mistakes – Error reporting”. They go over how to report errors at all 3 hospital locations.

Residents can contact Dr. Caron Rockman, Program Director, Dr. Mikel Sadek, Associate Program Director and or Dr. Leon Pachter, Chairman, or Michael Ambrosino, M.D., the Senior Associate Dean for Graduate Medical Education and DIO to discuss any issues of concern.

The NYU Langone Health Policy can be found here:

<https://nyumc.ellucid.com/documents/view/2473>

Corrective Action & Disciplinary Policy
<https://nyumc.ellucid.com/documents/view/3937>

Disaster Policy

In the event of a natural disaster, trainees should contact the program director, Caron Rockman, MD or associate program director Mikel Sadek MD, directly via e-mail or by phone. If they are unavailable, the trainees should contact the program coordinator or program manager via e-mail or by phone. Their contact information is listed in the Overview section of this program manual. Please also be sure to update all personal contact information in NYULMC's peoplesoft to ensure that you can receive any updates from the medical center.

<https://nyumc.ellucid.com/documents/view/2478>

Fellow Clinical and Education Work Hours Policy

DEPARTMENT OF VASCULAR SURGERY POLICIES AND PROCEDURES FOR RESIDENT DUTY HOURS

The Department of Vascular Surgery at New York University School of Medicine considers the Duty Hour Policy as absolutely mandatory and takes into account both the newly revised ACGME requirements as well as the New York State Department of Health Duty Hour policies. The most restrictive policy between the two is used here. Duty hours include all clinical and academic activities of the Resident; i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, transfer of patient care, time spent in-house on-call, and scheduled academic activities such as conferences. Duty Hours do not include reading and preparation time spent away from the duty site.

It is the policy of the Department of Vascular Surgery at New York University School of Medicine that the residents must maintain compliance with the following duty hour rules. Furthermore, all residents should use alertness management strategies while engaging in patient care. Surgical residents at NYU School of Medicine have reviewed the warning signs of fatigue, alertness management strategies, and strategic napping policies during the mandatory fatigue recognition and management online tutorial and similar lecture given by the Program Director. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

Mandatory Logging Period – Residents must be adhering to the Mandatory Logging Periods of April 1-30 and October 1-31.

Mandatory Time Free of Duty – Residents must be scheduled for a minimum of one day free of duty every week. At-home call cannot be assigned on these free days.

Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 16 hours in duration

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. All residents should use alertness management strategies while engaging in patient care as demonstrated during the mandatory fatigue recognition and management online tutorial and lecture. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

- a. It is essential for patient safety and resident education that effective transitions in care occur. Residents can take no longer than an additional three hours for sign out.
- b. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- c. In unusual circumstances, 4th and/or 5th year residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

- i. Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- ii. Document the reasons for remaining to care for the patient in question on the “Extension of Duty Hour Form” and submit that documentation in every circumstance to the Program Director.
- iii. Residents requesting extension of duty hours must also email the Program **Director, Dr. Caron Rockman**, the reason for extension and date and time the resident actually left the hospital.
- iv. Each request for extension of duty hours will be tracked and analyzed on both the resident and rotation level to be certain that these extensions are appropriate.

Minimum Time Off between Scheduled Duty Periods

- a. PGY-1 residents should have 10 hours free of duty between scheduled duty periods.
- b. Intermediate-level residents (R2, R3) should have 10 hours free of duty. In addition, they must have at least 14 hours free of duty after 24 hours of in-house duty.
- c. Residents in the final years of education (R4,R5) must be prepared to enter the unsupervised practice of Medicine and care for patients over irregular or extended periods but must complete and submit the “extension of duty hour form” and email Program Director. This must occur within the context of the 80hour, maximum duty period length, and one day off in seven standards.

Maximum Frequency of In-House Night Float

- a. Residents must not be scheduled for more than six consecutive nights of night float.
- b. Night float rotations must not exceed two months in duration, and there can be no more than three months of night float per year. There must be at least two months between each night float rotation.

Maximum In-House On-Call Frequency

- a. PGY-2 and above residents must be scheduled for in-hours call no more frequently than every-third-night (when averaged over a four-week period).

At-Home Call

- a. Time spent in the hospital by residents on “at-home call” must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- b. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80- hour weekly maximum, will not initiate a new “off- duty period”

Night Float Service at Tisch Hospital

House Staff Complement: R4, R2

Night Float Service at Bellevue Hospital

House Staff Complement: R5, R3 (the R1s work 12 hour shifts at all three institutions).

The Night Float Services at both Tisch and Bellevue will be responsible for all patient-care issues, consults, and OR cases starting on Sundays 7AM through Monday 7AM. They also cover Monday-Thursday 6PM-7AM. The members of this service will absolutely leave no later than 7am (other than for Wednesday and Thursday conference). The primary goals of the Night Float Service are:

- 1) To provide full-service patient care during the night hours, and
- 2) To support the primary surgical services so that the primary-team residents can maximize the benefit of their time in the hospital during the weekdays.
- 3) All patient and educational conferences at NYU School of Medicine have been moved to morning so that both the night float and the daytime teams can attend all conferences.

Process For Monitoring Compliance With The Duty Hour Requirements

The program uses New Innovations to capture duty hour data on a monthly basis (the GME office requires that programs log during the months of April and October). The Program Director reviews the data and speaks with residents who have been out of compliance to find out the reasons for the violation and confirms the violation exists. The results are then discussed at the monthly Departmental house staff committee which is comprised of the Vice-Chair for Education, Program Director, Associate Program Director and 2 residents from each of the PGY level. The committee discusses a plan of correction for the violations. Violations are also discussed at the Monthly Program Evaluation Committee Meeting and at the Annual Program Review Retreat.

The responsible attending surgeons and administrative staff continue to monitor the service structure with night float in place. Irregularities are reported to the Director of the residency and to the service chiefs. This procedure has been incorporated into the schedule. Attending surgeons and chief residents are responsible for monitoring the working hours of junior residents. They will immediately report to the Program Director whenever:

Circumstances cause extended work hours due to emergency or other situations.

Residents work hours have resulted in excess fatigue or stress.

Any intern working more than 16 hours

Any resident working more than 24 hours

Residents will themselves report to the Program Director or designee any circumstances causing excess fatigue or undue fatigue, stress or other situations which impair performance.

Any circumstances of excess fatigue, stress or illness are handled similarly by report of the resident to the attending surgeon, service chief and Program Director. Such residents are immediately removed from duty and not allowed back until cleared by the service chief and/or Program Director. Call rooms are available for strategic napping at all times and in all hospitals.

A summary of the ACGME rules and requirements is put together in a contract that each faculty member and resident MUST sign attesting that they will abide by the requirements and facilitate resident duty hour compliance. Failure of a faculty member to facilitate resident compliance will result in being placed on a non-teaching service and receiving NO resident coverage.

For further information, please refer to the NYU GME policy located on ATNYULMC.org in the Ellucid application.

Evaluation Policy

The Vascular Surgery program utilizes New Innovations for trainee, faculty and program evaluations.

New Innovation system

The Vascular Surgery residency Program utilizes an electronic evaluation system called New Innovations, which maintains confidential evaluations. This system operates by coordinating a schedule of evaluations that must be submitted by all of the participants in the program (including the residents, attending faculty, the Program Director, and other personnel at the medical center) and email reminders to each of these participants.

Each email reminder contains a link to the actual evaluation, so that a simple click enables the resident and/or faculty to complete the evaluation electronically.

Residents have access to complete evaluations on New Innovations 24/7.

The system compiles the evaluations into a report for the Program Director so that he is able to monitor compliance with all of the rules and requirements of the Program. If, for example, the evaluations point out a deficiency in a particular area, the Director is made aware and can take steps to remediate the deficiency. Additionally, the system also sends the Director reports about the instances of failure to complete the evaluations themselves, ensuring the ability to monitor compliance with the Program requirements.

- Faculty member from each rotation evaluates residents on that service on a monthly basis
- Junior residents complete an evaluation of their senior residents on a monthly basis
- Senior residents evaluate junior residents on a monthly basis
- All residents and faculty evaluate the program at the end of the year

What about Multisource evaluations? Who evaluates the trainee, where, when, how often?

The program evaluation committee holds an annual retreat to discuss all the program evaluations along with rotation changes that need to be made for the new academic year. In addition to the comprehensive annual retreat, there are also monthly meetings to discuss the same issues and other issues which may arise throughout the academic year.

ACGME Survey

The ACGME also conducts an annual survey of the residents and faculty about the Program and sends the information to the Program Director. The Program Director reviews the survey and takes steps to address any deficiencies that the survey identifies. Deficiencies are addressed by the Program Evaluation Committee, the Program Director and Core Faculty, along with input from the appropriate designated trainees.

For further information, please refer to the NYU GME policy located on ATNYULMC.org in the Ellucid application.

Fatigue Mitigation Policy

<https://nyumc.ellucid.com/documents/view/2475>

Vascular Surgery Fatigue Back up Plan:

The Department of Surgery has put in place the following back up plan for when a resident calls in sick or is unable to show up as scheduled due to fatigue. The Department will provide coverage by reassigning a resident from the following:

1. A resident who is doing an elective rotation
2. A resident from services such as breast, endocrine, endoscopy where the clinical demands are less on residents
3. A resident who is doing on site research and is credentialed as an assistant in service by NYU Langone Medical Center.

The Department also has PAs/NPs for days, nights and weekends that can fill in for a resident, PGY 3 or below, who may be out sick.

In addition, for the R4s and R5s, the attendings are available to step in with 24/7 in house attending at Bellevue, Tisch and the VA.

Coverage in situations as above is coordinated by direct communication with the Program Director or Associate Program Director.

Impairment Policy

<https://nyumc.elucid.com/documents/view/3098>

Moonlighting Policy

DEPARTMENT OF SURGERY

POLICIES AND PROCEDURE FOR RESIDENT MOONLIGHTING

Moonlighting Policy

I. Policy and Procedure

The NYU *Residency Training Program Agreement* prohibits a Resident from engaging in any moonlighting activity except upon receipt of prior written approval from the Program Director. The Director has the discretion to prohibit moonlighting activities that interfere with educational objectives, patient care responsibilities, and/or Duty Hour limitations and to develop a moonlighting policy for his/her training program that is more restrictive than the requirements set forth under this Moonlighting *Policy for Residents*.

The Vascular Surgery residency program will only allow moonlighting when the resident is on vacation or on leave of absence for research from the clinical program.

- A. **Moonlighting Application.** The Resident must initiate the *Application process*.
1. **Resident's Submission of Application.** Prior to the acceptance and commencement of any moonlighting activity, any Resident wishing to moonlight (as defined in Section II, Definitions) must submit a completed and signed *Application* to Dr. Rockman, Program Director, for approval. The Resident may not commence, under any circumstance, any moonlighting activity without prior written approval from Dr. Rockman. An *Application* may be obtained from the Department office in New Bellevue 15 North 1.
 2. **Director's Discretion.** The Program Director has the discretion to decide, categorically or individually, whether or not the proposed moonlighting activity is compatible with the training requirements for the program. The Director, therefore, may permit, prohibit, limit, or revoke permission to moonlight as s/he deems appropriate. In addition, NYU, or any individual Director, may deny any moonlighting activity that is deemed inconsistent with NYU policy. The Director will base his/her written approval or denial of a Resident's *Application* on factors that include, but are not limited to:
 - a. **Residency Review Committee Requirements.** The Resident's proposed moonlighting activity must comply with the requirements of his/her programs' Residency Review Committee regarding moonlighting.
 - b. **PGY Level.** The Resident must have completed at least one year of clinical training in an approved residency training program and possess a valid New York State medical license.
 - c. **Academic Standing.** The Resident must be in good standing, as evidenced by his/her evaluations.
 - d. **Total Duty Hours.** The Resident's total Duty Hours must not exceed the limitations set forth under NYU's *Duty Hours Policy for Residents*.
 - e. **Conflict of Commitment.** Residency education is a full-time endeavor. The Director, therefore, must ensure that the Resident's moonlighting workload interferes neither with the Resident's ability to achieve the

goals and objectives of his/her residency program nor with his/her ability to complete regular duties, including call and continuity practice.

3. **Program Director's Approval/Denial.** The Program Director must indicate his approval or denial of a Resident's *Application* by completing the appropriate section of the *Application*. Any Resident who moonlights in the absence of prior written approval from his/her Director is subject to disciplinary action.
 - a. **Moonlighting Denied.**
 - i. **Not Subject to Appeal.** The Program Director's decision to deny a Resident's *Application* is final and not subject to appeal.
 - ii. **Record Maintenance.** The Program Director will send the original denied *Application* to the Resident, maintain a copy in the Residents' department file, and forward a copy to the NYU Graduate Medical Education office.
 - b. **Moonlighting Approved.** In the event the Application is approved, the Director will send the original approved Application, with a copy of this Moonlighting Policy for Residents attached, to the Resident. Per ACGME requirements, the Director will maintain a copy of the approved Application in the Residents' department file. The Director also will forward a copy to the NYU Graduate Medical Education Office.
- B. **Resident's Responsibilities.** Upon receipt of an approved Application, the Resident must:
 1. **Comply with Program Assignments.** The Resident's commitment to his/her residency training program must take priority over any moonlighting activity. Failure to comply with program assignments will subject the Resident to disciplinary action.
 2. **Obtain Malpractice Coverage.** The Resident must either purchase sufficient malpractice insurance to cover his/her moonlighting activities or obtain written assurance from the Hiring Entity that it will provide malpractice insurance and workers' compensation coverage to the Resident. That insurance is separate from the coverage provided by NYU for the Resident's core training program. NYU's malpractice policy for Residents does not extend to medical services rendered outside of officially scheduled assignments, duties, or rotations.
 3. **Obtain License or Limited Permit and DEA Registration Number.** In accordance with New York State Education Law, the Resident must obtain a license or limited permit before s/he may begin any moonlighting activity. Pursuant to Drug Enforcement Agency regulations, the Resident may not use, under any circumstances, a DEA Registration Number assigned to the Resident by NYU while engaged in moonlighting activities outside the NYU System.
 4. **Refrain from Moonlighting During Regular Duty Hours.** The Resident MUST NOT moonlight during regular Duty Hours, as defined by his/her Program Director.
 5. **Adhere to Duty Hour Limitations.** The Resident is responsible for complying with the Duty Hour limitations set forth under NYU's *Duty Hours Policy for Residents* when moonlighting and, as such, must assure his/her NYU Director that the combined training program and moonlighting hours do not exceed those Duty Hour limits. Time spent moonlighting must be included in the calculation of Duty Hours.
 6. **Submit Weekly Schedule.** The Resident must provide the Program Director with the Resident's total working hours for any and all moonlighting activities each week. Under no circumstance will any Resident be allowed to work in excess of Duty Hour limitations.

7. **Refrain From Wearing NYU Identification When Moonlighting.** The Resident must not be visually identifiable as a trainee in an NYU residency training program when moonlighting at a Hiring Entity other than Tisch, Bellevue, the Veterans' Administration and the Hospital for Joint Diseases.
 8. **Arrange for Direct Remuneration.** Each Hiring Entity must remit remuneration and benefits earned by the Resident while moonlighting directly to the Resident.
 9. **Submit Ad Hoc Changes/Annual Renewal.** The Resident must submit a new [Application](#) to his/her Director annually and as changes to his/her training program requirements or previously approved moonlighting activities occur. Changes include any modification to the a) training program schedule (e.g., due to promotion to next PGY level); b) number of moonlighting hours worked; c) supervisor(s) to whom the Resident is assigned while engaged in an approved moonlighting activity; and/or d) sites where the moonlighting activity occurs. The Director must approve or deny each request for continued or amended moonlighting activity in writing.
- C. **Director's Monitoring Responsibilities.**
1. **Performance.** Once the Resident has begun an approved moonlighting activity, the Director must monitor and document the Resident's performance to ensure that factors such as Resident fatigue are not detracting from patient safety or contributing to diminished learning or performance.
 2. **Duty Hours.** The Director must review the Resident's weekly report of moonlighting hours so that the Director may monitor the Resident's total Duty Hours. The Resident, however, is responsible for ensuring that s/he does not exceed established Duty Hour restrictions as set forth under the NYU [Duty Hours Policy for Residents](#).
- D. **Moonlighting Revoked.** Any limitations to, prohibitions against, or revocations of moonlighting privileges made subsequent to an approval must be documented in writing and presented to the Resident by his/her Director. The Director must maintain a copy of such written notice in the Resident's department file and forward a copy to the NYU Graduate Medical Education Office. Once the Program Director has revoked the Resident's permission to moonlight, the Resident will not be eligible for reinstatement or reconsideration of his/her moonlighting privileges for six months.

On-call Policy

Vascular Surgery residency program follows General Surgery program which has night float services at Tisch and Bellevue hospitals for Sunday to Thursday. The Night Float service is an entirely separate rotation.

Night Float Service at Tisch Hospital

House Staff Complement: R4, R2

Night Float Service at Bellevue Hospital

House Staff Complement: R5, R3 (the R1s work 12 hour shifts at all three institutions).

The Night Float Services at both Tisch and Bellevue will be responsible for all patient-care issues, consults, and OR cases starting on Sundays 7AM through Monday 7AM. They also cover Monday-Thursday 6PM-7AM. The members of this service will absolutely leave no later than 7am (other than for Wednesday and Thursday conference). The primary goals of the Night Float Service are:

- 1) To provide full-service patient care during the night hours, and
- 2) To support the primary surgical services so that the primary-team residents can maximize the benefit of their time in the hospital during the weekdays.
- 3) All patient and educational conferences at NYU School of Medicine have been moved to morning so that both the night float and the daytime teams can attend all conferences.

There is a R4 and R2 on call for Tisch and R5/R3 on call for Bellevue and VA Hospital from 7AM until 8AM on Saturdays.

Calls at VA Hospital are from home. The R3 takes first call and R5 provides back up.

Attending supervision is indirect off-site, available by phone. Senior Residents R4s and R5s are available on site.

For more information regarding the lines of supervision and escalation when on Night Float rotations, please refer to the Departmental specific Supervision and Escalation Policy located in this manual.

Out-rotation/Elective Policy

NYU School of Medicine

Issuing Department: Graduate Medical Education

Effective Date: 04/21/11

Reissue Date: 01/01/2016

Out-Elective Policy and Procedure

I. Policy Purpose

Over the course of a House Staff Officer's post-graduate training, s/he may be permitted a program-specific number of electives. Accordingly, the Resident/Fellow may request authorization to explore a clinical or research experience not available through the New York University School of Medicine ("NYUSoM")/NYU Hospitals Center ("NYUHC") by seeking approval for an Out-Elective.

II. Applicability of the Policy

House Staff Officer's enrolled in ACGME-accredited, AOA-accredited, and CPME accredited specialty and sub-specialty programs

III. Definitions (if applicable)

- A. **ACGME** – Accreditation Council for Graduate Medical Education
- B. **AOA** – American Osteopathic Association
- C. **CPME**- Council on Podiatric Medical Education
- D. **Agreement** – Out-Elective Program Letter of Agreement
- E. **CPME**- Council on Podiatric Medical Education
- F. **Director** – NYU Director of Residency Training
- G. **House Staff Officer** - a physician who is enrolled in an Accredited or non-Accredited
- H. NYUSoM Training Program for a clinical specialty or subspecialty this includes all Residents and Clinical Fellows.
- I. **NYUHC**- NYU Hospitals Center
- J. **GME** – Office of Graduate Medical Education
- K. **Host Institution** - The site of approved clinical study undertaken outside the NYU System. A Host Institution can be a hospital, a private practice office, or any other clinical entity.
- L. **NYUSOM** - New York University School of Medicine

M. **NYUHC** - NYU Hospitals Center

N. **Out-Elective** - A program of study that is arranged on an individual basis *and* hosted by an institution that is outside the NYU System (as defined in this *Section II*). Out-Electives must be authorized by the NYU GME and be consistent with Residency Review Committee requirements.

O. **Request** – Out-Elective Request Form

P. **Standing Rotation** - A Standing Rotation is a required component of a residency-training program that takes place at a hospital or other setting where NYU has an institutional affiliation agreement. *This policy does not pertain to Standing Rotations.*

Q. **Supervisor** – Host Institution faculty responsible for the supervision and evaluation of an NYU Resident/Fellow.

IV. Policy

The Accreditation Council for Graduate Medical Education (“ACGME”) requires that Out-Electives a) be based on a clear educational rationale; b) have clearly stated learning objectives and activities; and c) provide resources not otherwise available within the House Staff Officer’s training program. In addition, Out-Electives must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Exceptions to those requirements must be justified and approved by the Out-Elective Subcommittee of the GMEC.

Out-Electives must be selected with the advice and approval of the House Staff Officer’s NYU Director of Residency Training (“Director”), who will base his/her recommendation on the House Staff Officer’s academic standing and factors which include whether or not the Out-Elective experience:

- Is available within the NYUHC;
- Enriches, but not replaces, the Resident/Fellow’s core experiences;
- Enhances the residency experience; and
- Provides sufficient and appropriate supervision to the Resident/Fellow.

When House Staff Officer’s education occurs outside NYU, NYU continues to have responsibility for the quality of that educational experience and must retain authority over the House Staff Officer’s activities.

In this document, references to Resident/Fellows are limited to NYU Resident/Fellows enrolled in specialty and sub-specialty programs accredited by the ACGME, AOA, and CPME.

V. Procedure

A. **Initial Considerations** - While it is within the Director’s discretion to grant initial approval for Out-Elective study to a Resident/Fellow in his/her program, under normal circumstances acceptable justification should include affirmation that the proposed training experience is *not available within NYU*.

B. **Additional Acceptable Justification** - The Director may, however, consider requests that:

- Provide defined educational opportunities specific to the House Staff Officer's career goals;
- Are deemed valuable to NYU; or
- Are humanitarian in nature.

C. **Requirements.**

1. **Good Academic Standing** - A House Staff Officer must be in good academic standing, as evidenced by his/her performance evaluations.
2. **PGY Year.** - A House Staff Officer must be a PGY-2 or higher to be eligible for an Out-Elective.

D. **Compensation and Malpractice Insurance Coverage** - Arrangements for the House Staff Officer's compensation and malpractice insurance coverage during the Out-Elective must be in place (see *Sections IV, Medical Licensure and Malpractice Coverage, and V, Financial Considerations*, in this document).

E. **Program-Specific Guidelines** - The Director will establish general Out-Elective guidelines for his/her program consistent with this *Out-Elective Policy and Procedure*.

F. **Selection of Out-Elective** - A House Staff Officer interested in pursuing an Out-Elective must select an area of interest and a location for such training. The House Staff Officer then must contact the supervising attending physician at the prospective Host Institution and obtain an informal promise of commitment from him/her.

G. **Completion of the Out Elective Request Form.**

1. **House Staff Officer's Responsibility.** The House Staff Officer must initiate the application process at NYU by completing an Out-Elective Request Form, available online at the GME Website under Policies and Procedures. The Request form must be signed and approved by the Host Institution Supervisor. The House Staff Officer must submit the completed form to his/her Director for approval and signature.
2. **Director's Responsibility.** The Director must approve or deny the House Staff Officer's Request in writing:
 - a. **Denial.** If the Director denies the House Staff Officer's Request, the Director will return the form to the Resident/Fellow so indicating. A copy of the denied Request will be maintained in the House Staff Officer's department file. The decision of the Director is final and not subject to appeal.
 - b. **Approval.** In cases where the Director approves the Request, he/she will complete the appropriate area of the form, initiate an Out-Elective Program Letter of Agreement ("Agreement"), and submit a summary statement summarizing the elective and addressing the following criteria:
 - The educational value of the experience
 - Unique value the experience provides
 - c. **Submission.** Submit all documents to the NYU Office of GME (three months prior to the scheduled out-elective). The elective will then need the approval of the Out-Elective Subcommittee of the GMEC, which meets quarterly.

- d. **NYU GME' Responsibility.** The NYU Office of GME will forward the completed and signed Request and Agreement to the Out-Elective Subcommittee for final execution.
- H. **Notification** - Once the Request and Agreement are fully executed, the NYU Office of GME will notify the Director and the Resident/Fellow of the final approval in writing.
- I. **Recordkeeping** - Copies of the approved Request and Agreement will be sent to the House Staff Officer and maintained in the files of the NYU Office of GME. The original Request and Agreement will be maintained in the Resident/Fellow's department file.
- J. **Evaluation** - The Director must ensure that an evaluation of the House Staff Officer's performance is obtained from the Supervisor or his/her designee at the end of the Out-Elective. The Director or his/her designee also should meet with the Resident/Fellow at the conclusion of the Out-Elective to discuss the experience and the evaluation with him/her.
- K. **Continuity Experience** - For those programs that have continuity requirements, continuity experience must receive priority over other responsibilities and may be interrupted only for vacations and outside rotations located at too great a distance to allow Resident/Fellows to return.

VI. Medical Licensure and Malpractice Coverage

- A. **Medical Licensure** - It is the responsibility of the House Staff Officer to understand and follow the applicable state licensure rules for House Staff Officer in Graduate Medical Education ("GME") programs in the state in which s/he will be training. Many states require, at minimum, a training certificate to be issued by their state's medical board prior to the commencement of any clinical activities; this requirement may include certain institutions within New York State.
- B. **Malpractice Coverage** - Malpractice coverage provided to House Staff Officer by NYU is effective only within the standard clinical training program as defined within current affiliation and/or program agreements; therefore, the Resident/Fellow has the primary responsibility for ensuring that a malpractice policy, provided by either the Host Institution or by the NYU Insurance Office, is in force to cover his/her Out-Elective activities.

It is the policy of NYU School of Medicine that House Staff Officer who elect to participate in an out-elective contact the Host Facility to ensure that the Host Facility will provide professional liability insurance through a qualified professional liability insurance carrier or through self insurance to cover the Resident/Fellows as applicable in their activities at the Host Facility.

If the Host Facility elects not to cover the House Staff Officer and if the out-elective is needed to complete ACGME requirements for the training program, the Resident/Fellow may request that the NYU Insurance Office authorize malpractice coverage for the out-elective. The House Staff Officer will not be covered by NYU malpractice insurance during an out-elective in the absence of a written malpractice insurance coverage authorization from the NYU Insurance Office. In most cases, this will result in a fee charged to the department for the extended coverage.

Professionalism Policy

The training program in Vascular Surgery adheres to the institutional policy on professionalism.

As part of the curriculum designed to enhance Professionalism, the Program requires that the trainees participate in the following 6 lectures. We also have incorporated the Professionalism Evaluations under the Direct Observation Program in clinics which is under the direction of Donna Phillips and the evaluations are in NI.

- a. Advanced Communication Skills for Surgical Practice
- b. Admitting Mistakes: Ethical and Communication Issues – Error reporting
- c. Delivering Bad News - Your Chance to Become a Master Surgeon
- d. Working With Professionals Around You: Team Communication
- e. Working Across Language and Cultures: The Case for Informed Consent
- f. Self-Care and the Stress of Surgical Practice
- g. UME: Residents as Teachers

Trainees are also evaluated on an annual basis by a Professionalism OSCE exercise conducted in the NY SIM Center.

NYU School of Medicine

Issuing Department: Graduate Medical Education

Effective Date: 04/08/2013

Reissue Date: 01/01/2016

Professionalism in Graduate Medical Education

I. Summary of Policy

The ACGME Common Program Requirements state the following with regard to professionalism in Graduate Medical Education:

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others;

IV.A.5.e).(2) responsiveness to patient needs that supersedes selfinterest;

IV.A.5.e).(3) respect for patient privacy and autonomy;

IV.A.5.e).(4) accountability to patients, society and the profession; and,

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

II. Policy Purpose

In addition to policies and expectations set by other organizations and institutions (such as the ACGME, AOA, AAMC, Joint Commission, and hospital policies), this policy sets the professionalism expectations of House Staff Officers and faculty in Graduate Medical Education at NYULMC.

III. Applicability of the Policy

This policy applies to all House Staff Officers at NYULMC. Additionally, when applicable, this policy sets expectations for program directors and faculty.

IV. Definitions (if applicable)

- A. **House Staff Officer** - a physician who is enrolled in an accredited or non-accredited NYUSoM or NYUHC Training Program for a clinical specialty or subspecialty this includes all Residents and Clinical Fellows.
- B. **Sponsoring Institutions**- NYU School of Medicine and NYU Hospitals Center

V. Policy

A. Professionalism

- a. Responsibilities: All House Staff Officers are expected to:
 - i. Adhere to The NYULMC Code of Conduct and all policies of Office of GME, NYULMC, HHC, VA, and any other policies that apply to House Staff Officers or the institution/location at which they are working.
- b. In the Curriculum
 - i. In the Common Program Requirements, the ACGME states that evaluation and teaching of professionalism “is most effective when done in the context of patient care and related activities, (e.g., conducting QI projects, leading a team, presenting M&M, reflections on practice, conversation with mentor.” Program Directors and faculty must ensure the integration of professionalism into all possible aspects of the curriculum.
 - ii. Programs must incorporate education about the appropriate scenarios in which a House Staff Officer should ask for help. Each program must determine appropriate escalation procedures. These escalation procedures must be provided to House Staff Officers.
 - iii. Programs must incorporate education about error reporting procedures for all locations at which House Staff Officers will work.
 - iv. House Staff Officers must be appropriately educated about retaliation, how to recognize retaliatory actions, and the appropriate methods for dealing with such.
- c. Evaluations and Feedback: Evaluations must be completed, as stipulated in the ACGME requirements and the NYU Evaluation Policy for Graduate Medical Education. In addition:
 - i. Both the evaluator and the individual being evaluated are expected to respect diversity of opinion.
 - ii. House Staff Officers must be open to accepting evaluations and feedback on their performance in all areas of training, and incorporate evaluations and feedback into their practice.
- d. Error Reporting, Concerns, and Complaints: House Staff Officer are at the front line of patient care, and are expected to report any errors or incidents using the appropriate methods. This practice is essential to patient care and quality improvement, and should be encouraged. In addition:
 - i. House Staff Officers are expected to submit any concerns or complaints as defined by the “House Staff Officer Concerns or Complaints” Policy. The appropriate

mechanisms for submitting such information at each institution are available in this policy.

- ii. If a situation or concern does not need to go through the formal processes listed above, House Staff Officers should approach their supervisor, the next highest ranking individual if the issue involved the supervisor, the Office of GME, and/or the Associate Dean of Graduate Medical Education.
 - iii. Programs are responsible for educating House Staff Officers about the error reporting methods at each hospital. Please refer to the “In the Curriculum” section of this policy.
 - iv. Programs must ensure that error reporting mechanisms are available to House Staff Officers at all times.
- e. Quality Improvement and Patient Safety: House Staff Officers are expected to:
- i. Participate in quality improvement and patient safety projects during their time of training.
 - ii. House Staff Officers are expected to be aware of quality improvement initiatives that are taking place at the hospitals in which they work. When possible and appropriate, House Staff Officers should actively participate in these initiatives.
 - iii. Programs are responsible for providing the appropriate education to House Staff Officers about institutional/hospital quality improvement initiatives.

B. Retaliation

- a. In order to provide all House Staff Officers with a culture of safety, and to ensure that they feel comfortable reporting errors and providing feedback, asking for help, and reporting lapses in professionalism by colleagues, any and all retaliatory actions taken against a House Staff Officer should be escalated to his/her supervisor, or the next highest ranking individual in the event that the House Staff Officer’s supervisor is involved. Such incidents can also be reported directly to the Office of GME, and the Associate Dean of Graduate Medical Education.

C. Unprofessional Behavior and Remediation

- a. Any lapses in professionalism will be handled according to the “Corrective Action and Disciplinary Policy for House Staff Officers.”

Recruitment and Selection Policy

Applicants for the Vascular Surgery residency must be in 4th year of medical school and have taken USMLE Step I and have ECFMG certificate if in medical school outside of U.S.

Recruitment and Selection Policy:

Application to the Program will be processed through the Electronic Residency Application Services (ERAS). Applicants will go through the National Resident Matching Program (NRMP) for the matching process. Our deadline for receiving applications through ERAS is November 1. Interviews are conducted from mid-November to mid-January.

All applications must be submitted via ERAS and must include:

- Medical School Transcript
- USMLE Scores step I and preferably Step II as well
- Letters of Recommendations
- Dean's letter
- Personal Statement
- ECFMG certificate if applicable

Desirable applicants must be well rounded, have scored well on both USMLE Step 1s and Step2s, have performed well on their surgery clerkships and have excellent letters of recommendations.

Supervision and Scope of Practice Policy (including Escalation)

DEPARTMENT OF SURGERY

Division of Vascular Surgery

This Policy for Supervision for Vascular Surgery Residents is intended to supplement the official institutional policy approved by the Graduate Medical Education Committee and is titled “New York University School of Medicine Supervision of Residents, Subspecialty Residents, and Fellows policy.” The full institutional policy is available at ATNYULMC.org under the Ellucid application.

- Resident supervision is the key to a successful residency training program. For a Vascular Surgery residency, this supervision must take place not only on the wards and in the outpatient/clinic setting, but in the operating room as well. Optimal supervision of the residents benefits all participants in the patient-resident-faculty relationship. When residents are optimally supervised, outstanding patient care is guaranteed. Furthermore, progressive resident responsibility can only be accomplished and allowed when there is continuous supervision, assessment and feedback. Finally, since the attending staff is ultimately accountable for the care delivered to patients and the supervision of the residents, a formal supervision policy guarantees that the surgical faculty is committed to both outstanding patient care and outstanding residency training.

- The goal of the Residency Training Program in Vascular Surgery at New York University School of Medicine is to provide an academic environment to train the surgeons of tomorrow. An important tenet of our training is insuring they are properly guided and supervised. Only in this way can our faculty guarantee patient safety and appropriate standard of care, promote resident development in the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies, and reinforce its commitment to training and supervision of the surgical residents. It is equally critical for our faculty to train our residents to become effective supervisors themselves. We expect all residents to closely supervise medical students and senior residents to oversee junior residents.

- The ACGME requirements state that, “Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience.” Furthermore, on-call schedules for teaching staff must be structured to ensure that supervision is readily available for residents on duty and the teaching staff must determine the level of responsibility accorded to each resident.

The Department of Surgery at NYU believes that resident supervision has many components and many objectives as outlined below.

1. The Faculty

- Attending surgeons who comprise the teaching faculty for the residents are chosen by the Chairman and Program Director based on their simultaneous commitment to residents (education, personal and professional maturation) and patients (optimize safety and level of care). Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident. Faculty will delegate portions of patient care to residents based on the needs of the patient and the residents’ skills. Characteristics that make for appropriate resident supervisors include:
 - a. Availability
 - b. Approachability
 - c. Open to diverse opinions
 - d. Dedication to truth and integrity

- e. Compassion
- f. Promote team approach to resident education and patient care

2. Tools and Assessments Used for Supervision

- a. Direct oversight by faculty on the wards, outpatient setting, and
- b. operating room.
- c. Skills laboratory- direct faculty oversight and assessment of
- d. competence in the simulation setting.
- e. Competency curriculum- Objective structured clinical examination (OSCE). The OSCE's, used to evaluate progress through the Competency Curriculum, are evaluated by faculty and report cards reviewed with residents.
- f. **VSITE** (American Board of Vascular Surgery In Training Examination) yearly examination to assess medical knowledge. The VSITE Examination is a combination of both vascular and general surgery medical knowledge questions. Because of the extensiveness of the examine, examinees are allowed seven hours to complete the examination.
- g. New Innovations- web-based evaluations of each resident by faculty, other residents, other healthcare team members, and the residents themselves. The teaching faculty is also evaluated by residents in an anonymous fashion.
- h. Scope of Practice- a list of all procedures (invasive and non-invasive) that specifies level of supervision necessary per resident year. The CCC determines the Scope of Practice every six months based on the observation and clinical advancement of the resident.
- i. **Procedural competency log in New Innovations include non-operative invasive procedures which are supervised and assessed by faculty members who determine level of competency. This will allow for an individualized, resident-specific scope of practice.**

Specific Policies for Supervision

Levels of Supervision

PGY 1 residents should be supervised directly or indirectly with direct supervision immediately available. Residents must communicate with supervising faculty on the service regarding the transfer of patients to the Intensive Care Unit and end of life issues. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision;

1. Direct supervision- the supervising physician is physically present with the resident and patient
2. Indirect Supervision:
 - a. With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
 - b. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
3. Oversight – The supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered.

Supervision for Inpatient Care

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

1. Supervising faculty members are available for immediate supervision in person or by telephone.
 - a. Bellevue Hospital: There is in-hospital 24 hours/7 days per week surgical faculty supervision and coverage.
 - b. Tisch Hospital and Manhattan VA Hospital: Specific schedules are prepared in advance and distributed to all residents and throughout the hospital. These schedules note which faculty member is responsible for resident supervision and patient coverage at all times.
2. To allow for supervised progressive responsibility, residents will make patient rounds on their service/hospital each morning. When appropriate, they will also round on patients in the afternoon or more frequently as needed. Patient care plans are formulated by the residents and then presented to the supervising faculty member. As outlined in the goals and objectives, the residents actively assume increasing patient care responsibility, while being closely supervised by the faculty.
3. Intensive care units at Bellevue and Tisch are supervised by surgical and/or critical care faculty 24 hours/7 days per week. This is in addition to the faculty member primarily responsible for the patient's care. At the VA Hospital the Anesthesia Critical Care faculty covers in-house. This is in addition to the on-call supervising surgical faculty member covering the VA Hospital.

Supervision of Outpatient Experience

1. At each site, the outpatient experience is directly supervised by the surgical teaching faculty.
 - a. Bellevue and VA clinics: Each clinic is staffed by at least one full-time faculty member who is present for the duration of the entire clinic, providing full-time supervision.
 - b. At NYU Hospital: The resident will attend an individual teaching attending's clinic/office hours and direct supervision will be provided by that member of the faculty.
2. In the outpatient setting, the resident performs a history and physical examination and presents to the faculty member. Together, all imaging studies and pathology reports are reviewed. With progressive responsibility, the resident will then present his/her plan of action to the supervising attending. When the plan is finalized, the resident and supervising faculty member will go together to the patient's room to further discuss with patient and clarify any issues.

Supervision in the Operating Room

1. All operative procedures are performed under the direct supervision of an attending surgeon. The attending surgeon must document his/her supervision throughout the case.
2. Standard operating procedure at Tisch, Bellevue, and the VA Hospital dictates that the responsible surgical attending be present in the specific operating room and personally perform the "time out" prior to deliverance of anesthesia.
3. For procedures performed in the intensive care unit or in the trauma unit of the Emergency Department, direct resident supervision is required. Critical care attending staffing is noted above with in-house coverage at Tisch and Bellevue and coverage until midnight at the VA Hospital.

Supervision of Duty Hours

1. All teaching faculty and all residents have received in-service regarding duty hour regulations.
 - a. Faculty must supervise resident duty hours and every teaching attending has signed a Departmental attestation that he/she not only understands the duty hour rules, but will facilitate resident compliance with all duty hour regulations.
 - b. All residents must monitor their own duty hours and senior residents must monitor duty hours of their junior residents working under them. Each resident has signed a Departmental attestation that he/she understands all of the duty hour rules and will abide by them and facilitate other residents complying with the hours regulations.
2. The Program Director supervises duty hour compliance through monitoring the reporting system in New Innovations.

Supervision to Guard Against Fatigue and Sleep Deprivation

1. All residents and all teaching faculty members have received fatigue and sleep deprivation tutorials. These educational tutorials have been designed to raise awareness of the dangers of sleep deprivation and fatigue and to educate as to how to recognize the signs and symptoms of fatigue and sleep deprivation.
2. It is the responsibility of all supervising faculty members, the Program Director, and the Site Supervisors to be vigilant and to identify any resident who may be impaired by fatigue or sleep deprivation.
3. Responsibilities of the supervising faculty member include:
 - a. Responsible, professional behavior dictates that when a resident recognizes that he or she is suffering from fatigue or exhaustion, he or she must notify their supervising attending or the program director immediately.
 - b. The supervising attending or Program Director will immediately relieve the resident of clinical responsibility and send him/her home to allow time for sleep.
 - c. The resident will be considered ONLY in a positive light for putting the safety of their patient first. Under no circumstances will this be considered a negative occurrence by faculty or other residents.
 - d. The chief resident must not only be aware of the possibility of their own fatigue, but will also monitor the junior residents for signs of fatigue. The chief resident will immediately relieve the fatigued resident of all clinical responsibility and they will contact the supervising faculty member and/or program director.
 - e. It is also the responsibility of supervising faculty member to recognize the signs and symptoms of fatigue amongst the residents, relieve the affected resident immediately, and arrange for alternative coverage for that physician.

Graduated Levels of Responsibility

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. **This progression of scope of practice is determined by the Clinical Competency Committee or CCC.**

1. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. This occurs

on an informal basis monthly, following each rotation, with the Program Director assessing New Innovations evaluations provided by the Vascular Surgery Core Faculty. On a more formal semi-annual basis, the CCC performs specific milestones evaluations of all trainees.

2. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

3. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence. This occurs on a continuous basis, based upon the Department of Surgery guidelines for the Resident Expectations of Surgical Education of Medical Students and Junior Residents.

Emergency Situations

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment to the health of a patient. In such situations, any resident, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and notified of the situation as soon as possible.

The resident will document the nature of that discussion in the patient's record.

SUMMARY

Residents, subspecialty residents and fellows treat patients at all of the affiliated hospitals under the supervision of staff attending physicians who are independently licensed and duly credentialed by each institution. All inpatients and outpatients will be assigned an attending physician of record who is responsible for his/her care and for determining and implementing the appropriate level of supervision of the trainee along with the Program Director.

Patients shall be notified of the name of the attending staff physician responsible for their care and that residents and fellows participating in their care are supervised by such staff physician(s). In providing clinical supervision to residents and fellows, supervisors should provide advice and support and should encourage trainees to freely seek their input.

Residents and fellows are expected to make liberal use of the supervisory resources available to them and are encouraged to seek advice and input from their supervisors.

The supervising physician's involvement in a patient's case shall be documented in the medical record.

POLICY FOR ESCALATION

Residents in the Department of Surgery at New York University School of Medicine are guided by rotation-based goals and objectives that include levels of supervision. They also are given a "Scope of Practice" both by postgraduate year and, for most procedures, based on their individualized skills and competency levels. These guidelines, however, do not always provide for the resident a rationale approach to when they should escalate information to supervising faculty and supervising chief residents. Residents must not hesitate to contact a supervising faculty or senior resident. The following serves as an escalation policy for residents:

NOTIFY a more senior team member (Attending and Chief Resident) IMMEDIATELY "within 10 minutes" for

- Death – unexpected
- Cardio-pulmonary arrest or Surgical Airway

- MRT (Medical Response Team) call – Please note that any criterion to call for an MRT needs to be communicated immediately (even if an MRT was not called)
- Level of care upgrade to a Post Op Unit or an ICU, no matter what the reason
- Deterioration in clinical status to include any of, but not restricted to, the following:
 - acute neurologic event (e.g. seizure; TIA; CVA), no matter what cause
 - hemodynamic instability, no matter what cause
 - pulmonary distress or oxygen desaturation, no matter what cause
 - cardiac arrhythmia, sustained, recurrent, or not rapidly controlled
 - tachycardia when recovering from bariatric surgery
 - high fever, unexpected or not quickly suppressed
 - oliguria, unexpected, not responsive to simple therapy
 - pain, worsening or out of proportion to physical exam (e.g. ischemic)
 - pain, chest/back/abdominal with known/suspected aortic aneurysm
 - pain, abdominal with known/suspected mesenteric ischemia
 - neurologic symptoms with known/suspected arterial ischemia
 - change in pulse/Doppler or neurovascular exam of an extremity
 - medication error with untoward side-effect
 - fall with obvious injury

NOTIFY a more senior team member IN AN URGENT MANNER “within 1 hour” for

- Death – even if expected or with DNR status receiving comfort care
- Deterioration in clinical status to include any of, but not restricted to, the following:
 - cardiac arrhythmia, even if self-limited or not needing specific treatment
 - high fever, even if expected or quickly suppressed
 - oliguria, even if expected or responsive to simple therapy
 - pain, unexpectedly persistent
 - unexpected vomiting even without aspiration
 - pneumothorax, even without requiring thoracentesis or tube thoracostomy
 - wound appearance change, worrisome for bleeding, infection, or disruption
 - medication error, even without untoward side-effect
 - fall, even without overt injury
- Significant change in vital lab value – even before a repeat, confirmation value is available. Depending on the clinical situation, immediate action may be needed.
- Radiographic imaging results – whether crucial findings are “positive” or “negative.”

The need to notify is considered mandatory. Moreover, the information relayed must be confirmed to have been received. This Departmental policy recommends alerting all--not just one—member of the team. The surgical attending must be notified of any of the above clinical events as soon as possible.

What if the attending does not answer or answer appropriately?

- Call R4 and or Dr. Berman. (General Surgery) Call Dr. Pachter if Dr. Berman cannot be reached
- On Vascular, Call Senior Vascular Fellow or Dr. Rockman (Vascular Surgery) Call Dr. Jacobowitz if Dr. Rockman cannot be reached

Time-off and Effect of Taking LOA Policy

**DEPARTMENT OF SURGERY
DIVISION OF VASCULAR AND ENDOVASCULAR SURGERY
POLICIES AND PROCEDURES FOR RESIDENT TIME OFF AND LEAVE OF ABSENCE**

The ABS requires 48 weeks of full-time clinical activity in each of the five years of residency, regardless of the amount of operative experience obtained. The remaining four weeks of the year are considered non-clinical time that may be used for any purpose, such as vacation, conferences, interviews, etc. All time away from clinical activity (i.e., non-clinical time), including vacation and time taken for interviews, visa issues, etc., must be accounted for on the application for certification.

The 48 weeks may be averaged over the first 3 years of residency, for a total of 144 weeks required in the first 3 years, and over the last 2 years, for a total of 96 weeks required in the last 2 years. Thus non-clinical time may be reduced in one year to allow for additional non-clinical time in another year.

For documented medical conditions, including pregnancy and delivery, that directly affect the individual (i.e., not family leave), residents may take an additional 2 weeks off during the first 3 years of residency, for a total of 142 weeks required, and an additional 2 weeks off during the last 2 years of residency, for a total of 94 weeks required. No approval is needed for this option if taken as outlined.

The Resident will be required to make up excess time missed before he or she will be eligible for promotion within or completion of the program and before the specialty board will allow the Resident to take the board examination.

Residents are allotted a total of four weeks of vacation time every academic year (see GME policy on ATNYULMC.org in the Ellucid application for more specific information). The Resident must request time away from his or her training program at the earliest date possible to allow time for the Program Director to arrange coverage in the Resident's absence. The Resident must submit corroborating documentation as requested to receive approval for time off (whether paid or unpaid) and, where applicable, to receive authorization to return to his or her training program.

Transitions of Care

Program Responsibilities in regard to Transitions of Care are as follows:

- The Program recognizes that its residents will be required to demonstrate competence in the handover process and that the Faculty of the Program will teach and document that competence and implement a learning plan for the resident who violates this Policy.
- The Program herein delineates its standard for transitions of care within the Department, Division and Program.
- The Program will implement the proper level of supervision for transitions of care as stated in its Policy of Supervision.
- All call schedules and rotation block schedules including attending schedules and contacts are made available to physician and non-physician providers via email. These schedules assure compliance with all applicable Duty Hour regulations and minimize the number of transitions of care in order to maintain continuity and safety of care.

Morning rounds start at 6am at Tisch hospital and 7am at Bellevue hospital where the entire fellow/resident team from the Night and new team for the Day along with the service PA/NP is present to discuss each patient on their service and transition of care takes place within 30 minutes so the night team leaves within the scheduled hours meeting duty hour regulations.

In the evening, patient care transfer takes place over the course of a half an hour (beginning at 6 pm at Tisch and 7 pm at Bellevue). Junior residents sign out the service to the overnight junior resident and the senior resident signs out to the covering senior resident. Advanced care practitioners participate in the sign-out process as well. We have attempted to minimize interruptions during this period by making nurses aware that this is protected time, and all pages are deferred, unless in an emergency.

The transfer of accurate information is facilitated by a Department of Surgery Sign-out Sheet. This is a list of pertinent patient information that is generated automatically by a combination of the electronic medical record and daily fellow/resident updates.

The fellow, resident, ACP and attending call schedules along with their contact information is distributed well in advance of each rotation so that everyone is aware who is the responsible team for patient care each day and night.

Transitions are supervised by Chief Residents. When the EPIC sign out form goes live in the Spring 2016, Faculty will begin formally evaluating transitions in real time to document competence on a consistent basis. **Currently transitions are supervised and evaluated by Faculty informally and competence is documented on the rotational evaluation form.**

To the best of its ability, the Program is attempting to standardize Handoffs as follows:

- Patient Intro
Name
Age, Sex
Surgical Problem(s)
- Periop/Hospital Course
Intra-or Periop Events
Unique anatomy
Prolonged hospital course

- Current Devices
 - Central Lines
 - Tubes (NG, Foley)
 - Drains

- 24 hr. Events
 - Abnormal vitals
 - Relevant I/O & Fluid management
 - Diet changes
 - Device changes
 - Other interventions

- Safety
 - VTE Prophylaxis
 - Anticoag/Cardiac Meds
 - Fall Risk

- System-Based Plan
 - Current status, task by system
 - Identify key consultants
 - Neuro/Plan
 - CV
 - Pulm
 - GI
 - FEN
 - Heme-ID
 - Endo
 - GU
 - PPX
 - Dispo

- Read-Back
 - Questions and Clarification
 - Read-back “action items and safety”

Book & Conference Fund

<https://nyumc.ellucid.com/documents/view/2448>

Patient Safety/Quality Improvement Resources, Expectations & Curriculum

Patient Safety and Quality Improvement Curriculum

A required Patient Safety and Quality Improvement curriculum was designed for all trainees in the Department of Surgery with a one hour conference every other month, led by an attending facilitator. The conference includes a presentation and discussion of the literature pertaining to each safety issue listed below. This is followed by a review of NYU-specific data and comparison to the national data. Attendees conclude with a review of the hospital's policy for each safety issue and a discussion of what can be done at the resident level to improve patient safety and outcome. This curriculum will meet the following goals:

- Competency in Practice Based Learning
- Competency in Systems Based Practice
- Better understand the current health care environment and the roles of the major players (i.e., governmental and non-governmental agencies, hospitals, professional societies and advocacy groups) that shape the practice of medicine
- Be familiar with quality and safety literature
- Learn how to create evidence-based practice guidelines to improve patient safety and outcomes for the hospital as well as our own personal practices

Curriculum includes:

- Overall review of the current health care environment including policy, reimbursement, safety initiatives and measures
- DVT prophylaxis
- Postoperative UTI
- Postoperative wound infection/wound protective devices
- Ultrasound guided CVL placement
- Postoperative confusion/hospital delirium

In addition to the didactic patient safety curriculum, the Department has a QI meeting every Friday with senior trainees to discuss every complication from the week on each service at Tisch and at Bellevue.

The department has also developed a Quality Improvement Committee, that will report to the hospital Quality Improvement Committee that includes department trainees.

Trainees also participate in resident-run Mortality and Morbidity conferences and root cause analysis as part of their core curriculum.

Education and Scholarly Activities for Trainees

It is expected that each year during the residency program, each resident will:

- demonstrate initiative by selecting an area of interest and, working with a mentor, pursuing a research project within this area
- design a research project or join an ongoing research project
- submit at least one abstract to a national vascular meeting
- submit at least one manuscript to a peer-reviewed journal
- demonstrate competency in all areas of research including grant preparation, experimental design, data collection, data analysis and data publication

If the resident is interested in doing scholarly activity or research, they should arrange and meeting for discussion with either the Program Director, Caron Rockman or Associated Program Director, Mikel Sadek.

Education and Scholarly Activities for Faculty

Department of Surgery has a robust mentoring program for junior faculty where each faculty member needs to:

- Publish a minimum of one paper year in a peer-reviewed journal
- Attend at least one national and one regional meeting per year
- Fulfill all teaching assignments for our medical students and residents as requested by Dr. Berman and Dr. Hochberg
- Participate in at least one medical school or hospital committee as our Department of Surgery representative.
- Apply for at least one grant from a governmental (NIH, DoD, NYCHHC) or a private funding source each year.

In addition, each Division has clinical research projects that the faculty are involved in. The department also has clinical databases in Bariatric, Breast Surgery, Endocrine Surgery, GI Surgery, and Vascular Surgery to perform Quality improvement based research.

The Department is also working on Faculty development sessions to promote presentation skills, teach the residents and medical students and learn to do direct observation for the trainees.

Clinical Competency Committee Description (CCC)

Clinical Competency Committee of the Vascular Surgery Integrated Training Program

The Program Director will appoint a Clinical Competency Committee. (V.A.1.)

1. Committee Membership
 - a. The Clinical Competency Committee will be composed of 4 members of the Program Faculty (V.A.1.a.)
 - b. The Clinical Competency Committee will be comprised of vascular surgery integrated core faculty who dedicate 30 or more hours per week to Trainee education.
2. The following is the written description of the responsibilities of the Clinical Competency Committee: (V.A.1.b.)
 - c. The Clinical Competency Committee must: [V.A.1.b).(1)]
 - i. Meet and **review all trainee evaluations** every six months. [V.A.1.b).(1).(a)]

These evaluations might include:

 1. rotation performance evaluations
 2. procedural competence evaluations and procedure logs
 3. multisource evaluations
 4. transitions of care evaluations
 5. research evaluations
 6. simulation evaluations
 7. unsolicited submissions to the Program Director and other Faculty that pertain to trainee performance
 - ii. **Prepare and assure the reporting of Milestones evaluations of each trainee semi-annually to ACGME;** [V.A.b).(1).(b)] and
 - iii. **Advise the Program Director regarding trainee progress, including promotion, remediation, probation and dismissal.** [V.A.b).(1).(c)] The CCC will monitor trainee progress on all remediation plans. The final decision for implementing such remains with the Program Director.

(Blue font denotes adaptation taken from ACGME Common Program Requirements for Graduate Medical Education)

Membership of the Vascular Clinical Competency Committee (CCC) for the 2019-20 Academic Year(s) is as follows: Dr. Joanelle Lugo, Dr. Mikel Sadek, Dr. Neal Cayne and Dr. Glen Jacobowitz.

Program Evaluation Committee Description (PEC)

Department of Surgery
NYU School of Medicine
Responsibility of the Program Evaluation Committee
Program Director: Caron Rockman, MD

Implementation and Charge of the Program Evaluation Committee (PEC) of the Training Program in Vascular Surgery

The Program Director will appoint a Program Evaluation Committee (PEC).

1. The Program Evaluation Committee will include at least 3 Core Program Faculty members and 2 Trainees.
2. This document will serve as a written description of the PEC's responsibilities.
 - a. The Faculty members of the PEC will serve for at least 2 terms.
 - b. The trainee representative(s) will serve for 2 year(s), as determined by the committee chair.
3. The PEC will participate actively in:
 - i. planning, developing, implementing, and evaluating educational activities of the Program;
 - ii. reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
 - iii. addressing areas of non-compliance with ACGME standards; and,
 - iv. reviewing the Program at least annually using evaluations of Faculty, Trainee and others, as specified below.
4. The Program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will be responsible for rendering a written Annual Program Evaluation (APE) based on each academic year. The PEC will meet at least once per year. The Program will monitor and track each of the following areas:
 - a. Trainee performance as determined by the Clinical Competence Committee
 - b. Faculty development
 - c. Graduate performance, including performance of Program graduates on the certification examinations in accordance with your program specific requirement
 - d. Program quality;
 - i. Assessment of resources
 1. Case numbers and clinical resources
 2. Personnel
 3. Funding
 4. Space
 5. Equipment
 6. Information technology
 - ii. Trainees and Faculty members will have the opportunity to evaluate the Program confidentially and in writing at least annually, and

- iii. The Program will use the results of Trainees' and Faculty members' assessments of the Program together with other Program evaluation results (ACGME Trainees and Faculty's surveys, ACC In-Training Examination) to improve the Program.
- e. Progress on the previous year's action plan(s).
- 5. The PEC will prepare a written plan of action (program improvement plan - PIP) to document initiatives to improve performance in one or more of the areas listed in section 3 as well as delineate how they will be measured and monitored.
 - a. The action plan (PIP) will be reviewed and approved by the teaching Faculty
 - b. The action plan (PIP) and its approval will be documented in meeting minutes.

Membership of the Vascular Program Evaluation Committee (PEC) for the 2019-20 Academic Year(s) is as follows: Dr. Glenn Jacobowitz, Dr. Michael Barfield, Dr. Thomas Maldonado and Dr. Todd Berland

Evaluation of the resident/fellow by the faculty

FACULTY EVALUATION OF RESIDENT



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by: Evaluator Name

Status
Employer
Program

1 Evaluates with history and physical data

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

2 Develops appropriate surgical plan for diagnosis and treatment

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

3 Judgment and problem solving in OR

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

4 Dexterity and technical skills

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

5 Understand operations for level of training

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

6 Comes to OR prepared

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
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1	2	3	4	5
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7 Integrates medical facts and clinical data

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

8 Possesses up-to-date knowledge/knows literature

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

9 Study habits and self education

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

10 Understands own limits

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

11 Improves own practice based on data and feedback

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

12 Counsels and educates patients and families

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

13 Demonstrates compassion for patients and families

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

14 Communicates with hospital staff and peers

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

15 Documents activity in medical records appropriately

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

16 Educates students and health care team

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

17 Educates junior residents

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

18 Integrity/Ethics

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

19 Dedication

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

20 Respect for patients, families, health care team

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

21 Feedback Response

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

22 Understands systems of patient care and role of health care team

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

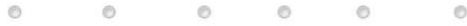
23 Refers patients to appropriate practices and services

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

24 Understands use of risk-benefit analysis

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	



25 OVERALL ASSESSMENT

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	



26 Completed objectives of rotation

- Yes
- No

27 Corrective action recommended

- Yes
- No

28 Comments

Vascular Surgery



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 (Vascular) Patient Care: Ward Care

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident is not able to recognize common vascular surgery presentations (acute limb ischemia, compartment syndrome, venous stasis, venous thrombosis/pulmonary embolism).</p> <p>This resident has problems in recognizing or managing common post-operative problems (such as low urine output, chest pain, atrial fibrillation).</p>	<p>This resident can perform a focused, efficient, and accurate history and physical for a patient presenting with a common vascular surgery presentation (acute limb ischemia, compartment syndrome, venous stasis, venous thrombosis/pulmonary embolism).</p>	<p>This resident can accurately diagnose some broad vascular surgery conditions such as acute limb ischemia, cerebrovascular disease, diabetic foot infections, peripheral vascular disease, dialysis access.</p>	<p>This resident can accurately diagnose most broad vascular surgery conditions (such as those mentioned in Level 2), and some focused vascular surgery conditions (such as arterial aneurysms and dissections, vascular graft infections, chronic visceral disease).</p>	<p>This resident can lead a team that cares for patients with complex past medical and surgical issues (e.g. a patient with multiple comorbidities requiring vascular surgical care).</p>
	<p>This resident can manage common post-operative problems of the vascular surgery patient with direct supervision (senior residents or staff physically present).</p>	<p>This resident can manage common post-operative problems of the vascular surgery patient via indirect supervision (consultation by phone).</p>	<p>This resident can independently manage complex post-operative problems and independently stabilize and transfer the vascular surgery patient to a higher level of care within the hospital.</p>	<p>This resident can provide supervision in the evaluation of complex post-operative problems, including supervising their stabilization and transfer within the hospital.</p> <p>This resident can recognize atypical presentations of vascular surgery patients and exhibits good judgment in when to proceed to the OR in complex presentations.</p>
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

2 (Vascular) Patient Care: Operative

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
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This resident is not able to perform basic surgical skills such as incision and drainage and knot tying.	This resident has basic surgical skills such as instrument handling, knot-tying, and simple suturing.	This resident can show respect for tissue and can move independently through some portions of common operations such as varicose vein surgery, percutaneous vascular access, arteriovenous fistula, lower extremity amputation, arterial embolectomy.	This resident can demonstrate proficiency in the handling of all instruments from common vascular surgery operations.	This resident demonstrates proficiency in use of instruments and equipment required for essential operations such as arteriovenous fistula, carotid endarterectomy, peripheral bypass surgery, aortic aneurysmal repair.
	This resident can perform basic (but not all) steps with direct supervision in some common operations such as varicose vein surgery, percutaneous vascular access, and lower extremity amputation.		Still requires coaching to complete those common operations.	
		This resident can make straight forward operative decisions.		This resident can perform all essential operations (such as arteriovenous fistula, arterial embolectomy, arterial thrombectomy, and carotid endarterectomy) and has significant experience in complex operations such as peripheral bypass surgery and aortic aneurysm repair.
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

3 (Vascular) Medical Knowledge

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not have medical student clerkship basic knowledge about common vascular surgery conditions (acute limb ischemia, compartment syndrome, venous stasis, venous thrombosis/pulmonary embolism).	This resident has medical student clerkship basic understanding of the symptoms, signs and treatments of:	This resident has basic knowledge about - many of the "broad" diseases of vascular surgery (with the addition of cerebrovascular disease, diabetic foot infections, peripheral vascular disease, and dialysis access).	This resident meets level 2 and also has also basic knowledge of the focused diseases in vascular surgery (arterial aneurysms and dissections, vascular graft infections, chronic visceral disease), and can complete an initial consultation, recommending appropriate initial care for the patient with these presentations.	This resident has comprehensive knowledge about varying patterns of presentation and alternative and adjuvant treatments and can make the diagnosis and provide the initial treatment for complex patients in vascular surgery.
	- the broad diseases of vascular surgery (acute limb ischemia, compartment syndrome, venous stasis, venous thrombosis/pulmonary embolism).			
Or about common essential operations such as varicose vein surgery, percutaneous vascular	- essential-common surgical operations of	- "essential-common" operations of vascular surgery (with the addition		

access, and lower extremity amputation.	vascular surgery (such as varicose vein surgery, percutaneous vascular access, and lower extremity amputation).	of carotid endarterectomy, arterial embolectomy and thrombectomy).		
		- and can complete an initial consultation, recommending appropriate initial care.		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

4 (Vascular) System s-Based Practice

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not have a basic understanding of resources available for coordinating patient care and how hospital and healthcare systems impact the patient who presents to the vascular surgery service.	This resident has a basic understanding of the team members coordinating care for the vascular surgery patient.	This resident knows the resources available to coordinate care and how to access them to help aid transitions in care for the vascular care surgery patient.	This resident can arrange disposition planning and prepare necessary materials for discharge of the vascular surgery patient.	This resident coordinates the activities of all health care team members (including nursing, PT/OT, social work, etc.) to provide optimal care for the vascular surgery patient for discharge or transfer.
	They are aware that variations in care occur.	This resident follows protocols for the vascular surgery service when they are presented.	This resident sometimes makes suggestions for changes that might improve the process.	This resident participates in hospital work groups designed to reduce errors.
				This resident participates in creating protocols for the vascular surgery service.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

5 (Vascular) Practice-Based Learning and Improvement

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4

This resident does not communicate effectively.	This resident participates in the vascular surgery conference with comments and questions.	This resident can teach learners at an appropriate level.	This resident can demonstrate effective teaching in the vascular surgery conference.	This resident recognizes teachable moments and engages the learner.
This resident does not demonstrate interest or ability in learning from the results of his or her practice.	This resident changes behaviors in response to feedback from supervisors.	This resident presents patient cases at the vascular surgery conference accurately and succinctly.	This resident can look for trends and patterns in the care of vascular surgery patients and use sources to understand these patterns.	This resident initiates learning assignments for others on the team.
		This resident uses external sources to answer questions about patient care.	This resident independently practices his or her skills and actively looks for opportunities to reduce errors.	This resident can facilitate the vascular surgery conference and discuss the patients in respect to current literature.
		This resident can develop learning plans based on feedback and can modify his or her own practice to avoid errors.		
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

6 (Vascular) Professionalism

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident has exhibited undesirable behaviors on this service such as being impolite, disrespectful, not respecting confidentiality, flagrantly violating duty hour requirements, or failing to timely perform duties.	This resident is polite and respectful, takes personal responsibility for patient care outcomes.	This resident maintains composure even in stressful situations.	This resident ensures that patient care responsibilities are performed.	This resident serves as a role model for others in terms of ethical behavior especially towards the consulting services and encourages prompt and polite responses to all consultations.
	This resident responds to pages and consultations on the vascular surgery service.	This resident asks for help when needed.	This resident accepts responsibility for errors in patient care.	This resident places the patient's needs above him or herself when appropriate.
		This resident is prompt in attendance at vascular surgery conference and other conferences.	This resident assures that team members under his or her supervision respond appropriately to responsibilities.	

9*

Please elaborate on at least one area where this resident should strive to improve (using the categories above a guides)

Endocrine and Surgical Oncology



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 (Endo and Surg Onc) Patient Care: Ward Care

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident is not able to recognize common Endocrine and Surgical Oncology surgery presentations (obstructive jaundice, hepatic mass evaluation, pancreatic pseudocyst, gastric cancer, breast cancer, ductal carcinoma in situ, adrenal cancer, hyperparathyroidism, thyroid nodule, thyroid cancer, melanoma).</p> <p>This resident has problems in recognizing or managing common post-operative problems (such as altered mental status, shortness of breath, chest pain, atrial fibrillation, low urine output, wound infection).</p>	<p>This resident can perform a focused, efficient, and accurate history and physical for a patient presenting with a common Endocrine and Surgical Oncology surgery presentation (such as obstructive jaundice, hepatic mass evaluation, pancreatic pseudocyst, gastric cancer, breast cancer, ductal carcinoma in situ, adrenal cancer, hyperparathyroidism, thyroid nodule, thyroid cancer, melanoma).</p>	<p>This resident can accurately diagnose some broad Endocrine and Surgical Oncology surgery conditions such as obstructive jaundice, hepatic mass evaluation, pancreatic pseudocyst, gastric cancer, breast cancer, ductal carcinoma in situ, adrenal cancer, hyperparathyroidism, thyroid nodule, thyroid cancer, melanoma.</p>	<p>This resident can accurately diagnose most broad Endocrine and Surgical Oncology surgery conditions (such as those mentioned in Level 2), and some focused Endocrine and Surgical Oncology surgery conditions (such as soft tissue sarcomas, recurrent hyperparathyroidism, pancreatic neoplasms, cystic/endocrine, exocrine, hepatic neoplasms, benign/malignant/metastatic, peritoneal neoplasms).</p>	<p>This resident can lead a team that cares for patients with complex past medical and surgical issues (e.g. a patient with multiple comorbidities requiring acute surgical care).</p>
	<p>This resident can manage common post-operative problems of the Endocrine and Surgical Oncology surgery patient with direct supervision (senior residents or staff physically present).</p>	<p>This resident can manage common post-operative problems of the Endocrine and Surgical Oncology surgery patient via indirect supervision (consultation by phone).</p>	<p>This resident can independently manage complex post-operative problems and independently stabilize and transfer the Endocrine and Surgical Oncology surgery patient to a higher level of care within the hospital.</p>	<p>This resident can provide supervision in the evaluation of complex post-operative problems, including supervising their stabilization and transfer within the hospital.</p> <p>This resident can recognize atypical presentations of Endocrine and Surgical Oncology surgery patients and exhibits good judgment in when to proceed to the OR in complex presentations.</p>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

2 (Endo and Surg Onc) Patient Care: Operative

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident is not able to perform basic surgical skills such as incision and drainage and knot tying.	This resident has basic surgical skills such as instrument handling, knot-tying, and simple suturing.	This resident can show respect for tissue and can move independently through some portions of common operations such as exploratory lap - open and lap, open cholecystectomy, hepatic biopsy open and lap, ileostomy, EGD, proctoscopy, axillary node dissection/sentinel node biopsy, mastectomy partial/simple, parathyroidectomy, thyroidectomy partial/total, melanoma.	This resident can demonstrate proficiency in the handling of all instruments from common Endocrine and Surgical Oncology surgery operations.	This resident demonstrates proficiency in use of instruments and equipment required for essential operations such as exploratory lap - open and lap, open cholecystectomy, axillary node dissection/sentinel node biopsy, mastectomy, parathyroidectomy, thyroidectomy, distal pancreatectomy.
	This resident can perform basic (but not all) steps with direct supervision in some common operations such as exploratory lap - open and lap, open cholecystectomy, hepatic biopsy open and lap, ileostomy, EGD, proctoscopy, axillary node dissection/sentinel node biopsy, mastectomy partial/simple, parathyroidectomy, thyroidectomy partial/total, melanoma.			
				This resident can make straight forward operative decisions.

Not Observed

3 (Endo and Surg Onc) Medical Knowledge

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident does not have medical student clerkship basic knowledge about common Endocrine and Surgical Oncology surgery conditions (obstructive jaundice, hepatic mass evaluation, pancreatic pseudocyst, gastric cancer, breast cancer, ductal carcinoma in situ, adrenal cancer, hyperparathyroidism, thyroid nodule, thyroid cancer, melanoma).</p>	<p>This resident has medical student clerkship basic understanding of the symptoms, signs and treatments of:</p>	<p>This resident has basic knowledge about many of the "broad" diseases (such as obstructive jaundice, hepatic mass evaluation, pancreatic pseudocyst, gastric cancer, breast cancer, ductal carcinoma in situ, adrenal cancer, hyperparathyroidism, thyroid nodule, thyroid cancer, melanoma) and "essential" operations (such as exploratory lap - open and lap, open cholecystectomy, hepatic biopsy open and lap, ileostomy, EGD, proctoscopy, axillary node dissection/sentinel node biopsy, mastectomy partial/simple, parathyroidectomy, thyroidectomy partial/total, melanoma) and can complete an initial consultation, recommending appropriate initial care.</p>	<p>This resident meets level 2 and also has basic knowledge of the focused diseases in Endocrine and Surgical Oncology surgery (soft tissue sarcomas, recurrent hyperparathyroidism, pancreatic neoplasms cystic/endocrine /exocrine, hepatic neoplasms benign/malignant /metastatic, peritoneal neoplasms), and can complete an initial consultation, recommending appropriate initial care for the patient with these presentations.</p>	<p>This resident has comprehensive knowledge about varying patterns of presentation and alternative and adjuvant treatments and can make the diagnosis and provide the initial treatment for complex patients in Endocrine and Surgical Oncology surgery.</p>
	<p>- the broad diseases of Endocrine and Surgical Oncology surgery (such as obstructive jaundice, hepatic mass evaluation, pancreatic pseudocyst, gastric cancer, breast cancer, ductal carcinoma in situ, adrenal cancer, hyperparathyroidism, thyroid nodule, thyroid cancer, melanoma).</p>			
	<p>- essential-common surgical operations of Endocrine and Surgical Oncology surgery (such as exploratory lap - open and lap, open cholecystectomy, hepatic biopsy open and lap, ileostomy, EGD, proctoscopy, axillary node dissection/sentinel node biopsy, mastectomy partial/simple, parathyroidectomy, thyroidectomy partial/total, melanoma).</p>			
<p><input type="radio"/></p>	<p><input type="radio"/></p>	<p><input type="radio"/></p>	<p><input type="radio"/></p>	<p><input type="radio"/></p>

Not Observed

4 (Endo and Surg Onc) Systems-Based Practice

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4

This resident does not have a basic understanding of resources available for coordinating patient care and how hospital and healthcare systems impact the patient who presents to the Endocrine and Surgical Oncology surgery service.	This resident has a basic understanding of the team members coordinating care for the Endocrine and Surgical Oncology surgery patient.	This resident knows the resources available to coordinate care and how to access them to help aid transitions in care for the Endocrine and Surgical Oncology surgery patient.	This resident can arrange disposition planning and prepare necessary materials for discharge of the Endocrine and Surgical Oncology surgery patient.	This resident coordinates the activities of all health care team members (including nursing, PT/OT, social work, etc.) to provide optimal care for the Endocrine and Surgical Oncology surgery patient for discharge or transfer.
	They are aware that variations in care occur.	This resident follows protocols for the Endocrine and Surgical Oncology surgery service when they are presented.	This resident sometimes makes suggestions for changes that might improve the process.	This resident participates in hospital work groups designed to reduce errors.
				This resident participates in creating protocols for the Endocrine and Surgical Oncology surgery service.
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

5 (Endo and Surg Onc) Practice-Based Learning and Improvement

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not communicate effectively. This resident does not demonstrate interest or ability in learning from the results of his or her practice.	This resident participates in the Endocrine and Surgical Oncology surgery clinic and conference with comments and questions.	This resident can teach learners at an appropriate level.	This resident can demonstrate effective teaching in the Endocrine and Surgical Oncology surgery clinic and conference.	This resident recognizes teachable moments and engages the learner.
		This resident present patient cases at the Endocrine and Surgical Oncology surgery clinic and conference accurately and succinctly.		
	This resident changes behaviors in response to feedback from supervisors.	This resident uses external sources to answer questions about patient care.	This resident can look for trends and patterns in the care of Endocrine and Surgical Oncology surgery patients and use sources to understand these patterns.	This resident initiates learning assignments for others on the team.
	This resident can develop learning plans based on feedback and can modify his or her own practice to	This resident independently practices his or her skills and actively looks for opportunities to reduce		

			avoid errors	errors.				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

6 (Endo and Surg Onc) Professionalism

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident has exhibited undesirable behaviors on this service such as being impolite, disrespectful, not respecting confidentiality, flagrantly violating duty hours, or failing to timely complete duties.	This resident is polite and respectful, takes personal responsibility for patient care outcomes.	This resident maintains composure even in stressful situations.	This resident ensures that patient care responsibilities are performed.	This resident serves as a role model for others in terms of ethical behavior especially towards the consulting services and encourages prompt and polite responses to all consultations.
	This resident responds to pages and consultations on the Endocrine and Surgical Oncology surgery service.	This resident asks for help when needed.	This resident accepts responsibility for errors in patient care.	This resident places the patient's needs above him or herself when appropriate.
		This resident is prompt in attendance at the Endocrine and Surgical Oncology surgery clinic and conference.	This resident assures that team members under his or her supervision respond appropriately to responsibilities.	This resident leads a team that promotes wellness of others by modifying schedules or intervening when necessary without compromising patient wellbeing.
				This resident sets an example for attendance at the Endocrine and Surgical Oncology surgery clinic and conference.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

7 (Endo and Surg Onc) Interpersonal and Communication Skills

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident cannot effectively communicate with patients and their families, hospital staff members, and/or the senior surgeon on the Endocrine and Surgical Oncology surgery team.	This resident uses a variety of communication techniques with patients when necessary.	This resident takes the initiative to provide timely updates to patients and their families on the Endocrine and Surgical Oncology surgery service.	This resident is capable of delivering difficult news to family members on the Endocrine and Surgical Oncology surgery service.	This resident is capable of leading end-of-life discussions.
	This resident responds politely to requests for consultation services of the Endocrine and Surgical Oncology surgery service.			
	This resident can perform a basic consent for common Endocrine and Surgical Oncology surgery operations such as exploratory lap - open and lap, open cholecystectomy, hepatic biopsy open and lap, ileostomy, EGD, proctoscopy, axillary node dissection/sentinel node biopsy, mastectomy partial/simple, parathyroidectomy, thyroidectomy partial/total, melanoma.	This resident can perform a clear consent for common Endocrine and Surgical Oncology operations.	This resident effectively communicates back to consulting services that use the services of the Endocrine and Surgical Oncology surgery service in a timely manner.	This resident is able to effectively communicate unexpected events to patients and family members.

Not Observed

8* What are this resident's strengths (using the categories above a guides)

9*

Please elaborate on at least one area where this resident should strive to improve (using the categories above a guides)

General Surgery (acute and elective)



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 (GS, Acute and Elec) Patient Care: Ward Care

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident is not able to recognize common General surgery presentations (hernia, cholecystitis, biliary pancreatitis, hiatal hernias, paralytic ileus, colon neoplasms and polyps, anorectal abscesses/fistulas/fissures).</p> <p>This resident has problems in recognizing or managing common post-operative problems (such as altered mental status, shortness of breath, chest pain, atrial fibrillation, low urine output, wound infection).</p>	<p>This resident can perform a focused, efficient, and accurate history and physical for a patient presenting with a common General surgery presentation (such as hernia, cholecystitis, biliary pancreatitis, hiatal hernias, paralytic ileus, colon neoplasms and polyps, anorectal fistulas/fissures).</p>	<p>This resident can accurately diagnose some broad General surgery conditions such as hernia, cholecystitis, biliary pancreatitis, hiatal hernias, paralytic ileus, colon neoplasms and polyps, anorectal abscesses/fistulas/fissures.</p>	<p>This resident can accurately diagnose most broad General surgery conditions (such as those mentioned in Level 2), and some focused General surgery conditions (such as functional constipation, anal dysplasia, chronic abdominal pain).</p>	<p>This resident can lead a team that cares for patients with complex past medical and surgical issues (e.g. a patient with multiple comorbidities requiring acute surgical care).</p>
	<p>This resident can manage common post-operative problems of the General surgery patient with direct supervision (senior residents or staff physically present).</p>	<p>This resident can manage common post-operative problems of the General surgery patient via indirect supervision (consultation by phone).</p>	<p>This resident can independently manage complex post-operative problems and independently stabilize and transfer the General surgery patient to a higher level of care within the hospital.</p>	<p>This resident can provide supervision in the evaluation of complex post-operative problems, including supervising their stabilization and transfer within the hospital.</p>
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

2 (GS, Acute and Elec) Patient Care: Operative

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
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<p>This resident is not able to perform basic surgical skills such as incision and drainage and knot tying.</p>	<p>This resident has basic surgical skills such as instrument handling, knot-tying, and simple suturing.</p>	<p>This resident can show respect for tissue and can move independently through some portions of common operations such as exploratory laparotomy - open and lap, hernia repair, cholecystectomy with or without cholangiogram, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery.</p>	<p>This resident can demonstrate proficiency in the handling of all instruments from common General surgery operations.</p>	<p>This resident demonstrates proficiency in use of instruments and equipment required for essential operations such as exploratory laparotomy - open and lap, hernia repair, cholecystectomy with or without cholangiogram, lap antireflux procedures, lap adhesiolysis, colectomy - open and lap, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery.</p>			
	<p>This resident can perform basic (but not all) steps with direct supervision in some common operations such as, hernia repair, cholecystectomy with or without cholangiogram, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery.</p>	<p>Still requires coaching to complete those common operations.</p>	<p>This resident can move through the steps of most common General surgery operations as noted in Level 2 without much coaching and perform basic steps (but not all) of some essential uncommon procedures, such as inguinal hernia, cholecystectomy, lysis of adhesions, small bowel resection, ostomy creation, lap and open colectomy.</p>	<p>This resident can perform all essential operations (such as exploratory laparotomy - open and lap, hernia repair, cholecystectomy with or without cholangiogram, lap antireflux procedures, colectomy - open and lap, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery) and has significant experience in complex operations such as diaphragmatic hernia repair, common bile duct exploration, anorectal fistulae complex repair.</p>			
				<p>This resident can make straight forward operative decisions.</p>			
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

3 (GS, Acute and Elec) Medical Knowledge

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not	This resident has medical	This resident has basic	This resident meets level	This resident has

<p>have medical student clerkship basic knowledge about common General surgery conditions (hernia, cholecystitis, biliary pancreatitis, hiatal hernias, paralytic ileus, colon neoplasms and polyps, anorectal hemorrhoids/fistulas/fissures).</p>	<p>student clerkship basic understanding of the symptoms, signs and treatments of:</p>	<p>knowledge about many of the "broad" diseases (such as hernia, cholecystitis, biliary pancreatitis, hiatal hernias, paralytic ileus, colon neoplasms and polyps, anorectal abscesses/fistulas/fissures) and "essential" operations (such as exploratory laparotomy - open and lap, hernia repair, cholecystectomy with or without cholangiogram, lap antireflux procedures, colectomy - open and lap, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery) and can complete an initial consultation, recommending appropriate initial care.</p>	<p>2 and also has basic knowledge of the "focused" diseases in General surgery (anal dysplasia, chronic abdominal pain), and can complete an initial consultation, recommending appropriate initial care for the patient with these presentations.</p>	<p>comprehensive knowledge about varying patterns of presentation and alternative and adjuvant treatments and can make the diagnosis and provide the initial treatment for complex patients in General surgery.</p>
	<p>- the broad diseases of General surgery (such as hernia, cholecystitis, biliary pancreatitis, hiatal hernias, paralytic ileus, colon neoplasms and polyps, anorectal abscesses/fistulas/fissures).</p>			
	<p>- essential surgical operations of General surgery (such as exploratory laparotomy - open and lap, hernia repair, cholecystectomy with or without cholangiogram, lap antireflux procedures, colectomy - open and lap, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery).</p>			
<p>○ ○ ○ ○ ○ ○ ○ ○ ○ ○</p>				

○ Not Observed

4 (GS, Acute and Elec) Systems-Based Practice

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident does not have a basic understanding of resources available for coordinating patient care and how hospital and healthcare systems impact the patient who presents to the General surgery service.</p>	<p>This resident has a basic understanding of the team members coordinating care for the General surgery patient.</p>	<p>This resident knows the resources available to coordinate care and how to access them to help aid transitions in care for the General surgery patient.</p>	<p>This resident can arrange disposition planning and prepare necessary materials for discharge of the General surgery patient.</p>	<p>This resident coordinates the activities of all health care team members (including nursing, PT/OT, social work, etc.) to provide optimal care for the General surgery patient for discharge or transfer.</p>
	<p>They are aware that variations in care occur.</p>	<p>This resident follows protocols for the General surgery service when they are presented.</p>	<p>This resident sometimes makes suggestions for changes that might improve the process.</p>	<p>This resident participates in hospital work groups designed to reduce errors.</p>

									This resident participates in creating protocols for the General surgery service.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

5 (GS, Acute and Elec) Practice-Based Learning and Improvement

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not communicate effectively.	This resident participates in the General surgery clinic and conference with comments and questions. This resident changes behaviors in response to feedback from supervisors.	This resident can teach learners at an appropriate level.	This resident can demonstrate effective teaching in the General surgery clinic and conference.	This resident recognizes teachable moments and engages the learner.
This resident does not demonstrate interest or ability in learning from the results of his or her practice.		This resident present patient cases at the General surgery clinic and conference accurately and succinctly.	This resident can look for trends and patterns in the care of General surgery patients and use sources to understand these patterns.	This resident initiates learning assignments for others on the team.
		This resident uses external sources to answer questions about patient care.	This resident independently practices his or her skills and actively looks for opportunities to reduce errors.	This resident can facilitate the General surgery clinic and conference and discuss the patients in respect to current literature.
		This resident can develop learning plans based on feedback and can modify his or her own practice to avoid errors.		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

6 (GS, Acute and Elec) Professionalism

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident has	This resident is polite and	This resident maintains	This resident ensures	This resident serves as a

exhibited undesirable behaviors on this service such as being impolite, disrespectful, not respecting confidentiality, flagrantly violating duty hour requirements, or failing to timely perform duties.	respectful, takes personal responsibility for patient care outcomes.	composure even in stressful situations.	that patient care responsibilities are performed.	role model for others in terms of ethical behavior especially towards the consulting services and encourages prompt and polite responses to all consultations.
	This resident responds to pages and consultations on the General surgery service.	This resident asks for help when needed.	This resident accepts responsibility for errors in patient care.	This resident places the patient's needs above him or herself when appropriate.
		This resident is prompt in attendance at the General surgery clinic and conference.	This resident assures that team members under his or her supervision respond appropriately to responsibilities.	
				This resident sets an example for attendance at the General surgery clinic and conference.

Not Observed

7 (GS, Acute and Elec) Interpersonal and Communication Skills

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident cannot effectively communicate with patients and their families, hospital staff members, and/or the senior surgeon on the General surgery team .	This resident uses a variety of communication techniques with patients when necessary.	This resident takes the initiative to provide timely updates to patients and their families on the General surgery service.	This resident is capable of delivering difficult news to family members on the General surgery service.	This resident is capable of leading end-of-life discussions.
	This resident responds politely to requests for consultation services of the General surgery service.	This resident exhibits respect, approachability and active listening when speaking with consulting services and team members.	This resident keeps members of the health care team up to date on patient statuses and care plan changes.	This resident is capable of negotiating and managing conflict among patients and their families, as well as among health care providers.
	This resident can perform a basic consent for common General surgery operations such as hernia repair, cholecystectomy with or without	This resident can perform a clear consent for common General surgery operations such as	This resident effectively communicates back to consulting services that use the services of the General surgery service in a timely manner.	This resident is able to effectively communicate unexpected events to patients and family members.

	cholangiogram, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery.	exploratory laparotomy - open and lap, hernia repair, cholecystectomy with or without cholangiogram, lap antireflux procedures, lap adhesiolysis, colectomy - open and lap, anal fistulotomy/Seton, hemorrhoidectomy and banding, pilonidal surgery, intra-abdominal abscess drainage, lap small bowel resection.	This resident can effectively consent a patient for a complex operation.					
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

8* What are this resident's strengths (using the categories above a guides)

9*

Please elaborate on at least one area where this resident should strive to improve (using the categories above a guides)

MIS and Bariatric



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 (MIS/Bariatric) Patient Care: Ward Care

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident is not able to recognize common general surgery presentations (abdominal wall hernias , biliary disease, peptic ulcer disease, gastroesophageal reflux).</p>	<p>This resident can perform a focused, efficient, and accurate history and physical for a patient presenting with a common general surgery presentation (biliary colic, symptomatic inguinal/ventral hernia, heartburn).</p>	<p>This resident can accurately diagnose some broad general/minimally invasive surgery conditions such as hiatal hernia, achalasia, duodenal/gastric ulcer, cholelithiasis.</p>	<p>This resident can accurately diagnose most broad general/minimally invasive surgery conditions (such as those mentioned in Level 2), and some focused general surgery conditions (such as ITP, esophageal neoplasms, gastroparesis, cholangitis, retained gastric distention, marginal ulceration, slipped band, blind loop syndrome).</p>	<p>This resident can lead a team that cares for patients with complex post medical and surgical issues (e.g. a patient with multiple comorbidities requiring surgical care).</p>
<p>This resident has problems in recognizing or managing common post-operative problems (such as incisional pain, referred pain, atelectasis, urinary retention, acute abdominal pain, intra-abdominal abscess, anastomotic leak, rectus sheath hematoma, small bowel obstruction).</p>	<p>This resident can manage common post-operative problems of the general/minimally invasive surgery patient with direct supervision (senior residents or staff physically present).</p>	<p>This resident can manage common post-operative problems such as such as incisional hernia, cholecystitis, gastrointestinal bleeding, anastomotic leak, internal hernia of the general /minimally invasive surgery patient via indirect supervision (consultation by phone).</p>	<p>This resident can independently manage complex post-operative problems and independently stabilize and transfer the general /minimally invasive surgery patient and bariatric patient to a higher level of care within the hospital.</p>	<p>This resident can provide supervision in the evaluation of complex post-operative problems, including supervising their stabilization and transfer within the hospital.</p>
				<p>This resident can recognize atypical presentations of general /minimally invasive surgery patients and exhibits good judgment in when to proceed to the OR in complex presentations.</p>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

2 (MIS/Bariatric) Patient Care: Operative

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident is not able to perform basic surgical skills such as laparoscopic equipment set up, proper patient positioning, safe trocar placement.	This resident has basic surgical skills such as instrument handling, knot-tying, and simple suturing.	This resident can show respect for tissue and can move independently through some portions of common operations such as laparoscopic inguinal/ventral hernia repair, laparoscopic cholecystectomy, laparoscopic antireflux procedures.	This resident can demonstrate proficiency in the handling of laparoscopic instruments from common general surgery operations.	This resident demonstrates proficiency in use of instruments and equipment required for essential operations such as laparoscopic hernia, cholecystectomy, antireflux procedures.
	This resident can perform basic (but not all) steps with direct supervision in some common operations such as Hasson port placement, Veress needle placement, laparoscopic inguinal/ventral hernia repair, laparoscopic cholecystectomy, laparoscopic antireflux procedures, cholecystectomy.			

Not Observed

3 (MIS/Bariatric) Medical Knowledge

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not have medical student clerkship basic knowledge about common general and bariatric surgery conditions (acute	This resident has medical student clerkship basic understanding of the symptoms, signs and treatments of:	This resident has basic knowledge about many of the "broad" diseases (such as abdominal wall hernia, biliary disease, gastroesophageal reflux, peptic ulcer disease,	This resident meets level 2 and also has also basic knowledge of the ?focused? diseases in general surgery and bariatric surgery (cholangitis,	This resident has comprehensive knowledge about varying patterns of presentation and alternative and adjuvant treatments and can make the diagnosis
	- the broad diseases of			

<p>abdominal pain, intra-abdominal abscess, anastomotic leak, rectus sheath hematoma, small bowel obstruction).</p>	<p>general surgery (such as abdominal wall hernia, biliary disease, gastroesophageal reflux, peptic ulcer disease).</p>	<p>anastomotic leak, rectus sheath hematoma, small bowel obstruction, ileus, gastrointestinal bleeding).and "essential" operations (such as, laparoscopic inguinal/ventral hernia repair, laparoscopic cholecystectomy, laparoscopic antireflux procedures, etc.) and can complete an initial consultation, recommending appropriate initial care.</p>	<p>hepatic/pancreatic neoplasms, hypersplenism, esophageal neoplasms, gastroparesis, morbid obesity, post gastrectomy syndromes, blind loop syndrome, marginal ulceration, gastric distention, slipped band), and can complete an initial consultation, recommending appropriate initial care for the patient with these presentations.</p>	<p>and provide the initial treatment for complex patients in general surgery and bariatric surgery.</p>
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

4 (MIS/Bariatric) Systems-Based Practice

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
<p>This resident does not have a basic understanding of resources available for coordinating patient care and how hospital and healthcare systems impact the patient who presents to the general/minimally invasive surgery service.</p>	<p>This resident has a basic understanding of the team members coordinating care for the general/minimally invasive and bariatric surgery patient.</p>	<p>This resident knows the resources available to coordinate care and how to access them to help aid transitions in care for the general/minimally invasive and bariatric surgery patient.</p>	<p>This resident can arrange disposition planning and prepare necessary materials for discharge of the general/minimally invasive and bariatric surgery patient.</p>	<p>This resident coordinates the activities of all health care team members (including nursing, PT/OT, social work, etc.) to provide optimal care for the general/minimally invasive and bariatric surgery patient for discharge or transfer.</p>
	<p>They are aware that variations in care occur.</p>	<p>This resident follows protocols for the general/minimally invasive and bariatric surgery service when they are presented.</p>	<p>This resident sometimes makes suggestions for changes that might improve the process.</p>	<p>This resident participates in hospital work groups designed to reduce errors.</p>
				<p>This resident participates in creating protocols for the general/minimally invasive and bariatric surgery service.</p>
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

5 (MIS/Bariatric) Practice-Based Learning and Improvement

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident does not communicate effectively.	This resident participates in the surgery conference by presenting cases, asking questions.	This resident can teach learners at an appropriate level.	This resident can demonstrate effective teaching in the surgery conference.	This resident recognizes teachable moments and engages the learner.
This resident does not demonstrate interest or ability in learning from the results of his or her practice.	This resident changes behaviors in response to feedback from supervisors.	This resident presents patient cases at the surgery conference accurately and succinctly. The resident is able to discuss pertinent lab and radiographic findings.	This resident can look for trends and patterns in the care of general/minimally invasive surgery patients and use sources to understand these patterns.	This resident initiates learning assignments for others on the team.
		This resident uses external sources to answer questions about patient care.		
		This resident can develop learning plans based on feedback and can modify his or her own practice to avoid errors.	This resident can facilitate the surgery conference and discuss the patients in respect to current literature.	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not Observed

6 (MIS/Bariatric) Professionalism

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident has exhibited undesirable behaviors on this service such as being impolite, disrespectful, not	This resident is polite and respectful, takes personal responsibility for patient care outcomes.	This resident maintains composure even in stressful situations.	This resident ensures that patient care responsibilities are performed.	This resident serves as a role model for others in terms of ethical behavior especially towards the consulting services and
	This resident responds to	This resident asks for	This resident accepts	

respecting confidentiality, flagrantly violating duty hour requirements, and failing to timely perform duties.	pages and consultations on the general/minimally invasive surgery service.	help when needed.	responsibility for errors in patient care.	encourages prompt and polite responses to all consultations.
		This resident is prompt in attendance at surgery conference and other conferences.	This resident assures that team members under his or her supervision respond appropriately to responsibilities.	This resident places the patient's needs above him or herself when appropriate.
				This resident leads a team that promotes wellness of others by modifying schedules or intervening when necessary without compromising patient wellbeing.
				This resident sets an example for attendance at the surgery conference.
<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>				

Not Observed

7 (MIS/Bariatric) Interpersonal and Communication Skills

Critical Deficiencies	Level 1	Level 2	Level 3	Level 4
This resident cannot effectively communicate with patients and their families, hospital staff members, and/or the senior surgeon on the surgery team.	This resident uses a variety of communication techniques with patients when necessary.	This resident takes the initiative to provide timely updates to patients and their families on the general/minimally invasive surgery service.	This resident is capable of delivering difficult news to family members on the general/minimally invasive surgery service.	This resident is capable of leading end-of-life discussions.
	This resident responds politely to requests for consultation services of the general /minimally invasive surgery service.		This resident keeps members of the health care team up to date on patient statuses and care plan changes.	This resident is capable of negotiating and managing conflict among patients and their families, as well as among health care providers.
	This resident performs face-to-face handoffs.	This resident exhibits respect, approachability and active listening when speaking with consulting services and team members.	This resident effectively communicates back to consulting services that use the services of the general/minimally invasive surgery service in a timely manner.	This resident is able to effectively communicate unexpected events to patients and family members.
	This resident can perform a basic consent for common general/minimally invasive surgery operations such as			
	This resident can perform a clear consent for common general/minimally invasive surgery operations such as laparoscopic			

Evaluation of the faculty by the resident/fellow

RESIDENT EVALUATION OF ATTENDING



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 Was readily available

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 Was very involved in teaching in the O.R.

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3 Has state-of-the-art knowledge on rounds

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4 Communicates very well

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5 Provides timely feedback

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 Please comment on any rating of 2 or below

7 Overall assessment of the faculty attending

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Multiple Evaluators

SR. RESIDENT EVALUATION OF JR. RESIDENT



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 Self-education and study habits

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 Teaching of residents

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3 Teaching of medical students

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4 Basic science information in this field

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5 Basic clinical information in this field

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 Knowledge of current developments and literature

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7 Knowledge of Ward procedures

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8 Performance of Ward procedures

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 Knowledge of operations performed in the OR

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10 Dexterity and operative technique in the OR

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11 Judgment and problem solving in the OR

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12 Relations with superiors

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
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1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13 Relations with peers

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14 Relations with ancillary staff

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15 Ability under stress

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16 Recognition of own capabilities

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17 Professional behavior

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18 Responsibility/Reliability

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
--------------------	-------------------	-------------	-------------------	---------------	-----

1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19 Please comment on any rating of 2 or below

20* Overall assessment of the resident

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

JR. RESIDENT EVALUATION OF SR. RESIDENT



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

1 Basic science information in this field

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	NA
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 Basic clinical information in this field

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	NA
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3 Knowledge of current developments and literature

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	NA
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4 Was very involved in O.R. teaching

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	NA
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5 Was very involved in teaching in the ward

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	NA
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 Provides timely feedback

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7 Helped me achieve the educational goals of the rotation

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8 Ability under stress

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 Recognition of own capabilities

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10 Professional behavior

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11 Responsibility/Reliability

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12 Leadership (R4 and R5 Chiefs only)

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
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1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13 Please comment on any rating of 2 or below

14 Overall assessment of the resident

1 = Unsatisfactory	2 = Below Average	3 = Average	4 = Above Average	5 = Excellent	N/A
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NURSE'S EVALUATION OF RESIDENT



Subject Name
 Status
 Employer
 Program
 Rotation
 Evaluation Dates

Evaluated by: **Evaluator Name**
 Status
 Employer
 Program

1 Evaluates with history and physical data

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 Develops appropriate surgical plan for diagnosis and treatment

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3 Judgment and problem solving in OR

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4 Dexterity and technical skills

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5 Understand operations for level of training

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

6 Comes to OR prepared

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1	2	3	4	5
---	---	---	---	---

7 Integrates medical facts and clinical data

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

8 Possesses up-to-date knowledge/knows literature

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

9 Study habits and self education

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

10 Understands own limits

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

11 Improves own practice based on data and feedback

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

12 Counsels and educates patients and families

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

13 Demonstrates compassion for patients and families

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

14 Communicates with hospital staff and peers

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

15 Documents activity in medical records appropriately

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

16 Educates students and health care team

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ○

17 Educates junior residents

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

○ ○ ○ ○ ○ ●

18 Integrity/Ethics

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

19 Dedication

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

20 Respect for patients, families, health care team

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

21 Feedback Response

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

22 Understands systems of patient care and role of health care team

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

23 Refers patients to appropriate practices and services

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	

• • • • •

24 Understands use of risk-benefit analysis

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	



25 OVERALL ASSESSMENT

Poor	Below Average	Average	Very Good	Superior	Cannot Assess
1	2	3	4	5	



26 Completed objectives of rotation

- Yes
- No

27 Corrective action recommended

- Yes
- No

28 Comments

Semi-Annual Evaluation (by the Program Director)

New Innovations

https://www.new-innov.com/Portfolio/Hostfso.aspx?Control=ReviewFor...

Semi-Annual Review
Review Period: 8/1/2009 - 12/31/2009 Residency Period: N/A - 12/31/2009 Meeting Date: 1/1/2010 7:00A-8:00A

Sample Review Form



Sample, Person
PRG 2
Internal Medicine

Report Data was last captured on: 12/22/2009

Resident Training Records

Start Date	End Date	Program Year	Status	PGY
Internal Medicine - Green - General Hospital				
7/1/2012	6/30/2013	1st Year in Residency	PRG 1	1
7/1/2013	6/30/2014	2nd Year in Residency	PRG 2	2
7/1/2014	6/30/2015	3rd Year in Residency	PRG 3	3

Compliance per Rotation

Drag a column header and drop it here to group by that column

Rotation	Start Date	End Date	Evaluation of Rotation	Evaluation of Faculty	Reviewed Curriculum
ACE	7/1/2009	7/31/2009	1 of 1	2 of 2	N/A
Ward B	8/1/2009	8/31/2009	1 of 1	1 of 2	1 of 1
CCU	9/1/2009	9/30/2009	1 of 1	1 of 2	1 of 1
Renal	10/1/2009	10/31/2009	1 of 1	2 of 2	1 of 1
Ward A	11/1/2009	11/30/2009	0 of 1	2 of 2	1 of 1
ICU	12/1/2009	12/31/2009	1 of 1	2 of 2	1 of 1

Evaluation Comments by Competency

Comment
<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Patient Care <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Accurate, comprehensive medical interviews; physical examinations; review of other data; procedural skills; makes diagnostic and therapeutic decisions based on available evidence, sound judgement and patient preferences. <ul style="list-style-type: none"> Has a solid base of knowledge, prompts insightful questions and possesses good management skills in the care and supervision of patients. <input checked="" type="checkbox"/> Interpersonal and Communication Skills <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Establishes an effective therapeutic relationship with patients and families; demonstrates relationship building through listening, narrative and nonverbal skills; provides education and counseling to patients, their families and colleagues; always "interpersonally" engaged; provides timely information to faculty and other residents about patients. <ul style="list-style-type: none"> Excellent overall performance. Great example of team leadership with superior preparation and flexible but firm guidance to others.

Evaluation Comments - All

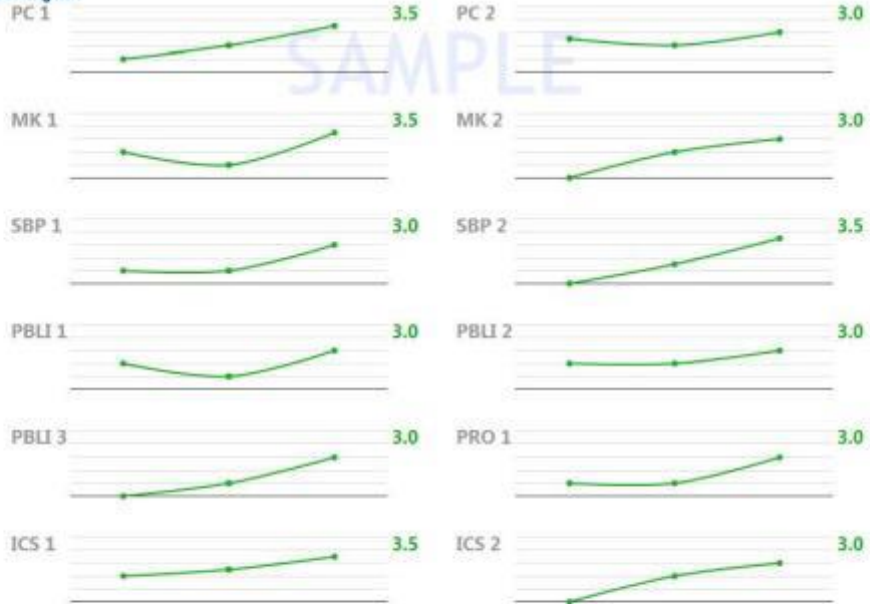
Comment
<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Patient Care <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Demonstrates respect, compassion, integrity, honesty and always considers needs of patients, families, colleagues? <ul style="list-style-type: none"> Has a solid base of knowledge, prompts insightful questions and possesses good management skills in the care and supervision of patients. <input checked="" type="checkbox"/> Interpersonal Skills and Communication <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Always shows exceptional communication, collaboration and respect for nursing staff <ul style="list-style-type: none"> Excellent overall performance. Great example of team leadership with superior preparation and flexible but firm guidance to others. <input checked="" type="checkbox"/> Medical Knowledge <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Overall Comment <ul style="list-style-type: none"> Above average resident with potential to be a superior primary care doctor. Thorough, organized with a good sense of judgment a great instinct for adjusting priorities as the situation dictates.

Procedures Logged

Click a column header and then click on the arrow to group by that column

Procedure Name	Independent Target	Review Total Passed	Review Total Not Passed	Residency Total Passed	Residency Total Not Passed	Independent
Carotid Endarterectomy	6	1	0	4	1	
Central Line Placements	3	1	0	3	0	✔
Hernia Surgery	5	0	0	0	0	
Laparoscopic Cholecystectomy	7	0	0	0	0	
Partial Colectomies	5	0	0	0	0	✔

Milestone Progress



Progress Summary

Overall Progress: Meets Expectations Requires Attention

Competency Progress

- Patient Care: Meets Expectations Requires Attention
- Medical Knowledge: Meets Expectations Requires Attention
- Practice-Based Learning and Improvement: Meets Expectations Requires Attention
- Interpersonal and Communication Skills: Meets Expectations Requires Attention
- Professionalism: Meets Expectations Requires Attention
- Systems-Based Practice: Meets Expectations Requires Attention

Only users with full access to this review may record progress.

Comments

Sample Faculty Member, on 12/22/2009 1:13 PM wrote:
This is a Sample comment.

Signatures

Summative Evaluation (by the Program Director)

July 1st, 2019

_____ M.D. has satisfactorily completed the requirements of the Vascular Integrated Surgery Residency including the final year as Chief Resident at the New York University School of Medicine. From July 1st, 2013 through June 30th, 2018 _____ surgical skills have developed well and are certainly above the level we would expect from a graduating resident. _____ relates well with patients, as well as colleagues and staff. His/Her behavior exhibits the highest level of ethics and integrity. _____ has demonstrated sufficient professional ability to enter practice competently and without direct supervision. He/She was an all-around outstanding resident and administrative chief resident in surgery. _____ will complete a fellowship in _____ at _____ Center starting July 1st, _____ and we expect him/her to do very well. _____ is well prepared to sit for the American Board of Surgery Qualifying and Certifying Examinations. She has demonstrated competency in the following areas:

Patient Care	Superior
Medical Knowledge	Superior
Practice based learning and Improvement	Superior
Interpersonal Communications Skills	Superior
Professionalism	Superior
Systems Based Practice	Superior

Dr. _____ has completed the following rotations:

PGY 1 (7/1/2013-6/30/2014)

7/1-7/30- General Surgery (Spencer)
7/31-8/27- General Surgery (Ranson)
8/28-9/24- Pediatric Surgery
9/25-10/22- Vascular CV
10/23-11/19- Vacation
11/20-12/17- General Surgery (Spencer)
12/18-1/14/07- Vascular PV
1/15-2/11- Transplant
2/12-3/11- Vascular- GS
3/12-4/8- Vascular CT
4/9-5/6- Surgical ICU
5/7-6/3- Vascular Surgery
6/4-6/30- Night Float

PGY 2 (7/1/2014-6/30/2015)

7/1-7/29- Surgical Oncology
7/30-8/26- Vascular Surgery-BH
8/27-9/23- MIS
9/24-10/21- Vascular Surgery-TH
10/22-11/18- Transplant Surgery
11/19-12/16- Cardiothoracic Surgery
12/17-1/13/08- General Surgery
1/14-2/10- General Surgery
2/11-3/9- Colorectal
3/10-4/6- Pediatric Surgery
4/7-5/4- Vacation
5/5-6/1- Surgical ICU
6/2-6/30- Vascular Surgery-VA

PGY 3 (7/1/2015-6/30/2016) (Pending rotation schedule)

PGY 4 (7/1/2016-6/30/2017) (Pending rotation schedule)

PGY 4 (7/1/2017-6/30/2018) (Pending rotation schedule)

Glenn Jacobowitz, MD
Division Chief
Vascular Surgery

Caron Rockman, MD
Program Director of Vascular Division of
Vascular Integrated Residency Program

Evaluation of the program by the resident

FELLOW/RESIDENT EVALUATION OF PROGRAM



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by: Evaluator Name

Status
Employer
Program

1 Conferences in General Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 Conferences in Surgical Oncology

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3 Conferences in Pediatric Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4 Conferences in Vascular Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5 Clinical training education in General Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 Clinical training education in Cardiac Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7 Clinical training education in Minimally Invasive Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8 Clinical training education in Pediatric Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 Clinical training education in Surgical Oncology

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10 Clinical training education in Transplantation

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
----------	---	--------------	---	---	---	----------	---	---------------

1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11 Clinical training education in Vascular Surgery

1 = Poor	2	3 = Marginal	4	5	6	7 = Good	8	9 = Excellent
1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12 I would like to see the following changes in the department

13 My training could have been improved by

14 I found the following problems with my General Surgery Training

15 I found the following helpful in my training

Evaluation of the program by the faculty

Faculty Evaluation of Program



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

MEDICAL KNOWLEDGE

1*

Residents demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PATIENT CARE

2*

Residents are able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

INTERPERSONAL AND COMMUNICATION SKILLS

3*

Residents demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, families and health professionals.

1 = Dis agree Completely	2 = Dis agree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PROFESSIONALISM

4*

Residents demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SYSTEMS-BASED PRACTICE

5* Residents have the ability to effectively call upon system resources to provide care that is of optimal value.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PRACTICE-BASED LEARNING IMPROVEMENT

6*

Residents have the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on self-evaluation and life-long learning.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

STRESS AND FATIGUE

7* Residents experience excessive levels of work-related stress and fatigue.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8* I have experienced excessive levels of work-related stress and fatigue.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PROFESSIONAL DEVELOPMENT

9* The program has provided me with opportunities for professional development.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10* I am satisfied with my role as an educator within the program.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11* I am able to request feedback and seek mentorship when necessary.

1 = Disagree Completely	2 = Disagree Somewhat	3 = Agree Somewhat	4 = Agree Completely	N/A
1	2	3	4	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

GENERAL

12* Please comment on your experience with the residency program.

1 = Not Good	2 = Good	3 = Very Good	N/A
1	2	3	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other Evaluations

Below please find the link to the ACGME Vascular Surgery Milestones. The Clinical Competency Committee, composed of four core Vascular Surgery faculty, will evaluate trainee performance on a semi-annual basis against the milestones. Milestones will be reported to the ACGME and will be discussed with the trainees during the Semi Annual Reviews.

<http://acgme.org/acgmeweb/Portals/0/PDFs/Milestones/SurgeryMilestones.pdf>

Examinations, Licensure & Certificate

Below please find the requirements for all Vascular Surgery Trainees:

- a. Prior to being interviewed for residency, applicants are required to take and pass USMLE step I and USMLE Step 2.
- b. Residents who graduated from a foreign medical school, except Canada, are required to be ECFMG certified prior to starting residency.
- c. Residents are required to have obtained their National Provider Identification number prior to beginning residency.
- d. Residents are required to be ACLS/BLS certified throughout their training.
- e. PGY 3, PGY 4 and PGY 5 residents are required to be ATLS certified.
- f. Residents are required to take and pass USMLE step 3 prior to the beginning of their final year of training.
- g. PGY 5 residents are required to be certified in Fundamentals of Laparoscopic Surgery prior to applying for the written board examination.
- h. The interns are required to take the ACS Fundamentals of Surgery Curriculum prior to starting residency. The Integrated Vascular Surgery residents in their R1 and R2 year are required to participate in this curriculum along with the General Surgery trainees.
- i. The current PGY 2 residents and residents graduating in June 2017 and after are required to be certified in Fundamentals of Endoscopic Surgery. While this is not formally required of the Vascular Surgery trainee, they have the option to participate based upon their interest.
- j. All residents are required to take the VSITE (Vascular Surgery In Service Training Examination) on an annual basis. The examination is set by the ABS and typically occurs in March.

Policy for Resident/Fellow and Faculty Member Well-Being

Division of Vascular Surgery

The NYU Department of Surgery's Division of Vascular is committed to the wellbeing of our Surgery Housestaff and Surgery Faculty Members. NYU Langone Health provides free medical/dental benefits to all employees earning less than 80K a year and significantly reduced the cost for those earning more. In addition, the Department of Surgery sponsors social events for both residents and faculty. The program director and faculty mentors address and encourage conversation with their resident mentees regarding wellness and it is a topic of discussion during semi-annual reviews with the program director.

NYU Langone Health is pleased to provide the faculty and residents with the following physical and mental health resources:

Mental Health Resources for NYU House Staff:

- **David Stiffler, MD** (covering for Dr. Ackerman while on maternity leave): email: J.David.Stiffler@nyulangone.org; phone 646-754-4742
 - 1 Park Ave House Staff Mental Health Program
 - Appts Mon-Thurs 6-9pm, Sat 10am-4pm (biweekly); email/call Dr. Stiffler for appt
 - **24 hour helpline:** 1-800-833-8707 (Master's or PhD level counselors answer the phones and provide immediate telephone assessment and crisis support)
- 1.

Bellevue Payroll:

- CIR will reimburse \$160 per session with a psychiatrist, up to \$5000 per calendar year, and can be combined with your benefit plan
- GHI-CBP: excellent out of network benefits for mental health
 - \$108 per session with a psychiatrist
 - \$60 per session with PhD psychologist

NYU Payroll:

- NYU United PPO (top tier): largest network for mental health, \$10-20 copay
- UHC HMO: no out of network mental health coverage
- Empire HMO: no out of network mental health coverage
- Recommend you review costs and coverage of each plan and keep above in mind re: mental health coverage

Mental Health Resources for NYU Faculty:

- NYU United PPO (top tier): largest network for mental health, \$10-20 copay
 - UHC HMO: no out of network mental health coverage
 - Empire HMO: no out of network mental health coverage
 - Recommend you review costs and coverage of each plan and keep above in mind re: mental health coverage
- 2 **24 hour helpline:** 1-800-833-8707 (Master's or PhD level counselors answer the phones and provide immediate telephone assessment and crisis support)

The program has also initiated a new Wellness Curriculum lecture series on the following topics beginning in 2019-2020.

- Wellness Curriculum Lecture Series to take place during core didactics on Thursday Mornings parallel with basic science curriculum
 - Lectures on:

- Cultural diversity, stress of surgical practice, managing your career (Dr. Hochberg)
- Resilience – Bouncing back from a professional or personal crisis (Dr. Hochberg)
- Sleep management presentation (Pulmonary Sleep Specialists)
- Ergonomics in the OR presentation (OT and PT specialists)
- Intro to personal finances- student loans, health insurance, life insurance, retirement planning (Presenter TBD)
- Mindful and Healthy Eating Lecture (Presenter TBD)
- Quick Exercises for the Busy Resident Presentation (Presenter TBD)
- NYU Housestaff Mental Health Services and CCA Presentations (Dr. Ackerman/Dr. Stiffler, CCA Representative)

Professionalism (SPICE) Curriculum

- The Department of Surgery has a robust curriculum on professionalism and interpersonal communications.
- The NYU Department of Surgery inaugurated this curriculum in 2007 and have improved and refined these interactive seminars each year.
- To test these competencies, we instituted annual OSCE (Objective Structured Clinical Examinations) with specially trained actors for our surgical resident learners.

The interactive group sessions are centered on the following topics:

- Medical Malpractice and the Surgeon
- Advanced Communication Skills for Surgical Practice
- Residents as Teachers Lecture
- Admitting Mistakes: Ethical and Communication Issues
- Delivering Bad News: Your Chance to Become a Master Surgeon
- Working With Professionals Around You: Team Communication
- Working Across Language and Cultures: The Case for Informed Consent
- Self-Care and the Stress of Surgical Practice
- Resilience – Bouncing back from a professional or personal crisis

There are six standardized OSCE scenarios given prior to the start of training at the R1 year and prior to commencing the R3 year. The cases are:

1. Identifying an impaired surgical resident colleague during a patient care “sign-out” discussion.
2. Communicating to a postop patient that a wrong sided incision was initially made for the hernia repair.
3. Working through a Chinese interpreter to explain to a Chinese woman that she has breast cancer.
4. Explaining to an absentee daughter that her mother, who is an ICU patient, has signed a health proxy indicating a “do not resuscitate protocol” which is against the daughter’s religious beliefs.
5. Participate in transfer of patient care responsibility effectively, professionally, and accurately of a patient of a non-surgical patient to a surgical service.
6. Delivering the bad news of an unexpected operative death to a patient’s spouse in the surgical waiting room

Module Name	Location	Audience
Sleep Alertness and Fatigue Education in Residency (SAFER)	iDevelop	ALL House Staff
Blood Transfusion Guidelines	Compass	House Staff in the following programs: Anesthesia, Cardiothoracic Anesthesia, Anesthesia Critical Care, Anesthesia Pain, Thoracic Surgery, Emergency Medicine, Internal Medicine, Internal Medicine, Primary Care, Interventional Cardiology, Pulmonary Critical Care, Neurosurgery, Maternal Fetal Medicine, Ob-Gyn, Urogynecology and Pelvic Surgery, Orthopedics, Orthopedics-Spine, Orthopedics-Hand, Pediatric Orthopedics, Orthopedics – Shoulder and Elbow, Orthopedics – Adult Reconstructive Surgery, Neurotology , Otolaryngology, Facial Plastics and Reconstructive Surgery, Neonatology-Perinatal, Pediatrics, Oral and maxillofacial Surgery, Plastic Surgery – Hand, Plastic Surgery, Surgery, Vascular Surgery, Transplant, Plastic Surgery – Craniofacial, Orthodontic, Plastic Surgery –Craniofacial, Plastic Surgery – Microsurgery, Breast Surgery, Surgery – Wound Healing and Tissue Repair, Urology, Urology – Female Pelvic Medicine and Reconstructive Surgery
House Staff Orientation Module	iDevelop	ALL house staff. Level 1 Checklist item for incoming house staff.
NYU Compliance: Code of Conduct	iDevelop	ALL house staff. Level 1 Checklist item for incoming house staff.
NYU Compliance HIPAA	iDevelop	ALL house staff. Must be completed annually.
Bellevue: HIPAA	BH Peoplesoft	ALL house staff. Must be completed annually.
NYU Compliance: Professional Compliance	iDevelop	ALL house staff. Level 1 Checklist item for incoming house staff.
NYU Compliance: Effective Compliance	iDevelop	ALL house staff. Must be completed annually.
Surgery Team Training (5 Module Series)	iDevelop	For all surgical house staff
Emergency Management: Intro to Emergency Management	iDevelop	ALL house staff. Must be completed annually.
Emergency Management: Med Sled	iDevelop	ALL house staff. Must be completed annually.
Emergency Management: EH&S Fire & Emergency Procedures	iDevelop	ALL house staff. Must be completed annually.

Mandated Online modules for House Staff

Module Name	Location	Audience
Sleep Alertness and Fatigue Education in Residency (SAFER)	iDevelop	ALL House Staff
Blood Transfusion Guidelines	Compass	House Staff in the following programs: Anesthesia, Cardiothoracic Anesthesia, Anesthesia Critical Care, Anesthesia Pain, Thoracic Surgery, Emergency Medicine, Internal Medicine, Internal Medicine, Primary Care, Interventional Cardiology, Pulmonary Critical Care, Neurosurgery, Maternal Fetal Medicine, Ob-Gyn, Urogynecology and Pelvic Surgery, Orthopedics, Orthopedics-Spine, Orthopedics-Hand, Pediatric Orthopedics, Orthopedics – Shoulder and Elbow, Orthopedics – Adult Reconstructive Surgery, Neurotology , Otolaryngology, Facial Plastics and Reconstructive Surgery, Neonatology-Perinatal, Pediatrics, Oral and maxillofacial Surgery, Plastic Surgery – Hand, Plastic Surgery, Surgery, Vascular Surgery, Transplant, Plastic Surgery – Craniofacial, Orthodontic, Plastic Surgery –Craniofacial, Plastic Surgery – Microsurgery, Breast Surgery, Surgery – Wound Healing and Tissue Repair, Urology, Urology – Female Pelvic Medicine and Reconstructive Surgery
House Staff Orientation Module	iDevelop	ALL house staff. Level 1 Checklist item for incoming house staff.
NYU Compliance: Code of Conduct	iDevelop	ALL house staff. Level 1 Checklist item for incoming house staff.
NYU Compliance HIPAA	iDevelop	ALL house staff. Must be completed annually.
Bellevue: HIPAA	BH Peoplesoft	ALL house staff. Must be completed annually.
NYU Compliance: Professional Compliance	iDevelop	ALL house staff. Level 1 Checklist item for incoming house staff.
NYU Compliance: Effective Compliance	iDevelop	ALL house staff. Must be completed annually.
Surgery Team Training (5 Module Series)	iDevelop	For all surgical house staff
Emergency Management: Intro to Emergency Management	iDevelop	ALL house staff. Must be completed annually.
Emergency Management: Med Sled	iDevelop	ALL house staff. Must be completed annually.
Emergency Management: EH&S Fire & Emergency Procedures	iDevelop	ALL house staff. Must be completed annually.

NYULMC Medical Library

Visit the NYU Medical Library on atNYULMC under Popular Links.

<http://central.nyumc.org/shared/lib/Pages/Home.aspx>

The screenshot shows the NYULMC Medical Library website home page. The browser address bar displays <http://central.nyumc.org/shared/lib/Pages/Home.aspx>. The page features a purple navigation bar with the following menu items: My Newsfeed, Medical Center, Human Resources, Directories, and Popular Links. Below this, a secondary navigation bar includes Clinical, Research, Education, and Administration. The main content area is titled "NYU Health Sciences Libraries Hub" and is organized into several columns and sections:

- Library News:** A list of recent news items, including "Preview the new Library Website!" (Mon, 07 Jul 2014), "Bellevue De La Chapelle Medical Library" (Thu, 26 Jun 2014), "The Return on Investment in Public Health" (Fri, 11 Apr 2014), "National Public Health Week" (Wed, 09 Apr 2014), and "March is National Social Work".
- Clinical Library Resources:** A section with a "View All" link and a "Clinical Resources" dropdown menu.
- Chat with a Librarian:** A chat interface with an "Available" status indicator and a text input field with the prompt "Type here to chat. Press ENTER to send."
- Find Library Resources:** A search section with tabs for PubMed, Journals, Databases, and eBooks, and a search box labeled "Search PubMed via NYU".
- Search Clinical Library Information:** A search box labeled "Search Clinical Library Information".
- Library Research Guides:** A list of guides including Medical Student Bookshelf, Radiology Residents, Clinical Mobile Resources, EndNote, Mendeley, RefWorks, and Papers, Introduction to PubMed, Evidence-Based Dentistry, Pediatrics, and Systematic Reviews.
- Faculty Publications:** A list of publications, including "Maternal Prenatal Smoking and Hearing Loss Among Adolescents", "Immuno-virologic outcomes and immuno-virologic discordance among adults alive and on anti-retroviral therapy at 12 months in Nigeria", "Role of CD40 in prion disease and the immune response to recombinant PrP", "A novel means of assessing evidence-based medicine skills", and "Predicting short-term conversion from CIS to MS: relevance of lesion distribution".
- Action Buttons:** Two prominent buttons at the bottom left: "Email a Librarian" and "Request an Article or Book".

On Call Rooms

GENERAL INFORMATION

Apartments **1A and 2G (rooms 2G2 & 2G3)** are used for temporary overnight lodging for House Staff and Physical Medicine and Rehab personnel. Apartment 1A is an individual studio apartment. Apartment 2G is a three-bedroom suite. Each room within the 2G apartment is identified with “1”, “2” or “3” on the door.

Room 1A – For House Staff personnel lodging ONLY.

Room 2G-1 -- For Physical Medicine and Rehab personnel lodging ONLY.

Room 2G-2 – For House Staff personnel lodging ONLY.

Room 2G-3 – For House Staff personnel lodging ONLY.

Physical Med & Rehab administrative staff will monitor key issuance, tracking and control for their personnel using 2G1. Security does not have a role or responsibility in this.

The keys for rooms 1A, and 2G-2 and 2G-3 will be dispensed by Greenberg Hall Security staff. Keys are tracked and monitored by the Graduate Medical Educational (GME) office.

KEYS

There are three rings located at the Greenberg Security Desk (Post 22). The aluminum plate will state either “APT 1A”, “APT 2G – 2” or “APT 2G – 3”. For “APT 2G – 2” and “APT 2G – 3”, the key ring will have two keys. One key will be to enter the apartment; the other key is for the room. Gender will not play a role in how the keys are distributed.

PROCEDURE

There will be a listing of authorized house staff in a binder at the GBH security desk, which is updated monthly. The keys will be issued on a first-come, first- served basis. **The intent is for one-night stays under normal circumstances.** Security will not monitor length of stays.

DO NOT LEAVE ANY PATIENT INFORMATION OR PERSONAL ITEMS BEHIND WHEN YOU LEAVE THE ROOM FOR THE NIGHT/DAY.

The procedure is as follows:

- A House Staff member will request a key to the apartment from the security officer in the Greenberg Hall Lobby.
- The security officer will inspect the member’s valid ID badge and cross reference it against the House Staff list provided by the GME office. The badge must state “House Staff”. “Visiting House Staff” are not authorized to use these rooms.
- Once validated, a line entry will be completed in the On-Call House Staff Lodging Record form; the key will then be issued.
- Weekdays at noon-time (1200 hrs) Monday-Friday, the GBH security officer will place a call to the GME office (212-263-5506) stating the status of the two sets of keys. The office is closed

weekends/holidays.

- If a key has not been returned, the GME office will be responsible to contact the House Staff member(s) to retrieve/obtain outstanding keys.
- If a key is not available when a House Staff member desires a room, the security officer will advise the requestor that the room(s) are taken / not available and have them contact the GME office if there is an urgent need for use of the room.
- If there are any problems during the shift, the security officer will contact a security supervisor at 212.263.5120 (24 hours).

ADDITIONAL ON-CALL ROOMS AVAILABLE –

Tisch call room 14th floor- #1490 and 14East used daily by residents to round/ enter patient data/ eat/ and sleep when on call

BH call room 15th floor- #15W9, #15E1 and 15W(15A)- used daily by residents to round/ enter patient data/ eat and sleep when on call

VA call room- 4th floor #4181North- used daily by residents to round/ enter patient data/ eat and sleep when on call

Committee Participation for House Staff

House Staff are encouraged to participate in various committees (listed below).

House Staff Leadership Committee

The House Staff Leadership Committee has been newly formed by merging the Combined House Staff Committee and the House Staff Council to serve as a forum for the house staff to consolidate and voice their concerns. The committee also serves a new role as a meeting for house staff to present program activity in each of the CLER focus areas. It is a meaningful forum for house staff to interact with one another and hospital leadership in a structured way, and within the context of NAS/CLER. The members have an important role in providing feedback from programs in terms of progress, and reporting problems and new ideas. A member will also Report to the Medical Board for BH and TH. House Staff members are peer-selected residents from each core program who are voted in and appointed by the Chair of the House Staff Leadership Committee. Additional House Staff representatives may attend committee meetings as non-voting members; provide information, advice and feedback.

The Committee meets quarterly with hospital leadership and members of the GMEEC.

New members are elected annually. Please be in touch with your Program Director, Coordinator, or Chiefs if you are interested in participating!

House Staff Patient Safety Council

The House Staff Patient Safety Council at the NYU School of Medicine was established in June 2012. Dr. Michael Wajda (Anesthesiology Residency Program Director, Vice Chairman of Education and Associate Professor of Anesthesiology) is the Council's faculty advisor. The House Staff Patient Safety Council is comprised of house staff who are committed to quality improvement and patient safety throughout the institution. The hospital administration and GME Office are very interested in having residents directly engaged in patient safety and quality improvement activities, and are all fully supportive of our Council. Four executive leaders are elected by fellow house staff at a HSC meeting in the beginning of the year.

New members are elected annually. Please be in touch with your Program Director, Coordinator, or Chiefs if you are interested in joining the council!

House Staff Wellness Committee

The House Staff Wellness Committee has been newly formed. Carol Bernstein, MD (Psychiatry Residency Program Director) is the Council's faculty advisor. The House Staff Wellness Committee is a subcommittee of the GMEC. It is comprised of House Staff officers. The mission of the House Staff Wellness Committee (HSWC) is to provide a structured, sustainable committee, which will identify and address issues related to the wellness and mental health needs of all House Staff at New York University Langone Medical Center (NYULMC), Bellevue Hospital Center (BHC), and the Veterans Affairs New York Harbor Healthcare System (VA-NY).

Additional Information

Identification Badges

There are at least three IDs that House Staff will need and potentially more, depending on the sites at which you will be working. The three are: NYULMC, Bellevue and the VA (Manhattan). Your program will help you determine if any additional ID badges are needed.

NYULMC ID badges

NYU Langone Medical Center policy requires all employees to wear an identification badge while on Medical Center property.

Identification badges are distributed by the NYULMC Security Office.

Location: 550 First Avenue, Room 182
Medical Science Building (MSB) – follow the yellow pathway

Phone: 212-263-5038

Bellevue ID badges

If you will be working at Bellevue Hospital, you MUST obtain a Bellevue ID badges. To do so, you may go to the Bellevue Hospital Police Office.

Location: 462 First Avenue, Room GD-17
Monday-Friday: 7:00am – 5:00pm
Closed: Noon-1:00pm

Phone: 212-562-2345

Veterans Affairs Medical Center (Manhattan Campus) ID badge

Obtaining of this ID badge requires the completion of appropriate security forms which vary depending upon your access requirements. These may include a Special Agency Check (electronic fingerprint scanning) and National Agreement Check & Inquiry.

MCIT Telecommunications

As an NYULMC Resident/Fellow, you will be assigned a personal long-range alpha/text pager capable of being activated via telephone, email or SMS text. Your personal pager will accompany you throughout your training years at NYULMC.

If you have questions about your pager please contact the Telecommunications Department.

Location: Greenberg Hall, 545 First Avenue
Level SC-1, Room 129

Hours: Monday-Friday: 9:00am – 5:00pm

Phone: 212-263-1120

Linen Services

Long white coats and scrubs are available to all members of the House Staff via machines located on the floors. You can retrieve your scrub code for these machines at the Linen Services Room. You must present your NYULMC ID badge when picking up or exchanging your linens.

Location: Kimmel Pavilion, 1st Floor, Room 808

Hours: Monday-Friday: 6:30am – 4:00pm
Closed: 10:00am – 11:30am for inventory
Saturday: 9:00am – 5:00pm

Phone: Extension 73134 or 33012 (inside hospital) or 212-263-3014 (outside hospital)

Machine Locations: Tisch Hospital: Floors 2, 5, 8 & 11
HCC: Floors 2 & 14
Kimmel: 3rd floor

Useful Links & Resources

Department	Main Number
NYU Benefits	212-404-3787
NYU Payroll	212-404-4200
NYU Employee Health	212-263-5020
NYU Security	212-263-5038
NYU MCIT	212-263-1120
NYU Linens	646-754-6209
NYU Telecommunications	212-263-1120
NYU Malpractice	646-501-3047
Bellevue HR	212-562-6283
Bellevue Payroll	212-562-4406
Bellevue Benefits	212-562-8218
Bellevue Clinical Systems	212-562-4797
Bellevue Security	212-562-2345
CIR (Union)	212-356-8100

ACGME:

<http://www.acgme.org/acgmeweb/>

ACGME Webinars:

<http://www.acgme.org/acgmeweb/tabid/431/ProgramandInstitutionalAccreditation/NextAccreditationSystem/Webinars.aspx>

New York Medical License:

<http://www.op.nysed.gov/prof/med/medlic.htm>