



PGY-1 General Surgery Rotation

Family Medicine Faculty Liaison: Eduardo Garza, MD.

Last review/update: 3/2018

General Surgery is a required 4-week block experience completed in the PGY-1 year. Training takes place in the Harrison Health Partners General Surgery Clinic, Kitsap General Surgery Clinic, CHI Franciscan Health Harrison Medical Center operating suites, local outpatient surgery centers, inpatient surgical ward, emergency department, and during continuity care clinics within the Family Medicine Practice.

ACGME Competencies and FM-Specific Milestones Addressed by Rotation

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
✓ **PC-1, PC-5**
2. **Medical 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;
✓ **MK-2**
3. **Systems-Based Practice** as manifested by actions that 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.
✓ **SBP-1, SBP-2**
4. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population;
6. **Interpersonal and Communication Skills** result in effective information exchange and teaming with patients, their families, and other health professionals;
✓ **C-3**

Family Medicine Program Requirement(s):

IV.A.5.a).(1).(d): “[Residents] *should demonstrate competence in providing basic pre- and post-operative care, recognizing patients requiring acute surgical intervention, diagnosing surgical problems, and using sterile technique.*”

IV.A.5.a).(2): “Residents *must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.*”

Competency-Based Objectives and Instructional Methods

A. Patient Care

Objectives

During supervised inpatient service experiences and outpatient supervised clinical experiences, residents must demonstrate ability to...

1. Perform a thorough, accurate and appropriately directed history/physical exam on surgical patients.
2. Order relevant lab & imaging studies for evaluation/care of surgical patients.
3. Interpret correctly those labs & imaging studies ordered for surgical patients.
4. Manage PRE-operative care of surgical patients, including:
 - a. assessment/management of pre-operative fluid & electrolyte balance .
 - b. assessment of nutritional status
 - c. preparation for anesthesia.
 - d. cardiac risk assessment for non-cardiac surgery.
 - e. optimization of chronic medical conditions like diabetes, hypertension, heart failure.
5. Manage POST-operative care of surgical patients, including:
 - a. assessment / management of post-operative fluid and electrolyte balance.
 - b. evaluation of post-operative wound status.
 - c. evaluation and treatment of post-operative pain.
6. Apply medical knowledge identified below to patients presenting with general conditions.

Instructional Methods

1. *Direct Instruction:* During General Surgery Clinic, inpatient General Surgery Service, operating room experiences, and select Academic Conference sessions.
2. *Guided Research:* Resident presentation of faculty-assigned topics based upon clinical cases.
3. *Supervised Clinical Management:* Application of the information to individual patient cases in General Surgery Clinic, inpatient General Surgery Service, and Operating Room experiences.
4. *Directed Readings:* As listed under Instructional Methods, B5.

B. Medical Knowledge

Objectives

During supervised clinical experiences and didactic teaching sessions, residents must demonstrate...

1. Understanding of basic human anatomy and application to surgical treatment.
2. Perioperative medical management of a patients, including:
 - a. assessment of coronary and pulmonary risk before non-cardiac surgery using ACC/AHA guidelines.
 - b. perioperative management of chronic and acute medications.
3. Ability to form differential diagnoses to diagnose and manage patients with common surgical diseases encountered by Family Physicians:
 - a. acute abdominal pain
 - b. biliary tract disease, including cholecystitis, cholelithiasis, and cholangitis
 - c. pancreatic disease
 - d. acute appendicitis
 - e. intestinal obstruction
 - f. diverticulitis
 - g. GI bleeding
 - h. inguinal, umbilical and femoral hernias
 - i. breast masses
 - j. rectal and anal pain
 - k. melena and hematochezia
 - l. abscesses
4. Proper intra-operative surgical techniques, including:
 - a. preparation and draping of operative field
 - b. first assist at major surgery
 - c. fluid replacement
 - d. wound closure techniques
5. Proper application of the principles of post-operative evaluation and care, including:
 - a. wound healing management (dressing changes, suture / staple removal)
 - b. management of fluids, electrolytes and nutrition (including hyperalimentation)
 - c. management of post-operative pain
6. Timely recognition and appropriate management of/prophylaxis for common post-operative complications, including:
 - a. fever evaluation/management
 - b. ileus
 - c. wound infections
 - d. atelectasis

- e. prevention of decubitus ulcers
 - f. DVT prevention
7. Procedural competency according to the Longitudinal Procedural Training Curriculum.

The following list of skills are integral to this curriculum and residents should seek opportunities to train in these procedures during rotation.

<u>A₀ Procedures</u> Procedural competence assumed by graduating from the program	<u>A₁ Procedures</u> Procedural Competence is required for graduation	<u>A₂ Procedures</u> Procedural Competence is optional prior to graduation	<u>B Procedures</u> Procedural Competence requires a focused training plan during residency	<u>C Procedures</u> Procedural competence likely requires additional training beyond residency
<ul style="list-style-type: none"> • Digital rectal exam • Fecal disimpaction • Local anesthesia/field block • Nasogastric or enteral feeding tube placement • Peripheral venous cannulation • Phlebotomy • Surgical aseptic technique • Surgical assist • US guidance of needle placement 		<ul style="list-style-type: none"> • Endotracheal intubation (10) • Excision of thrombosed external hemorrhoids (2) • I&D of a perianal abscess (1) • Paracentesis (3) • Removal of perianal skin tags (1 or demonstrated competency w/ excision of thrombosed external hemorrhoid) • Thoracentesis (3) 	<ul style="list-style-type: none"> • Anoscopy • Conscious sedation • Hematoma block • Non-obstetrical, point-of-care diagnostic applications (abdominal, cardiac, musculoskeletal, ocular, pelvic, skin/soft tissue, thoracic, vascular, etc.) • Thoracostomy insertion and management 	<ul style="list-style-type: none"> • Appendectomy • Anal spincterotomy • Colonoscopy • Epidural Anesthesia • Esophagogastro-duodenoscopy • Fine needle aspiration of a cyst, including breast • Flexible sigmoidoscopy • Needle biopsy of a solid mass • PICC • Venous Cut down

- For A1 and A2 procedures, the minimum number of procedures that must be logged electronically prior to graduation is listed in parentheses.
- Residents should attempt to complete as many Procedural Competency Assessment Tools as possible during the rotation.

Instructional Methods

1. *Direct Instruction*: During General Surgery Clinic, inpatient General Surgery Service, operating room experiences, Family Medicine Practice Minor Procedure Clinic, and select Academic Conference sessions.
2. *Guided Self-Study*: Supplemental reading material provided by clinical preceptor regarding evaluation/management of common surgical complaints and proper surgical approach/technique for operating room cases.
 Resources include:
 - a. *Schwartz's Principles of Surgery*, 9th Ed.
 - b. *Current Surgical Therapy*, 9th Ed. , by John Cameron
 - c. *Sabiston Textbook of Surgery*, 18th Ed. - Combination of pathophysiology, diagnosis, management of surgical conditions
 - d. *Cope's Early Diagnosis of the Acute Abdomen*, 20th Ed.
3. *Guided Research*: Resident presentation of faculty-assigned topics based

upon clinical cases.

4. *Supervised Clinical Management*: Application of the information to individual patient cases in General Surgery Clinic, inpatient General Surgery Service, Operating Room experiences, and continuity clinic encounters within the Family Medicine Practice.
5. *Directed Reading*:
 - a. *Evaluation of Acute Abdominal Pain in Adults*. American Family Physician. Volume 77, Number 7, April 1, 2008
 - b. *Diagnosis and Management of Acute Diverticulitis*. American Family Physician. May 1, 2013, Volume 87, Number 9
 - c. *Acute Pancreatitis*. American Family Physician. November 1, 2014, Volume 90, Number 9
 - d. *Surgical and Nonsurgical Management of Gallstones*. American Family Physician. Volume 89, Number 10, May 15, 2014
 - e. *Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations*. American Family Physician. March 15, 2013, Volume 87, Number 6
 - f. *Evaluation of Jaundice in Adults*. American Family Physician. February 1, 2017, Volume 95, Number 3
 - g. *Treatment of Adult Obesity with Bariatric Surgery*. American Family Physician. Volume 93, Number 1, January 1, 2016
 - h. *Fever in the Postoperative Patient*. Infectious Disease and Antimicrobial Agents. <http://www.antimicrobe.org/e23.asp>

C. Practice Based Learning and Improvement

Objectives

During supervised inpatient service experiences and outpatient supervised clinical experiences, residents must demonstrate ability to...

1. Demonstrate ability to incorporate faculty feedback into clinical/academic performance changes.
2. Demonstrate ability to use search tools online and in the Harrison Medical Center Library to find references which augment learning from cases seen in the General Surgery Clinic or on the Wards.

Instructional Methods

1. *Direct Instruction*: During General Surgery Clinic, inpatient clinical experience, and during consultation with surgical specialty staff.
2. *Guided Research*: Resident presentation of assigned topics based upon clinical cases.
3. *Supervised Clinical Management*: Application of the information to individual patient cases in General Surgery Clinic, inpatient services, and FM Continuity Clinic.

D. Interpersonal and Communication Skills

Objectives

During supervised inpatient service experiences and outpatient supervised clinical experiences, residents must demonstrate ability to...

1. Present clearly and concisely the consultation cases to precepting physicians and/or consulting staff.
2. Establish rapport with the patients and listen actively to promote the patients' welfare.
3. Construct appropriately organized, complete, and timely progress notes.

Instructional Methods

1. *Direct Instruction:* During General Surgery Clinic and ward consultations with specialty staff.
2. *Supervised Clinical Management:* Application during patient cases in General Surgery Clinic, inpatient services, and continuity care within the Family Medicine Practice.

E. Professionalism

Objectives

During supervised inpatient service experiences and outpatient supervised clinical experiences, residents must...

1. Demonstrate ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty in all patient/staff interactions.
2. Acknowledge errors when committed and demonstrate ability to analyze how to avoid future similar mistakes.
3. Demonstrate punctuality and reliability at all times, whether in clinic, didactic sessions, or performing inpatient duties.
4. Maintain a professional appearance at all times.

Instructional Methods

1. *Direct Instruction:* During General Surgery Clinic and ward consultations with specialty staff.
2. *Supervised Clinical Management:* Application of the information to individual patient cases in General Surgery Clinic, inpatient services, and continuity care within the Family Medicine Practice.

F. Systems Based Practice

During supervised inpatient service experiences and outpatient supervised clinical experiences, residents must...

Objectives

1. Utilize appropriately the health services and professionals within CHI-Franciscan Health Harrison Medical Center while advocating for patient interests. (Examples include: nutritionists, nurse clinicians, podiatrists, physical therapists, surgeons, wound care specialists, and nuclear medicine specialists as indicated.)
2. Use cost effective, evidence-based, medical practices.
3. Identify risks, benefits, and cost savings associated with performing surgical procedures in outpatient surgical centers when such an option is available.

Instructional Methods

1. *Direct Instruction:* During General Surgery Clinic, ward consultations with specialty staff, and select Academic Conferences.
2. *Supervised Clinical Management:* Application to individual patient cases in General Surgery Clinic, inpatient services, and continuity care within the Family Medicine Practice.

Points of Contact

Rotation liaison:

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Schedule (Kitsap General Surgery)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	Clinical Rotation	Clinical Rotation	Clinical Rotation	Brem OR	Family Medicine Rotation		
PM	Clinical Rotation	Clinical Rotation	Longitudinal Curriculum	Academic Conference	Family Medicine Clinic		
Night	"Home Call" approximately 1 night per week.						

Schedule (The Doctors Clinic - General Surgery)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	Clinical Rotation	LC	OR	Clinical Rotation	OR		
PM	Clinical Rotation	Family Medicine Clinic	OR	Academic Conference	Family Medicine Clinic		
Night	"Home Call" approximately 1 night per week.						

Evaluation Activities

Residents will receive an ***incomplete*** for the rotation and will not be eligible for graduation until the following items are completed.

1. Resident Evaluation: *(the resident may be evaluated by several department members)*

- Mid-rotation feedback:
Faculty are encouraged to provide daily verbal feedback; but written feedback is required if resident is failing at mid-rotation or at any other time. Family Medicine Associate Program Director or Program Director should be notified as soon as possible when a resident is in danger of failing the rotation.
- Final Evaluation
Using rotation-specific on-line evaluation form. Evaluations should be completed within two weeks of rotation end to provide timely feedback to the resident.
- Attendance Verification
Documentation of attendance at didactic sessions, procedural clinics, FM continuity clinics and experiential encounters will be maintained in resident training file.

2. Documentation: *(to be completed by end of rotation)*

- Procedures performed must documented in standard electronic format
- Appropriate EHR documentation of all encounters must be completed
- Any provided supplemental readings should be completed and returned to rotation coordinator.

3. Staff Evaluation: *(by the resident)*

- Residents evaluate rotation faculty/staff using standard on-line evaluation form. Evaluation is to be completed within two weeks of rotation end.

4. Rotation Evaluation: *(by the resident)*

- Resident assesses quality of the rotation on the standard rotation evaluation form (same as for rotation faculty evaluation). Evaluation is expected to be completed within two weeks of rotation end.



M. Watson, MD 3/02/2018
Program Director Date