General Surgery

Guidelines for Straub Clinic and Hospital General Surgery Rotation (Formulated by a previous Chief Surgical Resident)

Teaching Staff and Team Care Coverage

Team care attending general surgeons are as follows:

Dr. John Balfour
Dr. George McPheeters (Director of Surgical Education)

Morning Rounds

Each Resident makes individual patient "pre-rounds" prior to rounds with the entire General Surgery Team. This comprises the evaluation of all acute-care patients, including a review of pertinent laboratory and imaging studies, and entering complete progress notes in the patient chart and entering of orders.

Notify the Chief Resident immediately when unforeseen events will compromise your ability to complete your patient rounds prior to General Surgery Team Rounds.

Medical Students' notes are for educational purposes. You are responsible to review their notes and provide timely feedback. Co-sign these notes only after thoroughly reviewed. It is acceptable to make your own note brief when the Medical Student's note is appropriate; however, the Resident's note should include, at the very least, an independent assessment and plan.

Team Rounds

General Surgery Team Rounds start in the ICU at 6:30 a.m.

Each Resident should be thoroughly familiar with all of his or her patients. This is the only time that the full Team formally meets and systematically reviews all patients. Be ready to present assessments and plans to the Chief Resident. Read ahead of time. ICU patients are presented by organ systems.

In-Hospital Patient Care

Be proactive in patient care. When unsure in taking the initiative in implementing a patient care related decision, discuss this with the Chief Resident first.

Any patient care issues discussed during Team rounds should be taken care of immediately.

Unless you are post-call, you are expected to see your patients again later during the day to evaluate progress, reassess, review notes from the Attending, Consultants, ancillary services, etc.

When a patient is expected to be discharged, fill out the discharge order forms. The final decision for discharge must come from the Attending of record; therefore, you can write"Discharge if OK with Attending." This allows the Attending the flexibility to delay discharge if warranted.

Discussing pathology results, prognosis, or code status with the patient/family is reserved for the Attending.

Update your patient list daily.

Discharge/transfer summaries should be dictated as soon as possible, preferably before discharge. A written form must also be filled out prior to transferring patients to the Rehabilitation Hospital of the Pacific or to a nursing home.

A clinical pathway is available for gastric bypass patients.

All patients must be evaluated and assessed 4-6 hours after all procedures. A brief post-op note must be written. If you are not available, you must sign this requirement out to the on-call Resident who then has the responsibility to assure that this is done.

ICU Patient Care

There is no separate ICU Team. Intensivists do not automatically follow patients unless consulted. ICU patients require frequent visits and efficient, expeditious communications with the nursing staff. Daily plans and orders are discussed during morning Team rounds. Check on your patients at least a couple of times during the day. On-call Residents are expected to visit the ICU during evening and night shifts to monitor patients' clinical status.

Residents are expected to manage ventilators unless a pulmonologist or an intensivist is following the patient. However, you are not allowed to personally manually change the ventilator settings on the machines, that function is reserved for the respiratory therapists/care team.

No "routine" ICU labs or X-rays exist. Do not order "daily" labs or X-rays and do not order "standing" order labs beyond a 24-hour period (e.g., "Hemoglobin Q6 hours x 24 hours only"). Laboratory tests and imaging studies should all be ordered as needed, based on bedside clinical assessment.

General Surgery Clinic (Pre-Op)

Resident's pre-op patients:

- For an ambulatory (outpatient) case, a pre-printed H&P sheet is filled out and pre-op orders are written.
- For an admission (inpatient) case, an H&P is dictated and pre-op orders are written.
- All antibiotics should be given by anesthesia in the OR (not "on call to OR").

The following is a list of frequently used perioperative antibiotics:

- Cefazolin 1 gm IV for hernias, breast procedures, thyroid/parathyroids, lap choles, gastric surgeries.

- Cefotetan 1 gm (or Timentin 3.1 gm) IV for appendectomies, colectomies and rectal surgeries.
- Venodynes are ordered for cases requiring general anesthesia.
- A Foley is ordered for major abdominal surgeries and advanced laparoscopic cases.
- Ordering of blood products is discussed with the Attending.
- A bowel prep is usually ordered by the Attending.

Operating Room

Residents are assigned to cases by the Chief Resident the evening prior.

Pre-op patients in SAC prior to Operating Room encounters, unless you have already seen the patient in the clinic. This visit should include a review of the chart, interviewing of the patient, and checking the H&P and pre-op orders.

Residents must be notified at least one half-hour (30 minutes) before a case enters the OR, otherwise the case will not be covered by Team Care. The exceptions are emergent, life-threatening cases where such advanced notification is not always possible.

Read ahead of time – prior to assisting in the OR (Zollinger-Zollinger, *Mastery of Surgery*, *Cameron*, etc.)

If you will not be on time for the operative procedure, notify the Chief Resident. Note that the OR schedule may change without notice. Check the schedule of assigned cases at the OR front desk intermittently; to assure that you have not been assigned to an additional case or to determine when the case you have been assigned to will actually start. This is your responsibility!

An operative note is written in the chart by the Resident. Inquire with the Attending Surgeon who will dictate the operative note. Discussing the post-operative management of the patient (when to remove the NG tube, Foley, drains and catheters, when to start diets, etc.) with the Attending will make your morning rounds much easier.

Post-op orders and discharge orders for ambulatory (outpatient) cases are the responsibility of the Resident assigned to the case.

Tumor Board (Monday 12:30-1:30 p.m. Doctor's Dining Room)

Mandatory, unless you are post call. You must notify the Chief Resident in advance if you are not available. Lunch is provided.

Attending's Rounds (Saturday a.m.)

Mandatory. Be ready to present your patients and be sure that you have read ahead of time about relevant patient focused topics.

On-Call

In general, all admissions and all cases in which either you or the Chief Resident scrubs in on, when you are on-call, will be your patients. Update the Team's master patient list as soon as possible.

You may be asked by an ER physician to assess a patient (appendicitis, acute cholecystitis, small bowel obstruction, perforated viscus, etc.). Evaluate the patient as soon as possible and always discuss the case with the Attending Surgeon before admitting any patient. In cases requiring operative procedures, notify the Chief Resident. Then, you are usually expected to complete a written or dictated H&P, preop the patients, and to obtain informed consent. However, it is the Attending's responsibility to notify the OR and Anesthesia.

Obtain verbal sign-out on ALL patients. A written sign-out, as the only form of communication between Residents, is inappropriate and unacceptable.

In-house call is not to exceed 24 straight hours (30 hours if the last 6 hours is dedicated to transferring of patient care, continuity of care, or educational conferences). Communication among the Team members is key. DO NOT leave lots of scut work for the Resident on-call, such as checking labs, X-rays, calling Consultants, removing clips/staples from incisions , etc.; however, do not hesitate to ask the on-call Resident to reassess patients when necessary and clinically indicated.

Changes to the on-call schedule are allowed ONLY by the Chief Resident AND the Program Office (586-2920) must be notified of any changes immediately.

The General Surgery Team may cross-cover the Vascular Surgery Service (Dr. Masuda) after hours (replacing K+, Tylenol orders, Insulin orders, etc.). Notify either the Attending or the Vascular Surgery Resident in the event of significant findings such as a heparin overdose, chest pain or shortness of breath, mental status changes, wound discharge, pulse changes, etc.

Junior Residents are NOT allowed to place hemodialysis access catheters without supervision by the Chief Resident or the Attending.

Bedside Procedures

Interns (PGY-1) are not allowed to perform central venous catheter placements or tube thoracostomies without supervision by an Attending Surgeon or the PGY-5 Chief Resident, until they are signed off formally, based on turning in of the requisite procedure cards to the Program Office in The Queen's University Tower (see Section in this Guide, "Resident Responsibilities" for additional information). These procedures require informed consent.

Portable ultrasound is available for difficult venous access in the Emergency Department.

No procedure can be done without a Team Care Surgical Faculty Attending on record.

Medical Records

Make at least weekly visits to Medical Records and update your dictations and provide signatures when required. The nights you are on in-house call is the perfect opportunity to accomplish this.

It is always much more efficient to dictate the discharge summary at the time of patient discharge rather than spending a lot of time reviewing the chart later in order to do this.

Days Off

Divide up your patient list with the other Residents of the Team before leaving the hospital.