UCLA General Surgery Residency Program  
Rotation Educational Policy  
Goals and Objectives

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ROTATION: VETERANS AFFAIRS GENERAL SURGERY ROTATION

PROGRAM SITE DIRECTOR: Mark Sawicki, M.D.

SITES: West LA Veterans Administration Hospital

GOALS: To provide trainees an opportunity to participate in the perioperative and operative aspects of general surgery.

LEVEL OF TRAINEE: R1

ASSESSMENT:

Monitoring of the accomplishment of the stated objectives will be performed using the following methods:

1. Global Rating: end of rotation evaluation of resident performance to assess the resident’s demonstration of Core Competencies with respect to the stated objectives by faculty, other team resident members, students, and nursing staff.
2. Case Logs: auditing of operative cases pertinent to the specialty in the Surgical Operative Log.
3. Written Examination: performance on the annual ABSITE examination, Cardiovascular and Respiratory systems section.
4. Patient Survey: performance will be assessed by patient surveys administered though the rotation.

DESCRIPTION OF THE ROTATION:

1. All rotating will be part of the General Surgery team and responsible for the care of the general surgery patients.
2. The surgery residents will provide in-patient care including routine admissions and critical care of patients.
3. Residents will further participate in surgical operations needed on these patients under direct supervision by the surgical faculty.
4. The rotating residents will participate in all Department of Surgery educational conferences and didactic presentations.
5. Residents are expected to actively participate and present at the weekly Multidisciplinary Surgery Conference.
R1 RESIDENT

COMPETENCY BASED LEARNING OBJECTIVES:

Patient Care:

1. Perform a complete and thorough history and physical examination, with emphasis in elements unique to general surgery patients.
2. Initiate the laboratory evaluation and any other initial diagnostic studies with an understanding of the tests to be ordered.
3. Make informed decisions about diagnostic and therapeutic interventions on general surgery patients with the guidance of senior residents and faculty.
4. Be proficient in the preoperative preparation of the patients for general surgery and routine postoperative care.
5. Understand basic pathophysiology of general surgery disease and begin to master the skills necessary to care for the ICU patient under the guidance of the senior residents and faculty members.
6. Understand the basic indications for common radiological and interventional studies used in the care of GI surgery patients such as plain films, CT scans, and contrast studies.
7. Demonstrate the ability to effectively set priorities and coordinate the care of general patients.

Medical Knowledge:

ABDOMINAL SURGERY

1. Describe the embryological development of the peritoneal cavity and the positioning of the abdominal viscera.
2. Diagram the anatomy of the abdomen including its viscera and anatomic spaces:
   a. Musculoskeletal envelope
   b. Lesser sac
   c. Subphrenic spaces
   d. Morrison's pouch
   e. Foramen of Winslow
   f. Pouch of Douglas
   g. True pelvis
   h. Lateral gutters
   i. Contents of the retroperitoneum
   j. Major lymph node groups and their drainage
3. Surgical outcome is dependent on coexistent disease. Describe changes in the following organ systems that result from the aging process:
   a. Heart
   b. Brain
   c. Lung
   d. Hematopoietic system
e. Kidney  
f. Gastrointestinal tract

4. Explain absorption and secretory functions of the peritoneal surfaces and the diaphragm.

5. Describe the anatomy of the omentum and its role in responding to inflammatory processes.

6. Assess the following signs associated with the acute abdomen and describe their pathophysiology:
   a. Referred pain
   b. Rebound tenderness
   c. Guarding
   d. Rigidity

7. Specify characteristics of the history, physical examination findings, and mechanism of visceral and somatic pain for the following processes:
   a. Acute appendicitis
   b. Bowel obstruction
   c. Perforated ulcer
   d. Ureteral colic
   e. Diffuse peritonitis
   f. Biliary colic

8. List possible distinctions in the presentation and examination of the elderly patient with the following causes of acute abdomen:
   a. Perforated viscus
   b. Cholecystitis

9. Discuss the differences in the physiologic response to stress in the geriatric patient.

10. Explain the mechanism of referred pain in:
    a. Ruptured spleen
    b. Biliary colic
    c. Basilar pneumonia
    d. Renal colic
    e. Pancreatitis
    f. Inguinal hernia

11. Discuss the following causes of paralytic ileus:
    a. Postoperative electrolyte imbalance
    b. Retroperitoneal pathology
    c. Trauma
    d. Extraperitoneal disease (central nervous system, lung)

12. Illustrate use of the following diagnostic studies in the work-up of each process in #7 and #10 above:
    a. Laboratory evaluation
    b. Urinalysis
    c. Plain x-rays
    d. Contrast gastrointestinal (GI) studies
    e. Ultrasound
    f. Computed axial tomography (CAT)
    g. Biliary studies
    h. Renal studies

13. When considering the possibility of wound complications:
    a. What are the risk factors for abdominal wound infection?
b. What are the contributing factors for abdominal wound
dehiscence and evisceration?
d. What are the usual clinical presentations and timing?
e. What is the incidence of wound infection in surgeries
involving the biliary tree, upper GI tract, and colon?
g. List wound complications that are more problematic in the elderly patient.

14. Identify the anatomic locations for the following intra-abdominal abscesses; name
disease process(es) associated with each:
a. Left subphrenic space
b. Right subphrenic space
c. Subhepatic space
d. Lesser sac
e. Interloop
f. Pelvis
g. Left paracolic gutter
h. Right paracolic gutter
i. Psoas muscle

15. Differentiate between the conditions favoring Percutaneous drainage versus
operative drainage for each of the abscesses in #14. Describe the safest and most
effective approach using each technique.

16. Differentiate between the following intestinal fistulas and the organs to which they
most often communicate:
a. Esophageal
b. Gastric
c. Enteric (including duodenal)
d. Colonic

17. Explain the formation of fistulas in each of the following disease processes or
factors:
a) Operative complications (bowel injury with abscess
b) formation)
c) Inflammatory bowel disease
d) Acute pancreatitis
e) Foreign body or prosthetic material
f) Malignancy

18. Explain the role of a fistulogram in the diagnosis of intra-abdominal fistulas and
abscesses.

19. List the factors that prevent healing of a fistula.

20. Summarize the conditions favoring operative versus non-operative treatment for
fistulas listed in #16.

21. Describe the anatomy, clinical presentation, and complications of non-operative
management for these hernias:
a. Direct and indirect inguinal, femoral, and obturator
b. Sliding hiatal
c. Paraesophageal
d. Ventral
e. Umbilical
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22. Name the hernia types that are most common in elderly patients, and explain how they may become problematic.

23. Define a Richter's hernia and describe its clinical presentation.

24. Define a sliding hernia and describe its repair.

25. Differentiate between incarceration and strangulation.

ALIMENTARY TRACT

1. Review the anatomy, embryology, and biochemistry of the gastrointestinal (GI) tract with emphasis on systemic blood supply, portal venous drainage, neural-endocrine axis, and lymphatic drainage.

2. Discuss the abdominal anatomy, explaining its relationship to lower thorax, retroperitoneum, and pelvic floor.

3. Review the physiology of the GI tract with attention to the following aspects:
   a. Mucosal transport, including mechanism of absorption of nutrients and water
   b. Sites of electrolyte and acid-base regulation
   c. Physiology of deglutition and phases of digestion
   d. Neuroendocrine control of GI secretion and motility
   e. Regional controls of mucosal secretion and absorption (neural and hormonal)
   f. Enterohepatic circulation
   g. Neuromuscular control of defecation
   h. Digestion of sugars, fats, proteins, vitamins, and cofactors
   i. Rates of mucosal turnover
   j. Normal secretory rates for the stomach, small bowel, biliary tree, and pancreas
   k. Normal bacterial flora and their concentrations in the upper and lower GI tract
   l. Immunologic properties of the GI tract and how this barrier is affected by: trauma, sepsis, burns, malnutrition, and chronic disease

4. Review the nutritional needs of surgical patients.

5. Discuss the principles of intestinal healing:
   a. Normal GI tissue integrity and strength and how this relates to healing of anastomoses
   b. Effects of suturing and stapling techniques of the gut

6. Review the various embryologic abnormalities of the GI tract, including:
   a. Strictures
   b. Stenoses
   c. Webs
d. Atresias

e. Duplications

f. Malrotations

7. Review the common causes of the following conditions:

a. Ulceration of the proximal and distal GI tract

b. Causes of GI obstruction

c. Causes of paralytic ileus

d. Causes of GI hemorrhage

e. Causes of GI perforation

f. Causes of abdominal abscess formation or secondary peritonitis

g. Short gut and malabsorptive conditions

h. Acute and chronic mesenteric ischemia

i. Portal hypertension and venous thrombosis

j. Inflammatory bowel diseases

k. An acute abdomen

l. Ischemic bowel

8. Discuss diseases of the esophagus to include:

a. Motility disorders

b. Inflammatory disease

c. Esophageal injuries

d. Gastroesophageal reflux

e. Diverticular disease

f. Tumors (benign and malignant)

9. Outline the essential characteristics specialized diagnostic evaluation of the alimentary tract, including:

a. Barium swallow

b. Upper GI Series with small bowel follow-through

c. Enteroclysis

d. Ultrasound

e. Transesophageal echo

f. Computerized Tomography

g. Magnetic Resonance Imaging

h. Barium enema

i. Angiograms

j. Nuclear scans for bleeding or to evaluate for Meckel's diverticulum

k. Fiberoptic endoscopy (upper and lower)

l. Endoscopic ultrasonography

m. Rigid anoscopy and sigmoidoscopy

n. Tests of GI function including:

p. Manometry

q. pH measurement

r. Gastric analysis (basal and stimulated)

s. Radioisotope clearance studies

t. Technetium 99m

u. Technetium HIDA (hepatic 2,6- dimethyliminodiacetic
v. acid) dynamic biliary imaging
w. Gastric emptying studies
x. Transit times
y. Hormonal determinations
z. Absorption

10. Summarize current medical management and its potential limitations; explain the role of surgical intervention when management fails in the following:
   a. Gastroesophageal reflux
   b. Peptic ulcer disease
   c. Gastroparesis
   d. Esophageal varices
   e. Inflammatory bowel disease
   f. Upper and lower GI bleeding
   g. Diverticulitis

**Practice Based Learning:**

1. Develop a personal program of self-study and professional growth with guidance from the teaching staff and senior residents. An understanding of the etiology, pathogenesis, pathophysiology, diagnosis and management of gastrointestinal disorders will allow for sound surgical judgment, which relies on knowledge, rational thinking and the surgical literature.

2. Utilize current literature resources to obtain up-to-date information in the general surgery patients and practice evidence-based medicine.

3. Participate in teaching and organization of the educational weekly Surgery Conference.

4. Participate in activities of the Department of Surgery (including all teaching conferences) and assume responsibility for teaching and supervision of subordinate surgical house staff, and medical students.

5. Participate in the Department Morbidity & Mortality conference and utilize information to further improve patient care.

6. Participate in daily teaching rounds and be able to present patients in an organized and complete fashion

**Professionalism:**

1. Practice compassionate patient care maintaining the highest moral and ethical values with a professional attitude.

2. Demonstrate understanding of the needs and feelings of others, including the patient's family members, allied health care personnel (nurses, clerical staff, etc.), fellow residents, and medical students.

3. Communicate and collaborate effectively in a team of health care providers

4. Demonstrate respect, compassion and integrity in the care of general surgery patients on a daily basis
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5. Demonstrate mature and educated approach to Ethical issues commonly encountered in a cardiac surgery setting.
6. Show sensitivity to patients culture, age, gender and disabilities.
7. Recognize and appropriately handle sensitive cases of abuse.
8. Be self-aware and have knowledge of professional limits by practicing on-going medical education and self-improvement.
9. Be accountable to profession in their actions and decisions.

Interpersonal Relationships And Communication:

1. Create and sustain a therapeutic and ethically sound relationship with patients and patient families
2. Work effectively with other members of the medical team including allied health care personnel (nurses, clerical staff, etc.), fellow residents, and medical students.
3. Maintain professional interactions with other health care providers and hospital staff

Systems Based Practice:

1. Understand how the health care organization affects surgical practice of general surgery
2. Demonstrate cost effective health care
3. Be able to coordinate multi-specialty and multidisciplinary general surgery practice including discharge planning, social service, rehabilitation, and long term care
4. Follow established practices, procedures, and policies of the Department of Surgery and integrated and affiliated hospitals.
5. Maintain complete of medical records operative notes staff sheets and notes, patient database cards and other patient care related documentation in a timely, accurate and succinct manner.

REFERENCES:

TYPICAL WEEK: