Seismic Changes in Residencies

- Intern = worker bee
Seismic Changes in Residencies

- Intern = worker bee

- Resident = student/ member of the health care team
Seismic Changes in Residencies

• Intern = worker bee

• Resident = student/ member of the health care team

• Educational goals
  – Shifted from teaching on the wards and OR
  – To didactics, documentation and measurements
General Surgery Residency

- ACGME/RRC approved
- Last site visit - July 2004
- Approved for nine chief residents
  - Currently 8-9 per year
Core Competencies

1. Patient care that is compassionate, appropriate, and effective
   - demonstrate manual dexterity appropriate for their training level.
   - be able to develop and execute patient care plans appropriate for the resident’s level.

2. Medical Knowledge
   - established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care.
   - critically evaluate and demonstrate knowledge of pertinent scientific information.

3. Practice-based learning and improvement
   - appraisal and assimilation of scientific evidence to improve patient care
   - critique personal practice outcomes.
   - demonstrate a recognition of the importance of lifelong learning in surgical practice.
Core Competencies

4. Interpersonal and communication skills
   – communicate effectively with other health care professionals.
   – counsel and educate patients and families.
   – effectively document practice activities.

5. Professionalism through a commitment to carrying out professional responsibilities
   – maintain high standards of ethical behavior.
   – demonstrate a commitment to continuity of patient care.
   – demonstrate sensitivity to age, gender and culture of patients and other health care professionals.

6. Systems-based practice
   – practice high quality, cost effective patient care.
   – demonstrate a knowledge of risk-benefit analysis.
   – demonstrate an understanding of the role of different specialists and other health care professionals in overall patient mgmt
How to do all this??

• We already do, but we need to show it
General Surgery Residency
Continuing Education

• **Weekly conferences**
  – Weekly combined Case Conferences for the program
  – Transplant/Pediatric/Trauma/Vascular
  – Site specific conferences
  – M&M- weekly by site

• **Monthly meetings**
  • Journal Clubs
  • Visiting Professors Series
  • Brooklyn Surgical Society
  • NY Surgical Society
  • Selected Topics in Surgery-
General Surgery Residency Continuing Education

- Basic Science Curriculum, 2 yr cycle
  - monthly online examinations with reviews
  - ACS Curriculum to start this year
    - Need to be candidate member of ACS
- Semi-annual Oral Exams for Senior Residents
- Faculty advisors/mentoring
- Internet based resident management system
  - evaluations, schedules, examinations
  - internet based operative log system
- Animal/laparoscopic simulators
  - On site and off
Educational Tools
To prove we do the Core Competencies

• Goals and Objectives
  – Promotional guidelines
    • Academic achievement
  – Rotational Goals
• 360° EVALUATIONS
• Core Curriculum
• Credentialing for procedures
• Operative Logs- Computer Based; keep up to date
Educational Tools: Upcoming tools

• Didactic laboratory
  – Wet and dry lab
  – Specific curriculum for each level
• Resident portfolios
  – Proof of ongoing learning
• Completion of USMLE Step III by end of PGY 2 year
• Criteria for advancement
  – Academic
  – Evaluations
  – Operative experience
General Surgery Residency
Continuing Education

• Research/Advanced Degrees
  – Two to three residents in lab for 2 years
  – Funded Labs in Dept or in Medical School
  – Masters Program in Biomed Engineering
  – Masters in Public Health
  – PhD in Molec Biology
Other Oversight Issues

• Compliance issues
  – HIPPA
  – Fraud/Abuse compliance
  – BCLS/ATLS/PALS certification
  – Credentialling to do procedures

• Regulators: JCAHO, UHC, LEAPFROG
  • Surgical site verification
  • B-blockade in surgery
  • Order entry
  • Handwashing
  • Antibiotic use, prophylaxis
  • DVT prophylaxis
Summary of 405 Regs-1988
405.4/(b)6(ii)a-c

- Not to exceed 80 hr/week
- no more than 24 consecutive hrs
  - except:
    - to transfer patients (shift change)
    - purpose is not to assign new patient care activities
    - should be added to 80 hour week
- on duty separated by not less than 8 consecutive hrs
- one 24 hr period of non-working time/week
Surgical Exemption  
405.4/(b)6(ii)(d)1-4

• 24 hour limit (but not 80) hour week exempted if
  – documentation that trainees are resting
  – interruptions for patient care are infrequent and involve only those pts for whom resident has continuing responsibility
  – no more than every 3rd nite call
    – call followed by non working period of no less than 16 hrs = out by 3-4 pm
  – procedures in place to relieve fatigue following an unusually active on call period
Attending coverage

– rule 405.4/(f)(3)iii**

**There shall be sufficient number of (attending) physicians present in person in the hospital 24/7 to supervise the postgraduate trainees in their specialties to meet reasonable and expected demand.

...In hospitals which can document that the pts’ attendings are immediately available….onsite supervision can be carried out by postgraduate trainees who are in their final year or whom have completed at least three yrs of postgrad training

If there is no attending, you are not covered
Hospital Accradiator Will Strictly Limit Hours of Residents

By LAWRENCE K. ALTMAN and DENISE GRADY

ABSTRACT Accreditation Council for Graduate Medical Education, group that accredits nation's teaching hospitals, says it will impose strict new limits on number of hours worked by medical residents; rules, intended to reduce risk of dangerous errors by sleep-deprived young doctors, are to take effect in July 2003; they will limit work week to 80 hours, require at least 10 hours of rest between shifts, restrict duty to no more than 24 hours at a time and restrict outside work; will also require stricter supervision and accountability from hospitals that train residents; New York is only state with law limiting such work hours; council's action coincides with introduction of federal legislation that would also limit residents' hours.
3. Yale surgery program to lose ACGME accreditation

The Accreditation Council for Graduate Medical Education (ACGME) has withdrawn accreditation of the Yale-New Haven Medical Center surgery residency program, effective July 1, 2003.

An ACGME site visit found the program in violation of ACGME work hour standards, including the standard limiting on-call activities to every third night and giving residents at least 1 day in 7 off.

Residents in the program reported that they routinely work more than 100 hours a week. Yale officials said that the university's teaching hospital would spend more than $1 million to hire additional physician assistants and moonlighting physicians and thereby reduce the residents' workweeks to less than 80 hours, according to an article in the May 6 Chronicle of Higher Education.

"Clearly, the RRC is on a roll about this issue, and I suspect that there are going to be a series of high-profile programs coming under the gun," Yale surgery program director John Seashore, MD, told the Chronicle.

Yale surgery residents interviewed for a Boston Globe article ("Surgery residents' long hours draw warning for Yale," May 20) approved of the action. "I'm ecstatic," said one resident. "I love medicine. I care about medicine. But I also care about my family and friends."
...we wish to remind you that if any patient is seriously injured or dies while in the care of an intern or resident working excessive hours, your hospital may be found criminally liable.....

....Criminal charges may range anywhere from manslaughter to reckless endangerment, depending on the extent of injury and the degree of recklessness involved.....
## Typical Rotation Schedule

<table>
<thead>
<tr>
<th>PGY5</th>
<th>TRAUMA</th>
<th>G/SURG UHB</th>
<th>G/SURG KCH</th>
<th>VA</th>
<th>G/SURG LIC</th>
<th>VAC</th>
</tr>
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<tbody>
<tr>
<td>PGY4</td>
<td>TRAUMA</td>
<td>PEDS</td>
<td>G/ICU KCH</td>
<td>G/SURG KCH</td>
<td>TRANSPLANT</td>
<td>G/SURG UHB</td>
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<tr>
<td>PGY3</td>
<td>TRAUMA</td>
<td>G/SURG LIC</td>
<td>G/SURG KC</td>
<td>G/SURG UHB</td>
<td>ELEC</td>
<td>CT</td>
</tr>
<tr>
<td>PGY2</td>
<td>TRAUMA</td>
<td>CT</td>
<td>PEDS</td>
<td>BURN</td>
<td>VA 2 MO</td>
<td>G/SURG LIC</td>
</tr>
<tr>
<td>PGY1</td>
<td>G/SURG LIC</td>
<td>G/SURG KCH</td>
<td>G/SURG UHB</td>
<td>ELEC</td>
<td>CT</td>
<td>VAC</td>
</tr>
</tbody>
</table>

**Every third nite, avg 90-95 hrs/wk**

**Shift Work, avg 75-78 hrs/wk**
Net Effect

• More rest
• More time out of hospital
• Less patient contact--- less continuity
• Less operative experience (??)
• Responsibilities have shifted
  – To less number of individuals
  – To senior persons
  – More stress… (on whom???)
RRC Issues: Our Strengths

- Clinical volume
  - We need to prove it by documentation
- Number and diversity of cases
  - We need to prove it by documentation

(outpt clinics, thoracic, endocrine)
PRINCIPAL COMPONENTS

- head and neck
- breast
- skin and soft tissue
- alimentary tract
- abdomen
- vascular
- trauma and emergency care
- surgical critical care

SECONDARY COMPONENTS

- cardiothoracic
- pediatric
- plastic
- burn care
- urology
- orthopedics
- gynecology
- neurosurgery
- anesthesiology
- endoscopy
RRC Issues: Our Strengths

- Committed Faculty at all sites
  - New young faculty recruited
    - Laparoscopic, oncologic and trauma
- Didactic teaching (conferences)
  - We need to prove this
    - Sign in sheets, quizzes, evaluations, portfolios
- Our academic productivity
  - Very few residents in lab
- **ALL RESIDENTS** get jobs at the end of this trip
RRC Issues: 
Our weaknesses

• Board Pass Rate
  – 62-65% is unacceptable
  – Last year it was 100%
• Number of documented OR Cases
  – Deficiencies in pancreas, liver, trauma, crit care
  – Endoscopy (now 30, will be 80 total)
  – Too many residents?
• Ancillary services at KCHC
• Academics of the faculty
RRC Issues: Fix the weaknesses

• More didactic teaching, using
  – Online quizzes
  – Addition of ACS curriculum
  – Portfolios
• Careful monitoring of Op Logs
  – Real time review more frequently
  – If it isn't entered, we cannot follow it
  – Concentrate on areas we need – endo, crit care, oncology surgery
• Academics of attendings
• Downsize ??
Problems Peculiar to Our Program

• Lack of central organization of the residency
  – Multiple hospitals with different
    • Credentialling, computers, parking, salaries, and MISSIONS
  – Can’t all meet at once
• Recent departures of faculty/residents
• Resident absences for personal and professional reasons
  – FMLA, interviews, wkends off
  – Lack of health insurance in some
  – Rumors
• USMLE step III
• Health insurance issues
What we need

• Realize that SUNY is the only academic med center in Bklyn
• Change (even seismic changes) are good
• Look at the new recruits
• Better Teamwork
  – Less rumors, more facts
  – Feedback- use the evaluations to change things
  – Weekly chiefs meeting
• Better communication
• More Pride in who we are