

LOMA LINDA VA MEDICAL CENTER
GENERAL SURGERY ROTATION
RESIDENT ORIENTATION AND RESPONSIBILITIES

Welcome to the surgical service at the Loma Linda VA Medical Center. This rotation has been an integral part of the residency training program at Loma Linda University for almost 30 years. We want the rotation to be enjoyable, highly educational, and rewarding. There are three surgical services:

Green Service: oncology, thoracic and general surgery. It consists of a 5th year senior resident and three 1st year residents. The senior resident is the administrative chief resident.

Blue Service: bariatrics, foregut, abdominal wall repair, general surgery, gynecology. It consists of a 5th year senior resident and three 1st year residents (2surgery, 1 family medicine).

Red Service: vascular surgery. It consists of 2 senior residents (4th year and 2nd year residents).

SICU: oversees the care of surgical patients from all 3 services in the ICUs. It consists of a 1st year resident.

The senior residents run the services, overseeing patient care activities, solving problems, and assigning junior residents and medical students to OR cases.

1. Rounds

Patients should be divided between the junior residents (including those followed by students). Teaching rounds with both general surgery services and all attendings are held each Friday, and rounds with all 3 services and all attendings are held each Monday. On Tuesday/Wednesday/Thursday, rounds are arranged with the attending on each service. The rounds schedule for the Green/Blue services is Tuesday-Rendon, Wednesday & Thursday – Zmaj. The rounds schedule for the Red Service is: Monday-Thursday to the attending involved in the case, Friday-Bianchi.

2. Dress Code

Residents should not wear scrubs during clinic, attending rounds, or conferences (except when commuting to and from the operating room).

3. Punctuality

Residents must be punctual at clinics, rounds, meetings conferences and the OR. The resident responsible for the first surgical case must be in the OR at 7:30 am for the “time-out”. S/he should help with patient positioning and other preoperative activities. Specific residents and students should be assigned to each case the day before surgery, and should write their names and beeper numbers on the OR board. Residents and students should read about cases the night before. Preferably, residents will scrub on patients they saw in clinic. Residents who are on call or have other responsibilities when their cases are ready should ask one of the other team members for help with ward work during the operation.

4. Consults

Consults should be seen as soon as possible, but always within 24 hours. After the junior resident has seen the consult, it should be “chiefed” by the chief resident on call. If junior residents are unsure about the specifics of a consult (where they should be seen, how often they should be subsequently seen, etc), this should be clarified with the chief resident. All consults must be chiefed by an attending. At the chief resident’s discretion, the attending may be contacted during the night but always by the next day. Other health care personnel should be respected, regardless of the resident’s impression of the appropriateness of the consult.

5. Call

A resident’s lounge is available, with food, 24hr/day when on call. The call rooms are on 3NW: Senior room 3A-15, Junior room 3A-19, Student room 3A-18, and SUBI/Elective 3A-17.

Residents that have been on call in house will leave by 10am the next day. On the weekends, this is accomplished by rounding FIRST on all of the patients seen by the junior resident on call the night before, and that resident is then excused to leave prior to rounds finishing. The junior resident that is on call on Tuesday night continues to be on call Wednesday morning until the teams arrive back in the hospital from Grand Rounds. For major problems that arise, there is a surgery administrator on call 24/7 (see call schedule).

6. Service Rules

- 1) See “Appendix A: Service Rules”
- 2) Assignment of ER/consult general surgery patients
 - a) Oncology and thoracic patients will be assigned to the green service. Gynecology patients will be assigned to the blue service.
 - b) “Unassigned” general surgery patients stay on the senior resident’s service that saw them.

7. Resident Responsibilities Toward Other Surgical Services

The junior resident on call covers emergencies on all other surgical subspecialty services such as Urology, ENT, Orthopedics, etc, where residents are not in house. This coverage is only for emergencies (eg: respiratory failure, chest pain, etc). Once the emergency situation is dealt with, the appropriate resident for that service should be contacted to come and assume patient care.

8. Admission H&Ps

Patients in the hospital less than 24 hr (outpatient surgery, observation, etc.) should have their H&P on the shorter “Surg/Outpatient Short H&P” form. Patients in the hospital more than 24 hours should have the H&P on the longer “History and Physical Examination” form. Either H&P is valid for 30 days. If a patient is readmitted within 30 days of discharge and the admission is related to the prior admission, only an interval note (on a note titled “H&P”) is required. The interval note should refer to the prior H&P, along with relevant details that have changed since the last H&P.

9. Observation

Patients may be in the hospital less than 23 hr on observation status. The “start time” for the 23 hours is when the physician makes the decision to put the patient on observation status. When a patient is placed on observation a 1-2 sentence note (entitled “23-hour initial observation care note”) should say why the patient is being placed in observation. When the patient discharged from observation, another 2-3 sentence note (entitled “23-hour observation discharge note”) should say that the patient’s problem has resolved. A discharge summary is not necessary.

10. Elective Surgery

For clinic patients being scheduled for surgery, several items in the computer are required:

- a. Surgery Scheduling Request Form: electronically in CPRS (orders tab, click on either inpatient or outpatient orders).
- b. H&P: see #9 above.
- c. iMed Consent form: This is completed and signed by the physician, patient, and witness in the clinic. After the physician has completed the consent form and has signed it, s/he is free to leave and let the patient and witness sign together. Be sure to create the consent on a computer in which the patient will be able to sign it.

11. Documentation

- a. Supervision Levels- For operative notes and reports:
 - Level A – staff surgeon alone
 - Level B – attending in OR scrubbed
 - Level C – attending in OR not scrubbed
 - Level D – attending in OR suite (including offices) immediately available
 - Level E – emergency care, attending notified ASAP
 - Level F – non-OR procedure done in OR, attending identified
- b. Cosignature - The cosigning attending is the one that is expected to supervise the patient encounter.
- c. Progress notes – Should be pertinent and brief. Do not template medication/labs/etc. into the progress notes.
- d. Procedures - Use the note entitled “PROCEDURE”. The attending on call should be the cosigner.
- e. Discharge summaries – Be sure the date/location matches the discharge. Otherwise you may be doing a discharge summary for another service.
- f. Minor surgery- Use the two templated notes for “Minor Surgery”, one for the preop note, the other for the procedure note.

12. OR

- a. Elective cases must be scheduled by 10am the day before surgery.
- b. personal clothing that is visible may not be worn under scrubs.
- c. patients can not be left in OR without a surgical team physician.
- d. An attending must see all patients prior to surgery.
- e. Surgical site marking is done by one of the surgical team members in the holding area before surgery. This can be done by a resident.
- f. The “time out” will take place in the OR immediately before the case starts. This can be done with the patient asleep.

13. Clinics

New and preop Patients must be seen with an attending. The only residents excused from clinic are those in the OR or performing urgent on call work. Non-urgent work should be left until after clinic.

14. Miscellaneous Clinical Issues

- a. Beta blockers – (class I evidence) Beta-blockers lower perioperative mortality in CAD patients, and should be used on most patients. While NPO, metoprolol 5mg IV q6 hr may be used (ICU or basic floor). When taking po, use either the preop dose or atenolol 25-50 mg po bid. This can be stopped in the clinic postoperatively if the patient was not taking a beta-blocker preoperatively.
- b. Prophylactic antibiotics – (class I evidence) Prophylactic antibiotics decrease wound infection in some types of surgery. These must be given prior to making an incision, and there is no good evidence that continuing them postoperatively has any effect? Reasonable choice include Cefoxitin 2 g IV for bowel cases and Cefazolin 102 g IV for selected UGI and skin cases.
- c. DVT prophylaxis – (class I evidence) DVT prophylaxis decreases DVT and PE. All patients undergoing general anesthetic should receive DVT prophylaxis. Patients with higher risk (e.g.: Malignancy, abdominal surgery, obesity, etc.) may need 2 types of prophylaxis. Good choices for general surgery patients include SCDs and low dose unfractionated heparin (5000U sq q8 hr). DVT prophylaxis should continue until the patient leaves the hospital (and sometimes after that). There is no good evidence that low molecular weight heparin is superior to low dose unfractionated heparin for DVT prophylaxis in general surgery.
- d. Patient controlled analgesia – PCAs eliminate the problems in patients having to wait for busy nurses to deliver “pm” pain medications. PCAs should almost always be used instead of prn IV narcotics. Reasonable starting orders are for MS, basal 1 mg/hr, and demand 1 mg q 10 min.
- e. Nutritional Monitoring - The nutritional status of patients on TPN or tube feeding should be monitored with serum transthyretin and albumin (CHEM 13) levels every Monday.
- f. NG tubes - Patients that develop nausea or vomiting should be carefully evaluated to determine if they need an NG tube. Nausea inappropriately treated with antiemetics can result in aspiration and death.
- g. Ventilators – This facility has an instructional protocol in which patients that meet criteria for extubation can be extubated according to that protocol. If you have a patient that should not be

extubated for medical reasons, you should write an order that the patient should not be extubated for medical reasons until the respiratory therapists have spoken to you.

15. Clinical Trials

The surgical service actively participates in clinical trials. Currently Drs M Reeves and Bianchi have protocols that are actively accruing patients. Speak to them about enrolling patients to these trials.

16. Tumor Board

Tumor board is held each Wednesday at 1pm in the surgical conference room. The green chief resident is responsible for tumor board, and will assign tumor board patients to students or junior residents for presentation.

17. M&M

M&M is held each Wednesday at 7:00 am at LLUMC. A program support assistant will create an M&M list for the three services by Friday on the “S” drive. The senior residents must edit their list by 8am on Monday, and inform the program support assistant that editing is complete. The senior residents should edit for correct medical terminology, spelling/grammar, admission/discharge statistics and notations for patients suffering morbidity or mortality. A form must be completed for each occurrence.

18. After Hours OR/Studies/Transfer

OR – to activate the OR after hours, page the nursing supervisor (x5005 or pager 7220), who will make all arrangements. If you have time, call the on call CRNA to discuss the surgical issues that will be of interest to anesthesia.

CT/US - To obtain CT scans or ultrasounds on evenings, weekends, and holidays, use the “Outside Business Hours CT/US” button on the surgery order screen. The technician will automatically be paged, and the study will be done. You don’t need to do anything other than to press the order button.

Transfers – To transfer patients to other hospitals (ie: LLUMC for tests), talk to the doctor at the receiving hospital, fill out the gold “transfer form”, and page the nursing supervisor (x5005 or pager 7220). S/he will pick up the gold “transfer form” from you and make all arrangements. If you are called by a doctor or hospital to accept a patient in transfer from another hospital, refer the call to the ER

19. ICU Service

A first year surgery resident will oversee the care of ICU patients from all 3 services. This resident will be responsible for the ICU patients on weekdays until approximately 6pm, at which time care for these patients will be handed off to the junior resident on call? This “hand off” should start around 5pm. The ICU resident will see all of the ICU patients, and then make rounds with each of the three services that have patients in the ICU.

20. Family Medicine Residents

- a. During July-December, the family medicine resident will do an ambulatory rotation. This will consist of a standard rotation except that there will be no inpatient responsibilities or call.
- b. During January-June, the family medicine resident will do a standard rotation. This will consist of both inpatient and outpatient care.
- c. During the last 6 months of standard rotations, the family medicine resident will take inpatient call as the junior resident each Monday.
- e. The daily schedule will be:
 - 1) Monday – OR with C. Reeves
 - 2) Tuesday am – Clinic
 - 3) Wednesday – Clinic
 - 4) Thursday-Minor surgery clinic
 - 5) Friday am – Clinic

21. Medical Records

- a. Post op notes-must be completed before the patient leaves and PACU
- b. Operative dictation-must be completed on the day of surgery
- c. History and physical-must be completed within 24 hr of admission
- d. Discharge summary-must be completed within 24 hr of discharge

Residents will be paged when medical records become delinquent. If they are not completed, the attending will be paged to complete them. If they are still not completed, the chief of service will be paged to complete them. Residents will not pass the rotation until medical records are completed. Outside computer access (<https://citrix.lom.med.va.gov>) can be used to complete VA medical records.

22. Inpatient Nurse Practitioner

Frenalyn Domingo is the surgery inpatient nurse practitioner. She is an immense resource for inpatient care. You should rely on her to help carry out patient care items that are not completed on morning rounds. She can be reached by phone (x5021) or pager (f.domingo@archwireless.net) or 7471.

23. Teaching

This is an academic surgical service and teaching is one of its strengths. In addition to didactic teaching there is daily teaching on rounds and in the operating room. Part of student teaching is a 15 min period at the end of the cases for students to suture the subcutaneous tissue and skin.

Welcome Again!

Antonio Robles, M.D.
Chief, Surgical Service

Kristine Zmaj, M.D.
Director, VA Surgical Residency

Appendix A: Service Rules

- 1) 3 services
 - a) Green
 - i) General
 - ii) Concentrating on oncology and thoracic
 - iii) Attendings: M. Reeves, K. Zmaj, C. Reeves
 - iv) Residents: R5, R1, R1, R1
 - b) Blue
 - i) General
 - ii) Concentrating on advanced laparoscopy (bariatrics, foregut, hernia repair), Gyn
 - iii) Attendings: A. Robles, S. Rendon, J. Rivera
 - iv) Residents: R5, R1, R1 and 1 Family Practice Resident
 - c) Red
 - i) Vascular
 - ii) Attendings: C. Bianchi, T. Teruya, R. Vannix, J. Hopewell
 - iii) Residents: R4, R2
- 2) Summary: General surgery will be covered by green/blue and vascular surgery will be covered by red at all times except week nights.
- 3) Call
 - a) Week Days
 - i) Either Green or Blue will be on call for general surgery
 - (1) The R5 (and one R1) from that team will be listed as the on call senior (and junior) residents, until 5 pm. They will take all of the general surgery consults/admissions until 5 pm. After 5 pm, general surgery consults/admissions will go to the night call team (see 3b below)
 - ii) Red will be on call for vascular surgery
 - (1) Either the red R2 or R4 will be listed as the on call vascular resident until 5 pm. They will take all of the vascular surgery consults/admissions until 5pm. After 5 pm, vascular surgery consults/admissions will go to the night call team (see 3b below)
 - b) Week nights
 - i) The call team (consisting of a home call senior resident (R2-5) and an in house junior resident (R1) will be on call for both general and vascular surgery. In the morning of the next day, patients will be passed to the appropriate service as follows:
 - (1) General surgery patients will go to either Green or Blue, whichever was on call during the prior day.
 - (2) Vascular surgery patients will go to Red
 - c) Weekends
 - i) Either Green or Blue will be on call for general surgery
 - (1) The R5 (home call) and various R1s on different days (in house) from that team will be listed as the on call senior and junior residents. They will take all of the general surgery consults/admissions. The on call intern will take the floor calls for the general surgery inpatients.
 - ii) Red will be on call for vascular surgery

- (1) Either the red R2 or R4 (home call) will be listed as the on call vascular resident. They will take all of the vascular surgery consults/admissions. The on call intern will take the floor calls for the vascular surgery inpatients.
 - d) Family Practice Resident (Inpatient)
 - i) Takes call on Monday and follows same protocol as (3B above)
- 4) Rounds
 - a) Week days
 - i) General surgery
 - (1) Residents from each service will rounds on only their own patients
 - (2) Attendings:
 - (a) Mon: attending rounds
 - (b) Tues: Rendon
 - (c) Wed: Zmaj
 - (d) Thurs: Zmaj
 - (e) Fri: attending rounds
 - ii) Vascular surgery
 - (1) Residents from each service will round on only their own patients
 - (2) Attendings
 - (a) Mon: attending rounds
 - (b) Tues-Fri: arranged per attendings
 - b) Weekends
 - i) General surgery
 - (1) Both Green and Blue rounded on by the on call general surgery team (R5, 2 R1s, 1 SICU), and the on call general surgery attending
 - ii) Vascular surgery
 - (1) Red rounded on by the vascular resident (r2 or R4), and the on call vascular attending
 - c) Attending rounds
 - i) Monday 7 am –SICU
 - (1) Attended by all 3 service (Green, Blue, Red)
 - (2) All patients from all e services seen
 - ii) Friday 7 am – SICU
 - (1) Attended by general surgery services (Green, Blue)
 - (2) All general surgery patients (green, blue) seen
- 5) Clinic
 - a) Resident primary responsibility for clinic will be for their service clinics
- 6) Miscellaneous
 - a) SICU
 - i) Attending
 - (1) Staffed every other week by M. Eby and V. Seabaugh
 - ii) Resident
 - (1) Covered week days (until 5 pm) by R1 SICU resident
 - (2) Every other weekend rounds by SICU resident and resident on anesthesia
 - (3) During weekend rounds, the SICU resident does not see the red patients
 - b) Resident issues
 - i) K. Zmaj will have overall responsibility for surgical residents at VA

- ii) The following attendings will be responsible for the day to day conduct of resident issues and resident evaluations on their service.
 - (1) Green – K. Zmaj
 - (2) Blue – S. Rendon
 - (3) Red- C. Bianchi
- c) Resident vacation
 - i) The R2 and R4 on Red can never be on vacation at the same time
 - ii) No more than 2 residents from the 10 surgery residents (SICU, green, blue, red) can be on vacation at any given time.