Guidelines for Promotion from the PGY2 to PGY3 Level of Training in General Surgery
(May 2015)

The following guidelines should be considered in the promotion of PGY2 residents.

<u>Overall</u>

1. The resident should achieve a minimum overall global evaluation of 3 on each ITER over the academic year. CanMeds - All

2. The resident should have successful completion of the mentorship assignment. CanMeds - Scholar, Manager

3. The resident should have successfully completed the POS exam (unless excused by the PD because of extenuating circumstances) CanMeds - Medical Expert

4. The resident should have adequate performance (overall >68%) on the annual oral examination. CanMeds - Medical Expert, Communicator

5. The resident should have completed the FLS course. CanMeds - Medical Expert, Technical

6. Completion of all required PGCorEd modules by May 31st. CanMeds - non medical expert roles

Diagnosis and management of common presentations:

1. Based upon the resident's clinical performance and evaluations, the RPC should be confident in the resident's ability to diagnose or exclude from the differential diagnosis acute cholecytitis. The resident should be able to develop a management plan for patients with acute cholecytitis, including appropriate antibiotic treatment and timing of surgery and an understanding of the role of cholecystostomy tubes in selected patients. CanMeds - Medical Expert

2. Based upon the resident's clinical performance and evaluations, the RPC should be confident in the resident's ability to diagnose and develop a management plan for recurrent biliary colic, including timing of surgery. CanMeds - Medical Expert

3. Based upon the resident's clinical performance and evaluations the RPC should be confident in the resident's ability to diagnose and develop a management plan for acute cholangitis including need for antibiotics, timing, indications and methods of duct decompression and complications of these procedures. CanMeds - Medical Expert

4. Based upon the resident's clinical performance and evaluations, the RPC should be confident in the resident's ability to diagnose and create a plan of management for acute biliary pancreatitis, including initial resuscitation, investigations, radiologic and clinical scoring systems, management of nutritional issues, indications for interventional or surgical drainage of collections, management of pseudocyts, timing and indications for surgical debridement. CanMeds - Medical Expert

5. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to diagnose and council a patient in clinic or in the emergency department about the management of an inguinal hernia, including timing and indications for surgery. CanMeds - Medical Expert

6. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to diagnose and manage early post-op bowel obstruction, including timing and indications for surgery and management of nutrition. CanMeds - Medical Expert, Communicator

7. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to diagnosis or exclude from the diagnosis diverticulitis. This includes the ability of residents to describe the Hinchey classification of diverticulitis and appropriate medical, interventional and surgical techniques using this classification schema. CanMeds - Medical Expert

Patient discussions and performance of common procedures:

1. The resident should have submitted 3 completed OPRS forms for elective cholecystectomy for biliary colic with a minimum of 3s in each category by May 31st of the academic year. It is expected that a PGY2 resident should be able to complete a straightforward operation with minimal or some direction (see appended OPRS form) CanMeds - Medical Expert, Technical

2. The resident should have submitted 3 completed operative dictations to the PDs office by May 31st of the academic year. These dictations should be kept for the resident's portfolio CanMeds -Medical Expert, Communicator

3. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to independently gain consent for a cholecystecotmy in a non-pregnant patient, with appropriate attention to correctly explaining risks, benefits, common and severe complications. CanMeds - Medical Expert, Communicator

4. The resident should have submitted (to the PD) 3 completed (dictated) de-identified consultation notes for common General Surgery problems and 3 completed de-identified (dictated) operative notes for management of biliary colic. These should also be kept by the resident for their portfolio. CanMeds - Communicator

5. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability under the supervision of a faculty member or senior resident to complete maturation of a stoma in a clinically stable patient. CanMeds - Medical Expert, Technical

6. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to complete an upper endoscopy with minimal supervision and reach the TI during an uncomplicated colonoscopy in most cases with supervision. CanMeds - Medical Expert

7. The resident should have submitted (to the PD) 4 completed Resident Colonoscopy Assessment forms for the endoscopy rotation. These forms are to be submitted by May 31st of the academic year.

Patient Care and Management:

1. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to develop a management plan for post-operative management of patients who have undergone elective intestinal surgery including demonstration of fast track principles, including pain and symptom management. CanMeds - Medical Expert

2. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to satisfactorily complete the surgical briefing, the surgical safety checklist and debriefing for patients undergoing elective surgery. CanMeds - Communicator, Medical Expert

3. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to recognize patients who require surgical source control of hemorrhage or infection in the ICU setting. CanMeds – Medical Expert

4. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to develop collaborative care plans for ill patients with outreach and ICU teams CanMeds - Collaborator

5. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to safely handover patients following an on-call period. This includes accurate, timely completion of e-signout tools, accuracy and appropriateness of verbal communication following on call periods or at the conclusion of a regular work day. CanMeds – Communicator, Professional

Teaching:

1. Based upon clinical performance and evaluations, the RPC should be confident in the resident's ability to teach senior medical students about common problems in General Surgery, including appendicitis and incarcerated inguinal hernia, and post-operative problems, such as infectious complications and management of derangements in intravascular status. CanMeds – Medical Expert, Scholar

Operative Performance Rating System (OPRS)

LAPAROSCOPIC CHOLECYSTECTOMY

Evaluator:	**Resident:**
Resident Level:	**Program:**

Date of Procedure:	**Time Procedure Was Completed:**
Date Assessment Was Completed:	**Time Assessment Was Initiated:**

Please rate this resident's performance during this operative procedure. For most criteria, the caption above each checkbox provides descriptive anchors for 3 of the 5 points on the rating scale. "NA" (not applicable) should only be selected when the resident did not perform that part of the procedure.

Case Difficulty

1	2	3
Straightforward anatomy, no related prior surgeries or treatment	Intermediate difficulty	Abnormal anatomy, extensive pathology, related prior surgeries or treatment (for example radiation), or obesity
☐	☐	☐

Degree of Prompting or Direction

1	2	3
Minimal direction by attending. Resident performs all steps and directs the surgical team independently with minimum or no direction from the attending, to either the resident or to the surgical team.	Some direction by attending. Resident performs all steps but the attending provides occasional direction to the resident and /or to the surgical team.	Substantial direction by attending. Resident performs all steps but the attending provides constant direction to the resident and surgical team.
☐	☐	☐

Published with permission of Southern Illinois University Department of Surgery

Procedure-Specific Criteria

Incision / Port Placement

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Safe, efficient and optimal positioning of ports for procedure and anatomy		Functional but somewhat awkward port positioning; generally safe technique; some difficulty inserting ports		Poor choice of port position; unsafe technique in insertion or removal	
☐	☐	☐	☐	☐	☐

Exposure

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Optimizes exposure of Calot's triangle, efficiently directs gallbladder retraction and camera to maintain exposure and pneumoperitoneum		Adequate establishment and maintenance of pneumoperitoneum, camera angle and retraction but with occasional loss of exposure of key structures		Poor/inadequate pneumoperitoneum, camera angle and retraction with frequent loss of exposure of key structures	
☐	☐	☐	☐	☐	☐

Cystic Duct Dissection

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Expedient dissection, safe clip placement and duct division		Adequate but inefficient dissection, clips secure but spacing not ideal		Dissection of duct inadequate to place clips and divide safely	
☐	☐	☐	☐	☐	☐

Cystic Artery Dissection

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Expedient dissection, safe clip placement and artery division		Adequate but inefficient dissection, clips secure but spacing not ideal		Artery dissection inadequate to place clips and divide; excessive hemorrhage; used more than 8 clips	
☐	☐	☐	☐	☐	☐

Gallbladder Dissection

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Efficient; maintained clean plane between gallbladder and liver bed throughout, no parenchymal injury or bile spillage		Removed gallbladder intact but strayed from plane, somewhat inefficient, minimal bile spilled; extra cautery needed for liver bleeding		Inefficient; did not cleanly remove gallbladder; excessive bile spillage; repeated injury to liver parenchyma	
☐	☐	☐	☐	☐	☐

General Criteria

Instrument Handling

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Fluid movements with instruments *consistently* using appropriate force, keeping tips in view, and placing clips securely		Competent use of instruments, *occasionally* appeared awkward or did not visualize instrument tips		Tentative or awkward movements, *often* did not visualize tips of instrument or clips poorly placed	
☐	☐	☐	☐	☐	☐

Respect for Tissue

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Consistently handled tissue carefully (appropriately), minimal tissue damage		Careful tissue handling, *occasional* inadvertent damage		*Frequent* unnecessary tissue force or damage by inappropriate instrument use	
☐	☐	☐	☐	☐	☐

Time and Motion

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Clear economy of motion, and maximum efficiency		Efficient time and motion, some unnecessary moves		Many unnecessary moves	
☐	☐	☐	☐	☐	☐

Operation Flow

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
Obviously planned course of operation and anticipation of next steps		Some forward planning, reasonable procedure progression		Frequent lack of forward progression; frequently stopped operating and seemed unsure of next move	
☐	☐	☐	☐	☐	☐

Overall Performance

Rating of 4 or higher indicates technically proficient performance (i.e., resident is ready to perform operation independently, assuming resident consistently performs at this level)

5 Excellent	4 Very Good	3 Good	2 Fair	1 Poor	NA
☐	☐	☐	☐	☐	☐

Please indicate the weaknesses in this resident's performance:

Please indicate the strengths in this resident's performance:

Resident Colonoscopy Assessment

Resident: **Date:** **Cecal Intubation Rate:**

		Scope completed	If not completed furthest point reached
Case 1	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 2	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 3	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 4	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 5	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 6	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 7	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 8	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 9	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon
Case 10	Sex M F Case difficulty easy average difficult	Cecum TI	Sigmoid Left colon splenic flexure Transverse colon hepatic flexure Right colon

# of POLYPECTOMIES:

COMMENTS: