THORACIC SURGERY RESIDENCY HANDBOOK

2015-2016
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1. Program Overview

The Texas Heart Institute/Baylor College of Medicine Thoracic Surgery Residency is a three-year program that accepts four residents annually. The program director is Denton A. Cooley, M.D. and Division Chief Joseph S. Coselli, M.D. serves as associate program director.

The program's core values are integrity, respect for the individual, continuous commitment to excellence, dedication to discovery/innovation, and fostering leadership through education and teaching. These values are expressed through a program providing comprehensive training in adult and pediatric thoracic and cardiac surgery in an environment that stresses clinical excellence, clinical and basic research, and teaching as long-term goals for graduates.

To be eligible to apply, candidates must have successfully completed five years of an ACGME-accredited General Surgery Residency Program and be eligible for examination by the American Board of Surgery.

The program emphasizes the central role of the residents in the management of thoracic surgical patients. It strives to impart core values as lifelong goals for the residents and seeks to help them become educators for life. In recognizing the relatively senior status and long clinical experience of the thoracic residents - and the highly competitive nature of the selection process for this program - residents are viewed as colleagues as well as students, and it is considered a privilege to work with them. Residents obtain a large and diverse clinical experience of decision-making and hands-on operative experience.
A. Faculty and Staff

Faculty:
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Assistant, Peyton Davis: pcdavis@bcm.edu

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B. Clinical Training in Thoracic Surgery Residency

During the first year, residents spend three months on the cardiothoracic surgery service at each of the following institutions: Baylor St. Luke's Medical Center, Texas Children's Hospital, Michael E. DeBakey Veterans Affairs Medical Center, and MD Anderson Cancer Center.

This provides a broad diversity of experience that includes adult thoracic and cardiac surgery at the Texas Heart Institute at Baylor St. Luke's Medical Center; pediatric surgery at the nationally and internationally known pediatric surgical service at Texas Children's Hospital; experience on a thoracic oncology service at a world-respected oncology hospital, MD Anderson Cancer Center; and a large general thoracic and cardiac surgical experience at the Michael E. DeBakey Veterans Affairs Medical Center, one of the largest Veterans Affairs Medical Centers in the United States.

At the Michael E. DeBakey Veterans Affairs Medical Center, the first-year thoracic surgery resident works with a second-year resident to run a busy service that includes general thoracic and adult cardiac responsibilities and handles more than 500 cases annually. At Texas Children's Hospital, the resident participates in an equally active pediatric cardiovascular service that does more than 900 cases each year. Similarly, the resident participates in a thoracic oncology service at MD Anderson Cancer Center that undertakes more than 1,000 cases per year and in an adult cardiac and general thoracic service at Baylor St. Luke's Medical Center that undertakes more than 2,500 cases per year.

The second year thoracic surgery residents are assigned to three-month rotations at Ben Taub Hospital and the Michael E. DeBakey Veterans Affairs Medical Center, and six months at Baylor St. Luke's Medical Center. The resident at the Ben Taub Hospital is the only thoracic surgery resident covering a large thoracic trauma, general thoracic, and adult cardiac service, with more than 500 cases per year.

Once they reach their third year, thoracic surgery residents return to Baylor St. Luke's Medical Center where they serve as chief residents.

Click here to view a list of the members of the Thoracic Surgery Faculty.
### C. Thoracic Surgery Resident Rotation Schedule 2015-2016

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**Administrative Chief Resident:**
- Ellington
- Joymon
- Carillo
- Akvan

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**THI-A:** Reul, Livesay and Cozart

**THI-B:** Ott, Duncan and Hallman
D. Conference Schedules

The Department is dedicated to providing an excellent educational experience for residents. We know that much learning occurs during clinical experiences, such as seeing outpatients or performing surgeries. We also realize that didactic lectures and conferences are an integral part of increasing a resident’s knowledge base. Therefore, we have set aside dedicated time for these lectures and conferences. Attendance at these meetings is mandatory, and attendance is taken. The Wednesday morning conference time is protected time, and the resident is relieved of clinical duties during this time to attend these conferences. The conferences are broken into 3 sections: Adult Cardiac, Congenital, and General Thoracic.

*** Please see Appendix #1 for 2015-2016 conference schedules. Schedules may change over the course of the academic year.

SESATS

The SESATS review is scheduled each Monday morning at 6:30 am with Dr. Preventza. The SESATS program is a self-study and examination, published by the American Board of Thoracic Surgery, intended to be used by thoracic surgeons as a comprehensive computer-based tool to study and review essential aspects of cardiac and thoracic surgery.

Department of Surgery Grand Rounds

The Department Grand Rounds are scheduled each Wednesday morning, from September to May of each academic year, with a combination of local faculty and outstanding regional or national speakers. Topics include general, cardiothoracic, vascular, pediatric, and plastic surgery. Attendance at Grand Rounds is required for all surgical residents.

E. Basic Principles of Thoracic Surgery

Case coverage

1. All the attendings assigned to the services should be covered
2. Cases should be prioritized. Some of the attendings have additional help (i.e. PA’s, postdoctoral fellows, students etc.)
3. Be aware of add-on cases
4. Dictate op note as soon as the case is finished and write the work number
5. The day is not over until the last case is done
6. Don’t leave without checking X-rays, labs etc.
7. Coverage during meetings, vacations or special cases should be assigned by the administrative chief
8. All the beeper messages should be answered PROMPTLY

Rounds

1. Patient rounds should be done on a daily basis, regardless of type of case or post-op day, unless a sign-off note has been written
2. ICU patients should be visited at least twice a day
3. Continuous communication with attending is emphasized
4. All incisions and wound should be checked periodically especially before discharging the patient
5. Vital signs and labs should be checked periodically and before discharging the patient
6. You or the attending should contact as much as possible consultant physicians. This will decrease the errors secondary to miscommunication
7. Be clear and thorough in your discharge orders (activity, shower, follow up etc.) they seem to be trivial points for us but not for the patient

**Check Out**

1. All the residents in clinical rotations should contact the resident on call to let him/her know about patients, especially those in critical condition.
2. Try to check all X-rays and labs before leaving the hospital.
3. Let the resident on call know about expected patients in transfer, site of admission, diagnosis, plans and what attending should be contacted upon arrival.

**Weekday Calls**

1. It is divided in first call and back up call.
2. Call duty is from 6:00 pm to 7:00 am.
3. All beeper messages should be answered promptly, the backup resident should have his/her beeper ON and remain within hospital range.
4. In all critical or questionable situations as well for transfers or new consults, the resident on call should evaluate the cases personally.
5. At the end of the shift, the resident on call should update the rest of the clinical services residents of admissions as well as changes on their patients’ status.
6. The VA fellow will take call at the VA Hospital only while on that rotation.

**Weekend Calls (Friday-Monday)**

1. It is home call.
2. Call duty is from 7:00 am to 7:00 am.
3. Cases during the weekend should be covered by the resident on call.
4. There will be teams of two residents (one PGY 7 and one PGY 6) to cover during the weekend. One will be first call and the other back up. The team will round in all in-house patients. The rest of the residents will be off.

**Policy and Procedure for Time Off**

To ensure that the well-being of each resident and also the facilitation of superior patient care are maintained, a Resident Duty Hours Policy has been established and under the requirement of ACGME compliance.

In accordance with ACGME standards, the Thoracic Surgery Residency Program adheres to the general standards relating to duty hours. Residents will work 10-12 hour days per week; with at least one 24-hour off duty period per week, and limiting shifts to a maximum of 24 consecutive hours. The resident will typically receive every other weekend off. Also, on-call shifts would be no more frequent than every third night and residents would have a minimum of 10 hours off between shifts.

With a program of this size there are clearly numerous periods when fellows will have to leave rotations for vacation, job interviews, meetings, and personal reasons. It is clearly a matter of courtesy, quality in patient care and efficiency in running the service to insure that the responsible attending is made aware of planned absences from that service. The following procedures will be instated immediately to provide for appropriate communication between fellows and the affected service.

In the event of planned departures for events such as vacation, job interview, meeting, or personal reasons, the residents must fill out “Time-Off” request to the program coordinator in the Surgery Education office. Please also submit your request by email to a) Program Director, and b) Program Coordinator, and c) Administrative Chief Resident. Appropriate coverage of call schedule must be coordinated with the Administrative Chief Resident. In the case of emergency whereby immediate departure is necessary, please contact the Program Director and Administrative Chief Resident directly. This time off must also be documented in the duty hours submitted to GME.
1. Thoracic Surgery will comply with resident duty hour requirements
2. Residents will not be scheduled for more than 80 hours per week, averaged over a four-week period
3. One day in seven free of patient care responsibilities, averaged over a four-week period
4. Call no more frequently than every third night, averaged over a four-week period
5. A 24-hour limit on-call duty, with an added period of up to 6 hours for continuity and transfer of care, educational debriefing and didactic activities; no new patients may be accepted after 24 hours
6. A 10-hour minimum rest period will be provided between duty periods
7. When resident takes call from home and is called into the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit

**Vacation Policy/Time-Off**

All residents and fellows are provided 44 paid days off per academic year (July 1 – June 30). This time off is non-vested (meaning you are not paid for it if you leave before having utilized), does not accrue, and does not roll over from one academic year to the next. These 44 days include: 21 vacation days, 14 sick days (to be used only for personal illness), and 9 Paid Time Off (PTO) Days.

1. Vacation days should be scheduled in advance at least three months prior to each rotation
2. Vacation requests must go to the Academic Coordinator first and the Coordinator will process approvals for the faculty.
3. If you need to change your vacation time and/or need to be off (personal, conference, wedding, etc.), you will need to e-mail the Program Director and Academic Coordinator of the planned absence. Please also notify the Administrative Chief resident and the affected attending(s). Should something arise which necessitates immediate departure, you are to notify the Program Director and the Administrative Chief resident.
4. No two residents on the clinical services may be on vacation at the same time.
5. BCM Holidays (Labor Day, Independence Day, etc.) will be divided equally.
6. Time off is also in compliance by the American College of Surgeon and time of clinical training.
7. Please note vacation time off will not be allowed the last 2 weeks of June.
8. Each resident’s contract period is from July 1st to June 30th.
2. Graduate Medical Education House Staff Policies

Please see the following Baylor College of Medicine website http://intranet.bcm.edu/index.cfm?fuseaction=Policies.Policies&area=25 for complete and up to date information about GME policies and procedures.

BCM Policies and Procedures
Graduate Medical Education

GME Leadership

- **25.1.1** - Administrative Structure, GMEC, Designated Institutional Official

**Recruitment and Selection of House Staff; Eligibility & Appointment Requirements**

**Hiring: House Staff Physicians**

- **25.2.1** – Recruitment/Selection of House Staff Physicians
- **25.2.2** - Requirements for Appointment
- **25.2.3** - Financial Support for House Staff Physicians
- **25.4.1** - Responsibilities of House Staff Physicians

**Recruitment**

It is the policy of Baylor College of Medicine that recruitment into all graduate medical education programs at this institution follow the guidelines of fair practice established by the National Residency Matching Program (NRMP). This includes supplying all applicants who interview with a sample copy of the house staff physician contract. All applicants will be treated equally. No discrimination based on gender, age, nationality, ethnicity, religious background or sexual preference will be tolerated.

**Selection of House Staff Physicians**

Selection of house staff physicians shall not be influenced by race, gender, age, religion, color, national origin, disability, veteran status, or sexual orientation, but shall be based upon such factors as preparedness, ability, aptitude, academic credentials, communication skills, motivation, and integrity.

The selection of Thoracic Surgery Residents is via the NRMP Match (through ERAS). A Resident Selection Committee is led by the Program Director and Associate Program Director to assist them in the selection process of qualified applicants for training in Thoracic Surgery at the Texas Heart Institute/Baylor College of Medicine.

1. Applicants are eligible for appointment with one of the following qualifications:
   a. Graduates of medical schools in the United States and Canada accredited by the LCME.
   c. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
      i. Have received a valid certificate from the ECFMG.
      ii. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
   d. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
2. The resident applicant must apply through ERAS and the NRMP (Match) for Thoracic Surgery.
3. The resident applicant’s application is reviewed by the Program Director and Associate Program Director and/or their designees.
4. The resident applicant is interviewed by at least two faculty members.
5. The Program Director and Associate Program Director, with the assistance of the Resident Selection Committee, establish the rank order of applicants for the Thoracic Surgery Match.
6. The Program Director and Associate Program Director provide the selected applicants with a contract for one year of training at the PGY6 level (first year of Thoracic Surgery).
7. The applicant must qualify for a Texas Educational Permit or have an active Texas license to practice medicine.

The goal of the Resident Selection Committee is to select and match the best-qualified applicants for the program based on factors as outlined above.

Responsibilities of House Staff:

**Responsibilities and Policies: House Staff Physicians**

- 25.3.2 - Change in Specialty or Program
- 25.4.11 - Committee Assignments
- 25.4.2 - Communication
- 25.5.2 - Disaster Response
- 25.4.3 - Duty Hours Policy
- 25.5.3 - Evaluations
- 25.4.12 - Grievances
- 25.3.3 - Insurance / Benefits
- 25.3.5 - Leaves of Absence and Vacation
- 25.4.4 - Medical Records - Affiliated Hospitals/ BCM Owned Patient Care Facilities
- 25.3.6 - Moonlighting Policy
- 25.4.6 - Physician-Patient Relationships
- 25.3.4 - Prohibition of Restrictive Covenants
- 25.4.7 - Sexual Harassment Policy
- 25.4.8 - Vendor Interactions Policy

House staff physicians shall abide by BCM’s drug-free workplace policy. This policy can be found on the BCM intranet website under “Employee Relations → Substance Abuse” at [http://intranet.bcm.edu/?fuseaction=home.showpage&tmp=hr/employeerelations/subabuse](http://intranet.bcm.edu/?fuseaction=home.showpage&tmp=hr/employeerelations/subabuse).

**Reappointment**

**Program Methods for Assessment & Criteria for Promotion**

The Surgery Education Office and the Program Director and Associate Program Director review the evaluations from each rotation. Problem areas are discussed further with the Thoracic Surgery Education Committee that meets every month. Problems noted are considered and corrective actions are discussed.

Annual promotions are made contingent on satisfactory performance within the core competencies and are decided upon by the Thoracic Surgery Education Committee each January.

The following performance assessment approaches are used by the Thoracic Surgery Residency Program to determine residents’ eligibility for advancement from one rotation to the next and from one year/level of training to the next, as well as completion of the program and graduation:
- Core competency evaluations completed by supervising faculty for each rotation
- Evaluations completed by medical students
- Self-assessment evaluations
- Direct and indirect supervision and evaluation by the Program Director and Associate Program Director
- Semi-annual evaluations by Program Director and Associate Program Director
Mechanism for Remediation and/or Disciplinary Action

Failure of a resident to meet any one of the criteria for advancement will result in the following steps to be taken by the Program:

- The Program Director and Associate Program Director will counsel the resident regarding performance deficiency(ies), revisit the goals and objectives of the rotations and expectations of the program, and review the resident’s overall performance in the training program.
- The Program Director and Associate Program Director will provide information to the Surgery Education Committee for the Committee to convene and discuss the resident’s performance and to make recommendations and plans for remedial action in writing to the Program Director and Associate Program Director. The recommendations of the Surgery Education Committee are based on the severity of the deficiencies and on a majority vote (two-thirds) of the committee.
- The Program Director and Associate Program Director will meet with the resident again and provide a letter to the resident outlining the recommendations and plans for remedial action for acknowledgment and dated signature. If the resident is not available, the letter will be sent by certified mail (return receipt requested) to the resident’s address on file.
- The Program Director and Associate Program Director will present outcomes of remedial plans and overall performance of the resident to the Surgery Education Committee on a monthly basis.

Appeal of Non-Reappointment

Please refer to the BCM intranet website as follows for detailed information regarding appeal of non-appointment: http://intranet.bcm.edu/index.cfm?fuseaction=Content.Policies&area=25&expand=5

Responsibilities and Policies: Programs

- 25.5.4 - Reappointment and Promotion
- 25.5.5 - Record Retention
- 25.5.6 - Residency Closure / Reduction
- 25.5.11 - Completion of Training

Adverse Actions: House Staff Physicians

- 25.6.1 - Adverse Actions
- 25.6.2 - Appeal of Adverse Actions
- 25.6.4 - Conduct of Adverse Actions Hearings

The Program bases the policy regarding non-reappointment on the Baylor College of Medicine Graduate Medical Education policy 25.4.2 governing “Appeal of Non-Reappointment.”

Appeal of Non-Promotion

In the event that the Surgery Education Committee determines that a resident is not progressing as expected, remediation (non-promotion) may be required. Remediation will be considered for any resident that fails to achieve proficiency in any one of the six ACGME core competencies. Residents may seek appeal of non-promotion using the Graduate Medical Education policy “Appeal of Non-Promotion.”
Adverse Action

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy 25.6.1 governing “Adverse Action.”

Appeal of Probation

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy 25.6.2 governing “Appeal of Probation.”

Grievances and Due Process

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy 25.4.12 governing “House Staff Grievance Procedures and Due Process.”

Texas Medical Board Reporting

Duty to Report

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy governing “Texas Medical Board Reporting” as outlined by the Texas State Board of Medical Examiners (www.tsbme.org).

Sexual Harassment

It is the policy of Baylor College of Medicine (BCM) to provide a work environment free from sexual harassment in accordance with all state and federal laws. Any resident/fellow who wishes to report an incident of sexual harassment should contact the Office of Graduate Medical Education or the Office of Employee Relations, if he or she does not wish to report the incident to his/her program director. Reports may also be made anonymously, or not, to the BCM Integrity Hotline at 855-764-7292.

Vendor Interaction Policy

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy 25.4.8 governing “Vendor Interaction.”

Disaster Policy

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy 25.5.2 governing “Disaster Response.”

Vacations and Leaves of Absence

All residents and fellows are provided 44 paid days off per academic year (July 1 – June 30). This time off is non-vested (meaning the house staff physician is not paid for it if he or she leaves before having utilized), does not accrue, and does not roll over from one academic year to the next. These 44 days include:

* 21 vacation days
* 14 sick days (to be used only for personal illness)

A treating physician’s statement, from a non-house staff physician, is necessary if the illness or injury extends beyond three (3) consecutive calendar days. In addition, to return to work, a statement is required from the treating physician that stipulates the involved house staff physician is fit to return to duty. Further, if a house-staff physician is absent from work
for more than four (4) non-consecutive days in a calendar month, a statement may be required from the treating physician. The Senior Associate Dean for Graduate Medical Education shall resolve any disputes regarding the house staff physician’s fitness for duty (e.g., disagreements between the house staff physician, program director, or director of the Occupational Health Program).

A house staff physician may be eligible to use sick days under the federal Family and Medical Leave Act (FMLA).

Baylor College of Medicine (BCM), effective July 1, 2014, provides a Core benefit of Short Term Disability (STD) insurance to all residents and fellows. After 44 consecutive calendar days of personal disability (including maternity leave), the STD insurance policy would be available, and provide benefits up to a maximum of 20 weeks. Approval for STD benefits is made by the insurance carrier based on treating physician reports and the type of disability. As a Core benefit STD is provided at no cost to residents and fellows.

These STD benefits would include 60% weekly earnings, up to a maximum of $750 per week for a maximum of 20 weeks depending on the type of disability.

*9 Paid Time Off (PTO) days
This includes personal days, holiday, and educational leave (standard leave). A program is not permitted to provide any additional leave without the written approval of the Office of Graduate Medical Education.

In addition to the standard leave, the following policies will apply.

**Jury Duty:** Paid leave will be provided for jury duty as required by law.

**Military Leave:** House staff physicians with U.S. military obligations are allowed up to 14 calendar days of unpaid military leave per year. House staff physicians whose military obligations exceed 14 days are required to request an unpaid leave of absence. House staff physicians called to active duty will have a residency slot when they are released from such duty, pursuant to federal law. The house staff physician is required to submit to Human Resources – Regulatory Compliance a copy of his or her military orders or written statement from the appropriate military authority as evidence of a call to training or duty.

**Personal Leave:** A male house staff physician may be eligible to take personal leave under the federal Family and Medical Leave Act for the birth of his child, if they meet the minimum criteria for eligibility under the FMLA.

**Unpaid Leave-of-Absence:** A house staff physician may request and take unpaid leave of absence for up to 12 months for personal or family problems with the approval of the program director or his/her designee. Additionally, enrollment with at least half-time status in a degree program at an institution of higher education that is related to the house staff physician’s medical career is an acceptable reason for requesting and being approved for leave of absence. A letter stating the purpose of the leave, arrangements made for completing the Graduate Medical Education (GME) program, and the mechanism for payment of medical, dental, basic life, basic accidental death and dismemberment, short-term and long-term disability insurance premiums, the psychiatric counseling service benefit, and any supplemental benefits, if applicable, shall be signed by both the program director and the house staff physician with a copy kept on file in the Office of GME and the Human Resources – Benefits office. If all or any part of this leave of absence is due to illness or injury, the GME program director shall require a treating physician’s statement. Leave under the federal Family and Medical Leave Act may be granted in accordance with the guidelines set forth in this policy, if applicable.

**Family and Medical Leave Act:** A house staff physician may be eligible for job protection under the federal FMLA for his/her own serious medical condition or that of a spouse, child, or parent. Other qualifying events are the birth of a child or the house staff physician’s adoption or foster placement of a child. Job protection under this law is a maximum of 12 weeks within a 12-month rolling calendar time period. All requests for leave under this law must be reported to the Offices of GME and Human Resources. Final approval shall be made by the Human Resources Regulatory Compliance Office.
In order to be eligible for FMLA, a house staff physician must meet the minimum requirements under the FMLA. The requirements are a minimum of 12 months of employment at BCM (does not have to be consecutive) and at least 1,250 hours worked during the 12 month period immediately preceding the start of the leave of absence.

Absences due to illness, whether the house staff physician’s or a family member’s, must be verified by a completed FMLA medical certification in order to be considered for leave under the FMLA. The medical certification must be completed and signed by the treating physician of the house staff physician or the physician of his/her family member. A statement is required from the court system or the involved social services agency to confirm the foster placement or adoption of a child; a birth certificate, alone, is also acceptable when adopting. A fit for duty certificate (work release) must be presented to Human Resources – Regulatory Compliance no later than the first day the house staff physician returns to work from a leave under the FMLA for his/her own serious health condition.

If the house staff physician and his/her spouse are both employed at BCM, they are limited to a combined total of 12 workweeks of FMLA leave if the reason for the request is for the birth and care of a newborn child, foster care placement, or adoption of a child.

A house staff physician taking leave under FMLA for his/her own health condition must first use sick days, and if necessary, may take any available paid vacation and PTO.

Further information on the Family and Medical Leave Act (FMLA) can be found on the BCM Human Resources – Regulatory Compliance website or by calling 713/798-3310, or emailing leavesofabsence@bcm.edu

**Medical Leave:** A house staff physician who suffers from a serious health condition including the recovery period due to childbirth may be eligible for Medical leave if her/she does not meet the minimum requirements to be eligible for leave under the FMLA.

**Makeup:** GME programs shall provide house staff physicians with certifying Board requirements. Time missed for any reasons beyond that permitted by the relevant certifying Board must be made up. All made up time required for GME program completion will be paid. Each GME program shall have a written policy regarding makeup time and shall provide a copy of this policy to its house staff physicians.

When total (cumulative) time lost for any reason exceeds that permitted by the appropriate certifying Board, the house staff physician’s promotion to the next level of training will be delayed by an amount equal to the time that needs to be made up. This delay supersedes any existing letter of appointment regarding dates, year of appointment, and stipend, but does not negate the reappointment.

It is the responsibility of the program to document and report all time off as required per Baylor Human Resources and Payroll policies.

**General:** All accrued paid time off must be used for absences before any unpaid leave may be taken.

**Professionalism**

The expectations and standards of professionalism that are mandated by the Thoracic Surgery Residency Program, and their significance and implications with regard to residents’ compliance with such standards and expectations are outlined below.

**Professionalism Standards & Program Expectations**

- Exercise a high level of ethics, honesty and integrity in all aspects of interpersonal relationships and patient care.
- Highly professional and responsive behavior to the needs of the patient, medical professionals and the community.
• Interpersonal communication that adheres to professional courtesy and mutual respect among residents at all levels.
• Mature professional behavior: Avoidance of negativism such as gossip, stereotyping, hostility, defamation, slander, inappropriate comments, argumentative behavior, anger and undermining of colleagues, the Program and the organization.
• Commitment to serving as a role model for resident colleagues, students, staff and subordinates regardless of level of training.
• Willingness to engage in conflict resolution with colleagues in a courteous and timely manner.
• Full commitment to sustaining work team relationships through cooperation and collaboration with resident colleagues and other team members.
• Exercise of high leadership and moral skills.
• Full commitment to protect and advance the Program reputation individually and as a member of a team.
• Compliance with administrative responsibilities including call schedules, responsiveness to pages with courtesy and professionalism, and timely response to requests for evaluations of program and faculty.
• Full compliance with the policies, rules, and regulations of the Program, Baylor College of Medicine, and the affiliated institutions.

**Professionalism Misconduct**

Substandard conduct or any occurrence of professional misconduct or deviation from the standards described above by a resident at any level will result in the following:

Immediate counseling with resident(s) involved.

Immediate investigation and disciplinary action(s), the outcome of which may be:

- Documentation of such professional misconduct in the resident’s permanent record and reporting to state licensing agencies and the American Board of Surgery of failure to comply with professional conduct standards of the Program;
- Failure to reappoint and renew contract in the Program;
- Repeat rotation(s) or year(s) of training;
- Failure to graduate in the scheduled year with reporting of such to the Board in the professional conduct category;
- Immediate dismissal from the Program.

**A. Duty Hours and the Working Environment**

The Program adheres to the Baylor College of Medicine Graduate Medical Education policy 25.3.5 governing “Duty Hours.”

Baylor College of Medicine requires all graduate medical education programs to be in compliance with the Accreditation Council for Graduate Medical Education (ACGME) duty hours requirements, as stipulated in the Institutional, Common and Specialty-Specific Program Requirements. Each program must have its own duty hours policy. Every BCM house staff physician must log his/her duty hours on E*Value in a regular and timely manner. Failure to log duty hours as expected may be viewed as a failure in professionalism, and may result in a house staff physician being suspended from duty without pay until the logging responsibility is completed. Program compliance with duty hours requirements and policies will be monitored through E*Value, annual program evaluations, and the internal review process. All house staff physicians are expected to limit their program and program-related moonlighting activities to the maximum number of hours allowed by ACGME policy. Any disputes or other issues related to compliance should be referred to the Senior Associate Dean for Graduate Medical Education. BCM house staff physicians may use GME’s online anonymous form to report concerns about duty hours compliance or may report such concerns to the GMEC Ombudsman.

The BCM GMEC does not permit programs to request an expansion or extension of duty hours beyond the standard ACGME requirements.
Principles

1. The Texas Heart Institute/Baylor College of Medicine Thoracic Surgery Residency Program is committed to and responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
2. The learning objectives of the program are not to be compromised by excessive reliance on residents to fulfill service obligations.
3. Didactic and clinical education have priority in the allotment of the resident’s time and energy.
4. Duty hours assignments recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Supervision of Residents

1. The attending physician has both an ethical and a legal responsibility for the overall care of the individual patient and for the supervision of the resident involved in the care of that patient.
2. Although senior residents require less direction than junior residents, even the most senior resident must be supervised. The program should establish a chain of command that emphasizes graded authority and increasing responsibility as experience is gained.
3. The attending surgeon who is ultimately responsible for the patient’s care should make judgments on this delegation of responsibility; such judgments shall be based on the attending surgeon’s direct observation and knowledge of each resident’s skills and ability.
4. A fellow may not supervise chief residents.

Duty Hours

1. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period between all daily work hours and after in-house call.

Duty Hours Compliance Monitoring

The Program Director, Associate Program Director, and faculty will monitor compliance with duty hour policies by monitoring call and duty schedules, direct observation of the residents, interviews/discussions with the residents, and review of residents’ evaluations of rotations. Residents are instructed to notify the Program Director and Associate Program Director if they or other residents are requested or pressured to work in excess of duty hour limitations. The Program Director and Associate Program Director maintain an open-door policy so that any resident with a concern can seek immediate redress. If problems are suspected, the Program Director and Associate Program Director will gather duty hour data to clarify and to resolve the problem (BCM Policy 25.3.5).

On Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.

3. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the surgery service or department has not previously provided care. The resident should evaluate the patient before surgery.

4. At-home call (pager call) is defined as call taken from outside the assigned institution.
   a) The frequency of at-home call is not subject to the every third night limitation, or 24+6 limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
   b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
   c) When residents are called into the hospital from home, the hours they spend in-house are counted toward the 80-hour limit.

**Moonlighting**

Because residency education is a full-time endeavor and duty-hours regulations must be adhered to, it is the policy of the Thoracic Surgery Residency Program that moonlighting is not allowed (BCM Policy 25.3.6).

**B. Stress, Fatigue and Impairment**

The Program Director and Associate Program Director and faculty realize that residency training is a time of high stress. They will make every effort to monitor residents on their rotations for signs of stress, fatigue, and impairment. The resident can assist on his/her own behalf by adhering to duty-hour mandates and by communicating problems with his/her senior level resident, faculty, or the Program Director and Associate Program Director. The program strives to ensure that an environment conducive to communicating problems exists. It is the responsibility of the entire department and program to be aware of signs and symptoms of these problems.

In situations of stress, fatigue, or impairment, the faculty or resident may approach the Program Director and Associate Program Director, or the Program Director and Associate Program Director may themselves call a meeting with the resident. The problem will be discussed, and the Program Director and Associate Program Director will make recommendations for resolving the problem. Such recommendations may include use of services within Baylor College of Medicine such as the Employee Assistance Program, or referral to a counselor or psychiatrist.

**Signs & Symptoms of Stress, Fatigue, or Impairment**

Signs and symptoms or fatigue, stress, or impairment include some of the following:

- Recent changes in behavior, including irritability, mood swings, inappropriate behavior, a breakdown in logical thought, trembling, slurred speech
- Irresponsibility, such as failure to respond to calls, late arrivals at rounds or call, rounding at irregular times, neglect of patients, incomplete charting, unexplained absences
- Inaccurate or inappropriate orders or prescriptions
- Insistence on personally administering patients’ analgesics or other mood-altering medications rather than allowing nursing staff to carry out orders
- Poor concentration or poor memory, such as failure to remember facts about current and/or recent individual patients
- Depression
- Evidence of use or possession of alcohol or other drugs while on duty; intoxication at social events
- Anger, denial, or defensiveness when approached about an issue
- Unkempt appearance and/or poor hygiene
- Complaints by staff or patients
- Unexplained accidents or injuries to self
- Noticeable dependency on alcohol or drugs to relieve stress
Isolation from friends and peers
Financial or legal problems
Loss of interest in professional activities or social/community affairs

Attending Clinician & Supervising Resident Responsibilities

1. In the interest of patient and resident safety, the recognition that a resident is demonstrating evidence of excess fatigue and/or stress requires the attending or supervising resident consider immediate release of the resident from any further patient care responsibilities.
2. The attending clinician or supervising resident should privately discuss his/her opinion with the resident, attempt to identify the reason for excess fatigue and/or stress, and estimate the amount of rest that will be required to alleviate the situation.
3. The attending clinician should attempt to notify the chief/supervising resident on-call and/or the Program Director and Associate Program Director of the decision to release the resident from further patient care responsibilities at that time.
4. If excess fatigue is the issue, the attending clinician must advise the resident to rest for a period that is adequate to relieve the fatigue before operating a motorized vehicle. This may mean that the resident should go first to the on-call room for a sleep interval no less than 30 minutes. The resident may also be advised to consider calling someone to provide transportation home.
5. If stress is the issue, the attending, upon privately counseling the resident, may opt to take immediate action to alleviate the stress. If, in the opinion of the attending, the resident stress has the potential to negatively affect patient safety, the attending must immediately release the resident from further patient care responsibilities at that time. In the event of a decision to release the resident from further patient care activity, notification of program administrative personnel shall include the chief/supervising resident of the service, Program Director, and Associate Program Director.
6. A resident who has been released from further immediate patient care because of excess fatigue and/or stress cannot appeal the decision to the responding attending.
7. A resident who has been released from patient care cannot resume patient care duties without permission of the Program Director and/or Associate Program Director.

Resident Responsibilities

1. Residents who perceive that they are manifesting signs of excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the chief resident, the Program Director, and/or Associate Program Director without fear of reprisal.
2. Residents recognizing signs of fatigue and/or stress in fellow residents should report their observations and concerns immediately to the attending physician, the chief resident, the Program Director, and/or Associate Program Director.

Program Director & Associate Program Director Responsibilities

1. Following removal of a resident from duty, the Program Director and Associate Program Director will determine the need for an immediate adjustment in duty assignments for remaining residents in the program.
2. The Program Director and Associate Program Director will review the resident’s call schedules, work hours, extent of patient care responsibilities, any known personal problems, and stresses contributing to these issues for the resident.
3. The Program Director and Associate Program Director will notify the Director of the rotation in question to discuss methods to reduce resident fatigue.
4. In matters of resident stress, the Program Director and Associate Program Director will meet with the resident personally. If counseling by the Program Director and Associate Program Director is judged to be insufficient, the resident will be referred to appropriate professionals for counseling.

Resources: Counseling Services for House Staff

Baylor College of Medicine, along with the Graduate Medical Education office, is committed to providing safe, effective, timely, and respectful medical care while fostering an environment that promotes practitioner health. Medical and graduate training programs are rewarding and exciting, but they can also be stressful. The most common reasons for seeking counseling include relationship difficulties, anxiety and depression. For confidential services from the House Staff Physician Psychiatric Counseling Service, residents should call 713.798.4881 to schedule an appointment. This
number may also be used in case of emergencies. This counseling services program serves medical students, graduate students, residents, physician assistants, nurse anesthetist students and clinical fellows as well as their spouses and significant others.

**Services Offered**
- Individual Counseling
- Premarital Counseling
- Marital or Relationship Counseling
- Psychopharmacology

Services are provided at no cost for up to 12 sessions and are provided by members of the faculty in the Department of Psychiatry and Behavioral Sciences. *All provided services abide by the strictest rules of confidentiality.* The service does not issue any report to administrative personnel within your department or any others of Baylor College of Medicine.

**How Will I Know I Need the House Staff Psychiatric Counseling Service?**
- **Work Problems**
  - I keep thinking I’ve chosen the wrong profession.
  - My work is suffering.
  - I feel pulled in too many directions.
  - My relationship with my colleagues is strained.

- **Depression/Anxiety**
  - I’m depressed much of the time.
  - I’m anxious much of the time.
  - I feel angry much of the time.
  - I’m drinking more.
  - I think I have an eating disorder.

- **Relationship Problems**
  - I am having serious doubts about my marriage or relationship.
  - My partner tells me I’m retreating.
  - I don’t like going home.
  - My relationship gives me little pleasure.

C. **Resident Responsibilities**

The following document outlines various administrative responsibilities of all Thoracic Surgery residents. Compliance with the following is mandatory. Non-compliance will weigh heavily on assessment of the resident’s achievement in the Professionalism core competency.

**FULL COMPLIANCE WITH DUTY HOUR REGULATIONS AS REQUIRED BY THE ACGME MUST BE FOLLOWED, AND NO EXCEPTIONS WILL BE TOLERATED.**

**Duty Hours**

The ACMGE requires us to restrict duty hours to 80 hours per week. This rule applies to hours dedicated to clinical activities within the hospital. The 80-hour rule does not apply to time spent reading outside the hospital(s) or at-home call. Residents are charged with the self-reporting of all violations on this system. Please refer to “Duty Hours and the Work Environment” policy in the section above titled “Duty Hours and the Working Environment” for further information and explanation of duty hours restrictions.

Our program takes this requirement very seriously and monitors work hours on a regular basis. Recording of duty hours is ideally done on a daily basis in E*Value. Residents must record their hours daily (not just for the week), and the record should reflect actual hours worked.
**Conference Attendance**

All Thoracic Surgery residents are **required** to attend at least 75% of the mandatory conferences in order to be eligible for promotion into the next year. Residents will be considered absent if they are more than fifteen (15) minutes late to any conference session.

**Research Day (Every June):**

Each year, all residents and fellows in the Michael E. DeBakey Department of Surgery are expected to submit an abstract for presentation at the June Research Day. Faculty mentors are available to assist residents and fellows on projects in preparation for Research Day. Residents and Fellows should begin their planning at the start of every new academic year (June/July) with their faculty mentor. All residents and fellows are required to attend the Research Day event.

**Portfolios**

Any lectures (even five-minute case presentations), M&M presentations, case reports, letters of appreciation, special projects, publications, research reports, abstracts, etc. should be placed in the portfolio. This needs to be done frequently and as academic/research work is completed and/or presented.

**Procedure Case Logs**

As every resident knows, hospital privileges are earned by experience. These experiences must be recorded to prove that they have been completed. Accuracy is a necessity. Notably, if the experience is not recorded, it will not be considered to have been completed. Additionally, case log reports are reviewed regularly by the ACGME Surgery Resident Review Committee (RRC). These reviews require detailed records of resident experience in the program. Accurate case log statistics are critical to our successful continued accreditation.

The ACGME created the Resident Case Log System to allow residents to enter surgical and clinical case data. **Cases should be entered on a weekly basis. Monthly reports will be ran and reviewed at each education committee meeting to monitor compliance.** Procedures may be entered on a hand-held computer or other device with internet access. The Surgery Education Office will provide residents with their individual login and password. **All residents are required to enter cases in this system on a daily basis upon completion of the case – no exceptions.**

The Program Coordinators, Program Director and Associate Program Director review reports monthly to ensure that data entry is occurring in a timely manner.

**Medical Records**

Residents are required to maintain up-to-date medical records in order to remain in compliance with their contract. Delinquent records are reported to the Program Director and Associate Program Director for follow up. Operative reports must be dictated by the responsible resident at the time of surgery.

**Certifications**

All residents are required to maintain Advanced Cardiac Life Support (ACLS) status. One must be re-certified every two years. A copy of up-to-date cards must be kept on file in the resident’s folder as proof of certification. If the cards are
current, re-certification courses are available that require much less time commitment. If the cards have expired, one must repeat the entire course including lectures. Courses are available throughout the year at facilities in the Texas Medical Center. Residents are also responsible for maintenance of their Texas Medical Board permit/license, along with DEA/DPS numbers if obtaining a full license. The Michael E. DeBakey Department of Surgery and its Surgery Education Office are not responsible for lapses in these licensures.

**Lines of Supervision**

The Thoracic Surgery Program is a hierarchical program. When multiple levels of residents are working together as a team on a given service, it is expected that the senior level resident on the service will be ultimately responsible for the efficient conduct of the service. This will include assignment of duties to junior residents as appropriate. The senior level resident will also be responsible for communicating with the assigned attending. The junior residents on the service are expected to perform the duties assigned by the senior level resident and to report appropriately to the senior level resident. The attending physician is ultimately responsible for oversight of resident activities. In all cases, there is a designated attending physician who is readily available for resident consultation and oversight as defined by regulatory agencies that account for the hospital(s) and department policies. For further information regarding lines of supervision, please refer to “Guidelines for Resident Supervision.”

Teaching is an essential component of this residency program at all levels. The following is expected of residents in this program:

1. Residents at all levels will be responsible for the supervision and instruction of medical students.
2. Senior residents will be responsible for the supervision and instruction of junior residents.
3. Chief residents will be responsible for the supervision and instruction of all other residents and medical students.
4. Attendings will be responsible for the supervision and instruction of all residents in the program and medical students rotating through the program-affiliated institutions.

**Evaluations**

1. Each resident will be assessed for competence in the six required core competencies as defined by the ACGME. Evaluation of the resident’s performance will occur at the end of each rotation using E*Value. These evaluations are available for review by the program and the resident via E*Value, and will be placed in the resident’s file in the Surgery Education Office (BCM Policy 25.3.6).
2. If at any time a resident’s performance is judged to be detrimental to the care of the patient(s), action will be taken immediately to assure safety of the patient(s). A face-to-face meeting with the resident and the attending staff from the individual institution will be mandatory for any resident receiving an unsatisfactory (rating of 1 or 2) grade after completion of the rotation. Residents will have a chance to voice their opinions and provide a response to the grade at this time, as well as at a later meeting with the Program Director and Associate Program Director if they so choose.
3. Each resident will be given the opportunity to complete a formal written evaluation of the appropriate attending surgeon via E*Value, addressing the provision of clinical supervision (e.g. availability, responsiveness, depth of interaction and knowledge gained). The evaluations will be reviewed by the Program Director and Associate Program Director and integrated into discussions with the clinical faculty. Evaluations will be completed at the end of the resident’s rotation. The Program Director and Associate Program Director will strive to create an atmosphere that ensures residents are comfortable completing evaluations of attending faculty.
4. Semi-Annual Evaluations: The Program Director and Associate Program Director for the Thoracic Surgery Residency Program will meet personally with each resident semi-annually. These meetings will be documented in the resident’s cumulative record. Meetings between the Program Director / Associate Program Director and an individual resident may be more frequent in the event of specific and repeated problems or complaints against that resident.
5. Residents who are placed on probation will be notified as per the guidelines set forth by the Graduate Medical Education Committee of Baylor College of Medicine.

**Milestones**
As required by the ACGME, each resident will be evaluated twice a year on its milestones (semi-annually and annually). Please visit [http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/ThoracicSurgeryMilestones.pdf](http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/ThoracicSurgeryMilestones.pdf) for detailed information regarding the milestones for Thoracic Surgery.

**Department Holidays**

Residents are required to work and take call during the holidays as dictated by the rotation schedule and the call schedule.

**Parking**

Parking is provided and allotted as directed by the College and GME office as well as at the expense of residency fellows.

**Final Clearance Form**

Graduating residents and those leaving the program (preliminary residents) must check out with the Surgery Education Office and the Office of Graduate Medical Education to receive a diploma or certificate. All items specified on the departmental clearance form as well as the GME clearance form must be completed in order for the resident to receive a diploma.

**D. Communication**

Good communication is essential to the smooth operation of any organization and is especially critical where patient care is involved. This section discusses communication policies that must be followed both in and out of the clinical setting (BCM Policy 25.4.2).

**Up-to-Date Contact Information**

It is critical that we have your most up-to-date contact information, especially in the case of emergency. Please communicate any changes in address, phone number, emergency contact information, etc. to the Surgery Education Office immediately.

**Pagers**

Baylor College of Medicine issues pagers to residents to be used over the course of the training program. It is considered the preferred method of immediate contact for patient care and administrative needs. Rotation-specific pagers are required at some institutions. Pagers must be carried at all times. Pagers are the responsibility of the residents and fellows once issues and therefore the fee of $65 for any lost pagers will be at the expense of the residents and/or fellows. Pagers will also be collected during check-out from the program each June. Residents who do not return their pagers before leaving the program will be charged $65 and will not receive their diploma until this fee has been paid to the Michael E. DeBakey Department of Surgery in reimbursement for such charges.

**Email**

Baylor College of Medicine establishes free e-mail accounts for all residents upon entry into the program. This account is to be used for the duration of the residency program. An address will be assigned along with a changeable password. *Residents are required to check their email daily and respond in a timely and appropriate manner, as email is used as a standard means to communicate information within the department.*

**E. Dress Code**

It is important that proper and professional personal appearance is maintained at all times since each Thoracic Surgery resident represents the THI/Baylor Thoracic Surgery program. Dress codes are standard in most business-related
environments and promote an organization’s public image, encourage a productive work environment, and ensure compliance with health and safety standards.

The following apply to all institutions where Thoracic Surgery residents may be working.

- White coats will be clean: blood stains, coffee stains, dirt, tears, etc. are not acceptable.
- Scrubs must be changed before leaving the OR area if splattered with blood (check bottom of pants).
- Denim jeans (standard Levis, etc.) are never acceptable unless in an emergency.
- Shoes cannot be blood spattered: get dark OR shoes or wear shoe covers. We suggest keeping a second or separate pair of shoes in the call room or in a locker for when not in the OR.
- When we have dinners with visiting Professors, a shirt and tie is required for men and business attire for women (skirt, dress, or pants suit; no midriff tops that show skin and no excessively short skirts).

A well-groomed, appearance is always important and appropriate. Our competence may be judged by how well we can take care of ourselves. Remember, how we appear is very important in how you are perceived- by both us and everyone else you interact with.
3. Travel Policy

Education Office Travel
In order to encourage legitimate research and academic efforts, the department will pay for travel for residents to present at surgical meetings. However, to insure that the money is spent fairly and appropriately, the department has instituted a policy concerning resident travel policy.

Which residents are eligible for travel reimbursement?
All residents in the THI/BCM Thoracic Surgery Residency Program and all clinical fellows in BCM cardiothoracic surgery fellowships who are first author on an oral presentation at an approved meeting (listed in Approved Meetings section) within the continental United States or Canada. Reimbursement for travel for poster presentations will be limited to one trip per resident or fellow per year. If the resident or fellow is able to obtain funding from another source for additional poster presentations, they will be given permission to attend the meeting, but the department will not pay their expenses. Reimbursement for expenses will be provided by the Department of Surgery up to $1000.00.

Senior thoracic surgery residents will be given permission to attend one approved meeting during their third year. The expenses for this meeting will be reimbursed up to $1500.00 if the resident has met their research publication submission requirement (see below). Residents who have not met the research requirement will be given permission to attend an approved meeting, but will not be eligible for travel reimbursement.

All residents are expected to submit two manuscripts to peer reviewed journals before the start of their third year. The submission requirement is being phased in based on a given resident’s level of training as of July 2014. Current PGY-6 residents are expected to submit two manuscripts, and current PGY-7 residents are expected to submit one manuscript. Please see the Thoracic Surgery Resident Research Requirements section for additional details.

Which meetings are eligible?
Meetings that are eligible for reimbursement are listed in the list of approved meetings. Residents and fellows wishing to attend meetings not on the approved list may appeal to the THI/BCM Thoracic Surgery Residency Program Committee for funding.

Residents and fellows will be given permission to leave the day before their presentation and stay the night after their presentation. Permission to stay additional days will be at the discretion of the Program Director.
How to get reimbursed

In order to obtain permission to attend the meeting and be reimbursed, the following must occur.

Please note: There will be NO exceptions to these rules.

1. Any submitted abstract must be sent to the THI/BCM Thoracic Surgery Residency Program Coordinator in the Surgery Education Office within one week of submission. The easiest way to handle this is to make sure you submit your abstract to the Program Coordinator at the same time you submit it to the meeting.

2. The Program Coordinator must be notified of any abstract accepted within a week of receipt. At the same time, a signed request for travel form must be submitted. Travel forms are available via the Surgery Education Office. Again, the easiest way to handle this is to fax or email a copy of your acceptance letter to the Program Coordinator the day you receive it and follow it within seven days with the request for travel form.
   a. All expenses during the trip, including the hotel, will be paid for by the resident or fellow. Temporary loans are available through the Surgery Education Office if needed and will be given at the discretion of the Program Director.
   b. No reimbursement for expenses will be made without receipts. Baylor College of Medicine requires a copy of your hotel invoice (showing a $0 balance) and your airfare invoice, credit card statement, and/or cancelled checks for any payments made on this trip, as well as a copy of the front cover of the program brochure (listing conference name, location, and dates) as supporting documentation for reimbursements.
   c. Expenses eligible for reimbursement include
      1. Shuttle service to and from airport
      2. Room charges, taxes
      3. Meals (see below for specific guidelines)
      4. Airport parking (remote only)
      5. Airfare
      6. Internet access in the room
   d. The following will are NOT reimbursable expenses
      1. In-room movies
      2. Taxis to and from the airport (if shuttles are available)
      3. Mini-bar expenses
      4. Entertainment expenses (other than meals), including alcoholic beverages
      5. Car rental (unless pre-approved by the Program Director)
      6. Terminal airport parking
      7. Office expenses at the meeting (printing posters, handouts, etc.)

3. Residents and fellows will be reimbursed for meals using the same guidelines as Baylor College of Medicine faculty (see below):
   a. For trips within the United States, travelers are required to provide meal receipts not to exceed $55 per day including tip.
   b. Tips may not exceed 20% of the cost of the meal.
   c. For travel beginning after 3:00 p.m., the maximum meal allowance is ½ the regular daily maximum.
   d. Meals will not be reimbursed when attending a local (within a 50-mile radius of the Texas Medical Center) conference or seminar or when claiming local travel.
   e. Itemized receipts are required for all meal reimbursements.
Approved Meetings
Meetings that are eligible for reimbursement are listed below. Residents wishing to attend a meeting that is not on this list may appeal to the Education Committee for approval and potential funding.

**Academic Surgery, General Surgery and Regional Surgical Societies:**
- Academic Surgical Congress
- American College of Surgeons
- Association for Surgical Education/Surgical Education Week
- Association of VA Surgeons
- Central Surgical Society
- Michael E. DeBakey International Surgical Society
- South Texas Chapter, American College of Surgeons
- Southern Surgical Association
- Southwestern Surgical Congress
- Texas Surgical Society
- Western Surgical Association

**Cardiothoracic Surgery:**
- American Association for Thoracic Surgery
- American College of Cardiology
- American College of Chest Physicians
- American Heart Association
- International Society for Minimally Invasive Cardiothoracic Surgery
- Society of Thoracic Surgeons
- Southern Thoracic Surgical Association
- Western Thoracic Surgical Association

**GI, Endocrine Surgery, Surgical Oncology and Transplantation:**
- American Association of Endocrine Surgeons
- American Cancer Society
- American Society for Gastrointestinal Endoscopic Surgery
- American Society of Clinical Oncology (including GI and breast symposia)
- American Society of Colon and Rectal Surgeons
- American Transplant Congress
- Americas Hepato-Pancreato-Biliary Association
- Digestive Disease Week
- International Society of Geriatric Oncology (SIOG)
- Society for Surgery of the Alimentary Tract
- Society of American Gastrointestinal and Endoscopic Surgeons
- Society of Surgical Oncology

**Pediatric Surgery:**
- American Academy of Pediatrics - Surgical Section
- American Pediatric Surgical Association
- American Society of Parenteral and Enteral Nutrition
- Pacific Pediatric Surgical Association
- Texas Society of Pediatric Surgeons

**Trauma, Acute Care Surgery and Critical Care:**
- American Trauma Society
- American Association for the Surgery of Trauma
- Eastern Association for the Surgery of Trauma
- Society for Academic Emergency Medicine
- Society of Critical Care Medicine
- Surgical Infection Society
- Western Trauma Society

**Vascular Surgery:**
- Arteriosclerosis, Thrombosis and Vascular Biology
Thoracic Surgery Resident Research Requirements

Although not all thoracic surgeons need to be trained to be independent researchers, understanding the basics of research is a core competency for all practicing surgeons. Therefore, our training program has developed a program to provide opportunities for residents to learn the fundamentals of research. Additionally, the department will provide mentorship and resources to optimize resident participation in research projects. For example, residents will be guided in selecting faculty mentors. Further, residents will have access to a core of departmental experts in education, clinical study design and analysis, and scientific writing.

All thoracic surgery residents will be expected to submit two manuscripts to peer reviewed journals before the start of their third year. The submission requirement will be phased in based on a given resident’s level of training as of July 2014. Current PGY-6 residents will be expected to submit two manuscripts and current PGY-7 will be expected to submit one manuscript.

The manuscripts should be original research articles, review articles, or case reports, and should be submitted to established academic journals. Residents may be the first author or a co-author, as appropriate; manuscripts should comply with standard guidelines for authorship (http://www.icmje.org/ethical_1author.html). Submissions falling outside of these parameters will need to be approved by the THI/BCM Thoracic Surgery Residency Program Committee to qualify toward the overall requirement. During the semi-annual review with the Program Director, residents will review their research productivity.

Residents will be required to submit a copy of all abstracts, manuscript submissions, presentations (PowerPoint slides or poster) to the Program Director and the Vice Chair for Research. All resident research activities will be compiled by the Vice Chair for Research and will be submitted to the Department Chairman, the Program Directors and the THI/BCM Thoracic Surgery Residency Program Committee as an annual report.

Residents will be given permission to attend one approved meeting during their third year. The expenses for this meeting will be reimbursed up to $1500.00 if the resident has met their research publication submission requirement. Residents who have not met the research requirement will be given permission to attend an approved meeting, but will not be eligible for travel reimbursement.

Approved 05/29/2014
4. **Guidelines for Resident Supervision**

The purpose of this section of the handbook is to outline the policy and procedure requirements for supervision of postgraduate residents within the Department of Surgery.

**Definition of Attending Physician**

Each patient will be under the direct care of an attending physician, and this will be clearly noted on the patient’s admission card and paperwork. Residents work under the direct supervision of the attending physicians. Attending physician refers to those surgeons who staff the teaching service at each of the affiliated hospitals. Each surgeon must be Board eligible/certified in Thoracic surgery or an appropriate subspecialty, and must show interest in participating in the education of residents. Furthermore, surgeons on the teaching service must exhibit regular contribution to the education of the residents to maintain their status on the teaching service.

**Lines of Supervision**

The attending physician is ultimately responsible for the care of all patients on his/her service. Residents participate in this care under the direction of the attending. The attending physician controls resident participation through observation and direction, or consultation, and by imparting specific skills and knowledge to the resident. Attending supervision may be direct (person-to-person) supervision or through discussion, for example by telephone. At all times there will be an appropriately privileged attending surgeon immediately available to the resident or by telephone and able to be present within a reasonable period of time, if needed. The attending surgeons are responsible to assure continuity of care provided to patients.

It is recognized that other attending physicians may, at times, be delegated responsibility for the care of a patient and provide supervision instead of, or in addition to, the assigned attending surgeon. Within the scope of the training program, all residents, without exception, will function under the supervision of attending surgeons. A responsible attending must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, if needed. Each service will publish, and make available, “call schedules” indicating the responsible staff practitioner(s) to be contacted.

**Graduated Responsibility in Resident Training**

The surgery residency program is structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment throughout the course of their training. Each facility must adhere to current accreditation requirements as set forth by Baylor College of Medicine for all matter pertaining to the training program including the level of supervision provided. The requirements of the American Board of Surgery and the ACGME will be incorporated into training programs to ensure that each successful program graduate will be eligible to sit for a certifying examination.

**Roles & Responsibilities:**

**The Department Chair, Program Director, & Associate Program Director**

The Department Chair, Program Director, and Associate Program Director are responsible for implementation of and compliance with the requirements of the American Board of Surgery and the ACGME.

**Roles & Responsibilities: The Attending Surgeon**

The Attending Surgeon is responsible for, and must be familiar with, the care provided to the patient as exemplified by the following:

1. Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. Documentation of this supervision will be via progress notes, or
countersignature of or reflected within the resident’s progress note at a frequency appropriate to the patient’s condition. In all cases where the provision of supervision is reflected within the resident’s progress note, the note shall include the name of the attending surgeon with whom the case was discussed and the nature of that discussion.

2. Meet the patient early in the course of care (for inpatients, within 24 hours of admission) and document, in a progress note, concurrence with the resident’s initial diagnoses and treatment plan. At a minimum, the progress note must state such concurrence and be properly signed and dated. If a patient is admitted during the weekend or holiday for non-emergent care, a senior resident may evaluate the patient and discuss the patient’s circumstances via telephone with an appropriate attending surgeon. This discussion will be documented in the patient record. An attending physician will then see the patient within 24 hours, since there will always be an attending making rounds with the surgical team (residents and students) on weekends and holidays.

3. Participate in attending rounds. Participation in bedside rounds does not require that the attending surgeon see every patient in person each day. It does require physical presence of the attending in the facility for sufficient time to provide appropriate supervision of residents. A variety of face-to-face interactions such as chart rounds, x-ray review sessions, pre-operative reviews, and informal patient discussions fulfill this requirement.

4. Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are:
   a) Medically indicated,
   b) Fully explained to the patient,
   c) Properly executed,
   d) Correctly interpreted, and
   e) Evaluated for appropriateness, effectiveness, and required follow up.

   Evidence of this assurance will be documented in the patient’s record via the progress note(s), or through countersignature of the resident’s progress note(s).

5. Assure that discharge, or transfer, of the patient from an integrated or affiliated hospital or clinic is appropriate based on the specific circumstances of the patient’s diagnoses and treatment. The patient will be provided appropriate information regarding prescribed therapeutic regimen, including specifics on physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by countersignature of the hospital discharge summary or clinic discharge note.

6. Assure that residents are given the opportunity to contribute to discussions in committees where decisions being made affect their activities. Facilities are encouraged, to the extent practicable, to include resident representation on committees such as Medical Records, Quality Assurance, Utilization Review, Infection Control, Surgical Case Review, and Pharmacy and Therapeutics.

**Graduated Levels of Responsibility**

1. Residents, as part of their training program, may be given progressive responsibility for the care of their patients. A senior level resident may act as a teaching assistant to less experienced residents. Assignment of the level of responsibility must be commensurate with the resident’s acquisition of knowledge and development of judgment and skill, and consistent with the requirements of the accrediting body.

2. Based on the attending surgeon’s assessment of a resident’s knowledge, skill, experience and judgment, the resident may be assigned graduated levels of responsibility to:
   a) Perform procedures or conduct activities without a supervisor present; and/or
   b) Act as a teaching assistant to less experienced residents.

3. The determination of a resident’s ability to accept responsibility for performing procedures or activities without a supervisor present and/or act as a teaching assistant will be based on evidence of the resident’s clinical experience, judgment, knowledge, and technical skill. Such evidence may be obtained from evaluations by attending surgeons or the Program Director and Associate Program Director, and/or other clinical practice information.

When a resident is acting as teaching assistant, the staff practitioner remains responsible for the quality of care of the patient, providing supervision and meeting medical record documentation requirements as defined previously.
Supervision of Residents Performing Invasive Procedures or Surgical Operations

1. Diagnostic or therapeutic invasive procedures or surgical operations, with significant risk to patients, require a high level of expertise in their performance and interpretation. Such procedures may be performed only by residents who possess the required knowledge, skill and judgment to perform these procedures under the appropriate level of supervision by staff physicians. Attending surgeons will be responsible for authorizing the performance of such invasive procedures or surgical operations. The name of the attending surgeon performing and/or directing the performance of a procedure should appear on the informed consent form.

2. During the performance of such procedures or operations, an attending surgeon will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending surgeon and is a function of the experience and competence of the resident, and of the complexity of the specific case.

3. Attending surgeons will provide appropriate supervision for the evaluation of patients, the scheduling of cases, and the assignment of priority, pre-operative preparations, and the operative/procedural and post-operative care of patients.

Emergency Situations

An emergency is defined as a situation where immediate care is necessary to preserve the life of or prevent serious impairment of the health of a patient. In such situations, any resident, assisted by medical center personnel, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending surgeon will be contacted and apprised of the situation as soon as possible. The resident will document the nature of this discussion in the patient’s record.
5. Goal & Objectives of Thoracic Surgery Rotations

**Introduction**
Welcome to our Thoracic Service at Ben Taub Hospital. Our busy service allows you to gain confidence and improve technical and clinical skills to help you become a highly competent surgeon at the conclusion of your surgical residency.

**Thoracic Service Schedule**
*Thoracic Tumor Board:* Conducted every Tuesday from 8:00---9:00 AM at Radiology Department room 1---RD 81 010. It is a multidisciplinary forum for discussion of patients with pulmonary or oncological conditions. The thoracic team determines if patients require surgical intervention.

*Cath Conference:* Conducted every Tuesday from 3:00---4:00 PM at 6th floor 6D conference room. It serves as an educational experience to learn EKG interpretation and discussion of cardiology/cardiothoracic patients’ cases.

*BCM Surgical Grand Rounds:* Conducted on designated Wednesdays from 7:00---8:00 AM at Alkek Building N315, One Baylor Plaza.

*Thoracic Surgery Clinic:* Conducted every Wednesday from 9:00---12:00PM at Clinic A located on the 2nd Floor of Ben Taub Hospital by Purple Elevators.

*BTH Surgery M&M Conference:* Conducted every Friday from 7:00---8:30AM 4th floor Conference Room. Requires semiformal dress code.

**BCM Faculty: Attending Physicians:**
Dr. Peter Tsai
Dr. Todd Rosengart
Dr. Matthew Wall
Dr. Kenneth Mattox

**Thoracic Service Staff:**
Meglis Davis, PA/Thoracic Service Manager
Responsibilities and Supervision Guidelines:

Postgraduate Level (PGY---7)

The thoracic surgery resident will interact with, and potentially serve in a teaching function and supervise the general surgery residents on appropriate aspects of thoracic surgical care. Ultimately, it is the decision of the attending physician as to which activities the residents will be allowed to perform within the context of the assigned level of responsibility.

The thoracic surgery resident at the Ben Taub General Hospital is a PGY---7 who is responsible for all aspects of inpatient, outpatient, clinics, consultations, invasive and non-invasive procedures and the intensive care unit. The PGY---7 is responsible for delineating tasks of general surgery residents including the 4th Year General Surgery Resident.

Thoracic Residents

1. The Thoracic Resident is responsible for the care and management of every patient and consults on their service.
2. The Thoracic Resident will physically be present on every operative case on the service unless the Faculty surgeon is actively participating in the operation with an appropriate level resident.
3. The Thoracic Resident will attend the scheduled teaching conferences.
4. The Thoracic Resident will be responsible for the content and completion of the weekly M&M protocol at the assigned deadline.
5. The Thoracic Resident (with assistance from the Thoracic Surgery PA) will be responsible for running clinic and disposition of patients seen in the service’s clinic.
6. The Thoracic Resident is responsible for presenting all operative cases, complications, and deaths in the weekly morbidity and mortality conference.
7. The Thoracic Resident is responsible for scheduling all inpatient operative cases (with assistance from the Thoracic Surgery PA).
8. The Thoracic Resident is responsible (with assistance from the Thoracic Surgery PA) for scheduling Clinic/Pulmonary Tumor Board operative cases.
9. The Thoracic Resident is responsible for re-scheduling, calling and communicating with scheduled outpatient/clinic/Pulmonary Tumor Board operative patients (with assistance from the Thoracic Surgery PA).
10. The Thoracic Resident is responsible for documenting all patient calls in the electronic medical record.
11. The Thoracic Resident formulates a plan for all waitlist patients.

General Rules on the Thoracic Surgery Service

1. All pages will be answered promptly.
2. The Chief Resident will be the communication link between their service and the attending staff surgeon and PA.
3. All operative reports will be completed immediately after completion of the surgery.
4. All death summaries will be dictated by the resident tending to the patient at the time of the patient’s death.
5. The discharge resident (with assistance from the Thoracic Surgery PA) will dictate all discharge summaries at the time of discharge. The person performing the discharge will dictate discharge summary. In general, discharges will be conducted by 8:00 AM.
6. The Thoracic Surgery resident will perform any discharges that occur during the weekend or holidays.
7. All medical student/PA student clinic or progress notes will be cosigned by a M.D. or PA.
8. The surgeon of record will be responsible for entering a preoperative note on all patients in the form of an informed consent explaining the procedure, the risks and complications, the fact that the patient understands the surgery and its alternatives. The surgeon of record will also be responsible for the content of the consent.

9. The surgeon of record is responsible for explaining the preoperative and postoperative management as well as choice of operation on each case at the weekly M&M conference. In general, the surgeon of record is responsible for having radiology or visual aids (power point presentation) available on their cases.

10. In general, the tentative operative schedule for the week should be made available to attending physicians and Thoracic PA on Mondays. The operative schedule for the next day surgery should be reviewed on the day prior to scheduled surgery with the attending staff surgeon.

11. All residents will be dressed in appropriate attire for the scheduled conferences.

12. All patients and hospital employees and BCM faculty will be treated in a courteous and friendly manner. Next of kin will be kept informed by the operating surgeon.

13. Residents will observe the rules and regulations unique to each individual hospital in addition to the policy stated in the Baylor House Staff manual.

Medical Knowledge
Demonstrate established and evolving medical knowledge in anatomy, physiology, and pathology and a wide variety of cardiothoracic diseases.

Interpersonal and Communication Skills
Apply interpersonal skills in a team environment composed of peers, nurses, students, staff and supervising faculty; listen and communicate effectively with patients and families

Professionalism
1. Practice with high standards of ethical principles in clinical care and patient confidentiality
2. Demonstrate progressively mature behavior and leadership skills; accept constructive criticism
3. Respond to the needs of the patient and the medical and professional community

Practice-Based Learning and Improvement
Demonstrate practice-based learning, especially in basic surgical procedures, emergency procedures and perioperative care of the cardiothoracic surgery patient; demonstrate commitment to improving patient care

Systems-Base Learning
Apply knowledge to practice cost effective quality patient care

Scholarly Activity
Engage in discussion and participate in case presentations at educational conferences

Supervisory Lines of Responsibility
The thoracic resident reports directly to the supervising faculty.

Academic Discipline and Resident Complaints
The responsible faculty in each institution monitors academic and clinical performance for each thoracic resident. At the Ben Taub Hospital it is the Deputy Program Director, Dr. Matthew Wall. Academic and clinical expectations are discussed with the resident upon starting the Ben Taub Hospital rotation, updated periodically and completed by an exit discussion with the Deputy Program Director at the end of the evaluation period. Inadequacies in academic or clinical performance are discussed with the resident and placed in writing in their files at these times or earlier if necessary.
Resident complaints or grievances at the Ben Taub Hospital are discussed with the Deputy Program Director who will discuss these with the relevant faculty or other personnel. If no resolution is reached, the complaint or grievance goes first to the Program Director, then to the Chief of the Division of Cardiothoracic Surgery, and then to the Chairman of the Department of Surgery. Grievances not satisfactorily resolved within the Department of Surgery will proceed to the Graduate Medical Education Committee. The chair of this committee will appoint an ad hoc committee (with at least 2 non-involved housestaff) for a decision, which is sent to the Associate Dean for Graduate Medical Education. Either party may appeal the decision of the committee to the Associate Dean who will adjudicate the matter with the final decision of the Associate Dean being binding on both parties. (Refer to Policy on House Staff Physicians manual)

On Call Schedule of the Cardio-Thoracic Surgery Service at Ben Taub General Hospital

The Thoracic Resident is on call from home and available for emergencies by beeper twenty-four hours a day. The thoracic surgery resident and the PGY-4 general surgery resident on the thoracic rotation share in-house call for appropriate acuity patients. There is always an in house General Surgeon available for emergencies.

Morning Rounds are made on Saturdays and Sundays with no obligations except emergencies during this period.

Residents that are out of town or on vacation for any reason arrange coverage for their service from the Program Directors Office.

The Thoracic Surgery Resident is the senior most Surgical Resident at the Ben Taub General Hospital.

The Thoracic Surgery Patients are managed by the Thoracic surgery resident and the PGY-4 General Surgery Resident assigned to thoracic.

It is the responsibility of the Thoracic Surgical Faculty and The Thoracic Surgical Resident to ensure that the General Surgical Residents are taught appropriate fundamentals in the management of Cardio-Thoracic disease.
Patient Care:
The resident will be able to present a cohesive plan for the evaluation and management of adult cardiothoracic surgical
diseases. This will involve all phases of care including preoperative assessment, intraoperative decision-making, technical
performance, immediate post-operative care, and long-term follow-up.

Medical Knowledge:
The resident is expected to achieve a broad base of knowledge and skills concerning the diagnosis and treatment of
disorders commonly seen by the adult cardiac and aortic surgeon.

Practice-Based Learning and Improvement:
The resident should be able to investigate and evaluate their patient care practices, appraise and assimilate scientific
evidence, and continually strive to improve their patient care practices.

Interpersonal and Communication Skills:
The resident should be able to demonstrate interpersonal and communication skills that result in effective information
exchange and teaming with patients, their patients' families, and professional associates.

Professionalism:
The resident must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles,
and sensitivity to a diverse patient population. Professionalism is based on the principles of primacy of patient welfare,
patient autonomy, and social justice. It involves all of the following responsibilities: competence, honesty, patient
confidentiality, appropriate relations with patients and co-workers, improving quality of care, improving access to care,
just distribution of finite resources, commitment to scientific knowledge, maintaining trust by managing conflicts of
interest, and a commitment to professional responsibilities.

Systems-Based Practice:
The resident will appreciate the wide variety of disciplines involved in the delivery of modern medical care and be able to
effectively utilize those systems to provide quality and cost effective health care.

Goals and Objectives

Duration:
- PGY-6: 3 Months
- PGY-7: 6 Months
- PGY-8: 12 Months

Goals: Upon completion of the successive rotations on the Cardiovascular Surgery Service at Texas Heart
Institute/BSLMC, by knowledge and experience gained, residents will be able to orchestrate and oversee all aspects of
preoperative assessment, operative procedures and postoperative management of adults who have any of the gamut of
cardiac, vascular and thoracic conditions. Because of the international patient clientele who seek treatment at this tertiary
care institution, residents will also have gained experience in working with many healthcare disciplines representing
various clinical, administrative, social and support services. The resident will also be expected to be able to perform the
following procedures: aortocoronary bypass; valve repair and/or replacement; arterial endarterectomy and/or bypass;
cardiac transplantation; implantation of ventricular assist devices; repair of abdominal aortic aneurysms and thoracic
aortic aneurysms.
Objectives:

Year 1 (3 Months)

Patient Care:
- Maintain awareness of safety for patient and others participating in care of operative patients, mindful of patient's status throughout the procedure and maintaining one's own calm response during emergencies.
- Learn and perform skillfully how to assist in cardiac, vascular and thoracic operations, i.e., sternotomy for open heart surgery patients, careful and expedient harvesting of internal mammary artery and/or saphenous vein for coronary bypass conduits, and aesthetic closure of incisions with satisfactory homeostasis.
- Learn to assist properly all forms of cardiopulmonary bypass cannulation.
- Learn and skillfully assist with proper exposure of various organs, prepare surgical field for major vascular operations, i.e. aortic aneurysms, aortoiliac, aortofemoral and femoropopliteal occlusive disease, renovascular occlusive disease, etc.
- Learn and performs skillfully sternal closure, proper placement of temporary pacing wires, intrathoracic drainage tubes and postoperative management/removal.
- Learn techniques for effecting proper management of postoperative bleeding, differentiating between mechanical and coagulopathic origins, and appropriate treatment approaches for each.
- Develop ability to manage postoperative cardiovascular surgery patients, both in the early recovery/ICU phase and in later postoperative/early cardiac rehabilitative phase.
- Learn to implant and/or replace generators for epicardial pacemakers and implantable defibrillators. Participate in operations for arrhythmia surgery, developing operative technique, i.e., MAZE procedure.
- Document well the procedures, assessments, and care given to patients.

Medical Knowledge:
- Learn and perform thoroughly the proper preoperative evaluation of patients with major thoracic and cardiovascular abnormalities; strengthen knowledge of intrathoracic anatomy.
- Begin to develop expertise in understanding cardiothoracic and vascular pathology, interpretation of diagnostic studies (cathes, grams, MRI, CT, x-rays, lab results, nuclear medicine results) and integration into treatment plan.
- Develop understanding regarding types of vascular grafts and prostheses vs. native vessels for bypass conduits in various clinical situations and patients.
- Develop understanding regarding types of valve replacement and valvuloplasty prostheses to use in specific indications for different patients.
- Develop understanding and recognition of all cardiac arrhythmias, those which are life-threatening vs. less serious conditions, physiology, and various treatment options for patient management (medical therapy, interventional therapy, and surgery)

Practice-Based Learning and Improvement:
- Participate in presentations and discussion of cases at weekly M&M conferences.
- Attend weekly core curriculum conferences and monthly journal club sessions which cover all aspects of general thoracic, congenital and acquired cardiac diseases, and cardiothoracic pathophysiology.
- Develop basic skills for conducting research using the scientific methods and in collaborating with surgical staff re: writing clinical papers.

Interpersonal & Communication Skills:
- Further develop humanitarian qualities, showing integrity, respect, empathy for patients and families, communicating well and establishing trust and rapport.
- Grow professionally from constructive criticism.

Professionalism:
- Practice ethical behavior, responsible, reliable, effective communication, showing regard for opinions and skills of professional staff and resident colleagues.
- Learn to prioritize and manage, while on call, multiple critically ill cardiovascular surgery patients, working in concert with staff surgeons and others in a multidisciplinary professional environment.
- Represent Texas Heart Institute and Baylor College of Medicine honorably.

**Systems-Based Practice:**
- Develop appreciation for expenses of health care, i.e., charges for diagnostic tests, medical supplies, medications, efficient planning/scheduling of tests, procedures, etc. Minimize waste and expense while maximizing best use of system resources (including time), all the while maintaining quality patient care and safety.
- Learn and use the contributions from social services (care coordinators, discharge planners, etc.) to facilitate timely, quality, and streamlined patient care.

**Year 2 (6 Months)**

*Residents are expected to develop further all aspects of training from year 1, and are given progressively more responsibility with complex cases, based on technical skills and medical judgment:*

**Patient Care:**
- Learn to assist and perform skillfully valve replacements, valvuloplasties.
- Learn to assist and perform delicate proximal coronary anastomoses.
- Learn how to assist with and perform proper and safe opening of redo sternotomy patients.
- Learn to assist and direct the intricacies of managing patients through period of discontinuing cardiopulmonary bypass and resumption of patients' independent circulation.
- Learn and perform placement of LVAD's, RVAD's and other mechanical cardiac assist devices in critical patients and all resuscitative measures.
- Assist with harvesting of donor organs and with surgical implantation of cardiac transplantation.
- Participate in multidisciplinary approach to postoperative management of cardiac transplant patients during recovery/intensive care phase of hospitalization.

**Medical Knowledge:**
- Continue to expand knowledge, read, accessing educational programs available via internet and programmed learning courses via Texas Heart Institute Library and Learning Resource Center.
- Develop understanding of different types of valve prostheses, valvuloplasty prostheses, and the attendant postoperative management requirements.
- Participate in preoperative assessment of patients referred for cardiac transplantation. Learn techniques of organ preservation.
- Learn and skillfully assist with proper exposure for major vascular aneurysm repair, i.e., ascending, arch and descending thoracic aneurysms, thoracoabdominal aneurysms, and peripheral aneurysms.

**Practice-based Learning and Improvement:**
- Continue participating in and using information from weekly M&M conferences.
- Continue to develop skills imparted at journal club regarding appraisal and evaluation of scientific literature, with implementation into practice.

**Interpersonal & Communication Skills:**
- Continue to develop humanitarian qualities, integrity, respect, and empathy for patients, families, staff and colleagues. Promote clear communications and trust.
- Continue to process constructive criticism productively.

**Professionalism:**
- Maintain professional and mature behavior in all aspects of work.
- Continue to honor patient confidentiality and related HIPAA expectations.
- Continue to represent Texas Heart Institute and Baylor College of Medicine honorably.
Systems-based Practice:
- Continue daily in teaching and development of other trainees on service, i.e., CV fellows, international medical students, physician assistants, etc.

Year 3 (12 Months)
*Residents are expected to develop further all aspects of training from year 1 and 2, and are given progressively more responsibility with complex cases, based on technical skills and medical judgment:*

**Patient Care:**
- Continue to develop surgical and endovascular skills for treating major vascular aneurysms.
- Continue developing skills for performing proper and safe opening of redo sternotomy patients.
- Skillfully perform cardiac transplantation.

**Medical Knowledge:**
- Continue learning the intricacies of managing patients awaiting cardiac transplantation.
- Expand knowledge, assessment skills and operative skills for treating adult patients with history of congenital heart disease who have had surgical procedures and who now present with attendant cardiac, thoracic or vascular pathology.

**Practice-Based Learning and Improvement:**
- Continue learning and contributing to multidisciplinary approach to postoperative management of end stage cardiac failure patients during all phases of hospitalization.
- Demonstrate consistent commitment to improving all aspects of patient care

**Interpersonal & Communication Skills:**
- Continue to develop humanitarian qualities, integrity, respect, and empathy for patients, families, staff and colleagues. Promote clear communications and trust.
- Continue to process constructive criticism productively.

**Professionalism:**
- Maintain professional and mature behavior in all aspect of work.
- Continue to honor patient confidentiality and related HIPAA expectations.
- Continue to represent Texas Heart Institute and Baylor College of Medicine honorably.

**Systems-Based Practice:**
- Continue to promote best practices, particularly during administration of chief resident responsibilities.

**Supervisory Lines of Responsibility:**
The cardiothoracic surgery residents report directly to supervising faculty on whose service they are assigned. The on call resident reports to the respective staff surgeon who is on call each night.
1. Overview of Rotation

This 6-week rotation is designed to teach the third-year resident to perform preoperative evaluations, to participate as a surgeon (when appropriate) or assistant in thoracic and foregut surgeries, and to care for patients postoperatively. Your educational experience in these areas will have specific focus on patients with the following clinical problems:

- Non-Small Cell Lung Cancer (NSCLC)
- Solitary Pulmonary Nodules
- Pneumothoraces
- Pleural Effusions
- Malignant Pleural Mesothelioma
- Gastroesophageal Reflux Disease (GERD) and Hiatal hernias
- Esophageal motility disorders
- Esophageal perforation
- Esophageal cancer

You will be well prepared for this rotation if you have already mastered:

- Basic surgical skills – dissection, knot tying, suturing and respect for tissues
- Basic laparoscopy skills – port placement, camera driving, use of graspers, and handling of tissue laparoscopically
- Basic laparoscopic knowledge – use of CO2 insufflation and its attendant associated physiology
- The staging system and mediastinal lymph node map for NSCLC
- The staging system for esophageal carcinoma
- Radiographic chest anatomy
- Interpretation of esophageal function testing

2. Faculty

Dr. David J. Sugarbaker (DJS)  (cell, 617-824-0791)
Dr. Bryan M. Burt (BMB) (cell, 617-840-7411)
Dr. Shawn S. Groth (SSG) (cell, 617-834-5882)

Weekly Attending Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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Conference Schedule
1) Wednesday 7am  Surgery Grand Rounds
2) Thursday 7am  General Surgery M&M
3) Friday 7am  Division Regroup

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3. Expectations

- Dr. Burt and Dr. Groth are the Service Directors responsible for your overall experience on the service.

A. GENERAL GUIDELINES FOR FELLOWS/RESIDENTS:

1. All Fellows/Residents should provide cell phone # to all clinical staff on day 1 of rotation. On the day you begin service, please “share your contact” information via group text message to:
   - Dr. Sugarbaker (617-824-0791)
   - Dr. Burt (617-840-7411)
   - Dr. Groth (617-834-5882)
   - Phillip Bowden, NP (713-325-1834)
   - Lisa Icard, Clinic Manager (661-210-6380)
   - Sarah Moser, Division Administrator (847-220-0868)
   - Sherrie Benson, clinic MA (832-882-9250)

2. The resident should seek to meet with Dr. Burt and/or Dr. Groth at the very start of their rotation.

3. The residents are expected to care for the patients as if they are their own.

4. The residents are expected to prepare for cases as if they would be on their own.

5. The residents are expected to prepare for clinic as if it was their own.

6. Attendings expect to be contacted with any significant change in a patient’s clinical status. DO NOT HESITATE TO CALL AN ATTENDING.

B. EXPECTATIONS FOR FELLOWS AND RESIDENTS IN CLINIC:

Select patients in order according to their appointment time. Update the clinic board prior to entering exam room. Then please review the following and present in an organized and complete fashion:

1. **Room #, Name, Age, Where the patient is from**
2. **Surgery, date of surgery calculated as postop days/months/years; include neoadjuvant or adjuvant treatment**
3. **Review surgical pathology: report surgical stage and lymph node status**
4. **Assess vitals including room air oximetry, and weight. Assess walk oximetry and PFTs for all pneumonectomies, pleurectomies, and patients currently on oxygen**
5. **Review list of current medications with patient and their family**
6. **Review current symptoms and progress**
7. **Review all imaging, labs, and MD Notes from both within and outside of BSLMC**
8. **Physical Exam:**
   - **a. Cervical and Supraclavicular lymph nodes**
   - **b. Incision. Assess for recurrence**
   - **c. Chest wall**
   - **d. Rate and Rhythm**
   - **e. Auscultation-Wheezing, Rales**
   - **f. Abdomen**
   - **g. Pitting Edema**
9. **Define a plan of care and follow-up visit**
10. **If pre-op patient, prepare procedure consent and tissue bank consent.**
11. **All patient interactions need to be done in a confidential, respectful and professional manner in accordance with HIPAA and hospital policy (keep doors closed)**
12. **Fill out Clinic Face Sheets with all applicable information and update at subsequent visits.**
13. Do not routinely cut and paste information from prior notes without careful editing. It is acceptable to copy relevant objective reports (i.e.: pathology, radiology)
14. Documentation of clinic visits will occur immediately after visit and must be completed on the day of clinic.

C. EXPECTATIONS FOR FELLOWS AND RESIDENTS IN THE OPERATING ROOM:

1. Residents come prepared for cases
2. The resident and attending should define learning objectives prior to the case, and then regroup afterwards
3. Residents will write the white board for each case:
   a. H+P including HPI, PMH, PSH, Meds, ALL, Soc, Labs, Imaging Studies, Echo, PFTs
   b. Ten Steps that summarize the operation
4. Residents will assure imaging studies are viewable in the operating room
   a. Please display all relevant images on iSite (most of our studies are here and it will not auto-close).
   b. On certain occasions, the images must be displayed directly from the original discs (which must in these cases be delivered to the OR by the resident)

D. EXPECTATIONS FOR FELLOWS AND RESIDENTS ON THE WARDS:

1. Take control of the service as if it was your own. This means synthesize all available data and make and present your plan.
2. Attendings are always available to discuss the ongoing care of the patients, and expect to be updated with any significant change in clinical status of the patients.
3. Please input discharge orders and medications into St. Luke’s epic the night prior to patient discharge so that discharge medications can be obtained/delivered prior to patient leaving the hospital.

4. Learning Outcomes (Core Competencies)

A. Medical Knowledge

WEEK 1:
I. Preoperative Evaluation
   A. Describe the threshold for FEV1 and DLCO to safely perform a pneumonectomy or lobectomy
   B. Define postoperative predictive FEV1 based on VQ scan

II. Anatomy
   A. Describe bronchial anatomy during bronchoscopy
   B. Describe foregut anatomy during upper endoscopy
   C. Describe chest anatomy noted on chest CT

WEEK 2:
III. NSCLC
   A. ANATOMY
      1. Describe bronchopulmonary segmental anatomy.
   B. PATHOLOGY
      1. List the various NSCLC histological subtypes, ranking them from most common to least common.
      2. Recite which NSCLC histology has the best prognosis and which has the worst prognosis.
   C. STAGING
1. Recite the locations of the American Thoracic Society regional lymph node stations.
2. Identify which techniques can be used to sample a particular lymph node station.
3. Define the TNM staging system for NSCLC and be able to stage a patient based on information about the tumor, the presence or absence of lymph node metastasis, and the presence or absence of distant metastasis.
4. Describe the role and the sensitivity of each of the following techniques in the diagnosis and staging of NSCLC:
   a. Clinical Staging:
      1) History
      2) Physical Examination
      3) Chest X-Ray
      4) CT
      5) PET
      6) MRI
   b. Pathological Staging
      1) Image-guided biopsy of tumor
      2) Mediastinoscopy
      3) Chamberlain Procedure
      4) VATS/thoracotomy and biopsy
      5) Endobronchial Ultrasound-Guided Transbronchial Needle Aspiration (EBUS-TBNA)
      6) Endoscopic ultrasound-Guided Fine Needle Aspiration (EUS-FNA)

D. TREATMENT
1. Stratify patients into the most appropriate treatment regimen based on physiological fitness and TNM stage.
2. Describe the indications of each of the following surgical techniques based on TNM stage, tumor location, and physiologic fitness:
   a. Pneumonectomy
   b. Sleeve resection
   c. Lobectomy
   d. Anatomic segmentectomy
   e. Wedge resection
   f. Chest wall resection
3. Recite the indications for neoadjuvant and adjuvant chemotherapy.
4. Recite the indications for neoadjuvant and adjuvant radiation therapy.

E. PROGNOSIS
1. Recite the survival rate and risk of recurrence based on TNM stage and treatment

IV. Solitary Pulmonary Nodule
A. Define solitary pulmonary nodule.
B. Recite the differential diagnosis of a solitary pulmonary nodule.
C. Recite the risk of malignancy in a solitary pulmonary nodule based on smoking history.
D. Describe the evaluation and management of a solitary pulmonary nodule.

WEEK 3:
V. Malignant Pleural Mesothelioma (MPM)
A. ANATOMY
   1. Describe the anatomy of the visceral and parietal pleura
B. PATHOLOGY
   1. Recite the two principal MPM histologies
C. STAGING
1. Describe the role of each of the following techniques in the diagnosis, staging and preoperative evaluation of patients with MPM

2. Clinical Staging
   1. History
   2. Physical Examination
   3. Chest x-ray
   4. Chest CT (with vs. without contrast)
   5. PET/CT
   6. MRI

3. Diagnosis and Pathological Staging
   1. Thoracentesis
   2. Image-guided pleural biopsy
   3. Surgical biopsy
   4. Mediastinoscopy

D. TREATMENT
   1. Recite the indications for neoadjuvant and adjuvant chemotherapy.
   2. Recite the indications adjuvant radiation therapy.
   3. Recite the indications and contraindication of cytoreductive surgery

E. PROGNOSIS
   1. Recite the prognosis of after chemotherapy vs. multimodal therapy, including cytoreductive surgery

WEEK 4:

VI. Pleural Fluid Collections
   A. Classify pleural fluid collections as either a transudate or an exudate based on pleural fluid analysis (Light’s criteria).
   B. Provide a differential diagnosis of a pleural fluid collection based on a patient’s history and pleural fluid analysis.
   C. Describe the pathophysiology of pleural fluid collections.
   D. Describe the diagnostic work-up of pleural fluid collections.

E. Describe the management of the following pleural fluid collections:
   A. Effusions in the ICU
   B. Pleural space infections
   C. Malignant effusions
   D. Chylothorax

VII. Pneumothorax
   A. Describe treatment options for spontaneous pneumothoraces and recite indications for each approach

WEEK 5:

VIII. GERD and Hiatal Hernias
   A. ANATOMY
      1. Describe the pathophysiology of reflux
      2. Define type I, II, III and IV hiatal hernia.
   B. HISTORY
      1. Recite the typical and atypical symptoms of GERD
   C. COMPLICATIONS OF GERD
      1. Recite potential complications of GERD
      2. Describe the appropriate management of benign peptic strictures
3. Define Barrett’s esophagus
4. Describe the management of Barrett’s esophagus
5. Recite the risk of developing esophageal cancer in a patient with Barrett’s esophagus based on the degree of dysplasia

D. EVALUATION OF GERD PATIENTS
1. Describe the role of each of the following in the diagnosis of GERD:
   a. Upper endoscopy
   b. Esophagram
   c. Esophageal manometry
   d. Esophageal impedance
   e. pH study

E. TREATMENT
1. Recite the indications for anti-reflux surgery
2. Recite the steps of a laparoscopic Nissen fundoplication and hiatal hernia repair
3. Recite the indication for a Collis gastroplasty
4. List the complications of anti-reflux surgery
5. Describe the risk of and reasons for failure of antireflux surgery
6. Describe the cost effectiveness of medical vs. surgical treatment for GERD.

IX. Esophageal Motility Disorders
A. Interpret esophageal manometry results.
B. Interpret esophageal impedance results.
C. Interpret esophageal pH study results.
D. Recite the manometric criteria for each of the following esophageal motility disorders:
   1. Achalasia
   2. Diffuse esophageal spasm
   3. Nutcracker esophagus
   4. Ineffective esophageal motility
   5. Hypotensive LES
E. Describe treatment options for achalasia

X. Esophageal Perforation
A. Recite the differential diagnosis of pneumomediastinum
B. Describe the evaluation of pneumomediastinum
C. Recite the differential diagnosis of esophageal perforation.
D. Describe the appropriate diagnostic evaluation of esophageal perforation.
E. Describe the most appropriate treatment of esophageal perforation.

WEEK 6:
XI. Esophageal Cancer
A. ANATOMY
   1. Recite the blood supply to a gastric conduit
   2. Recite vascular anatomy of the celiac axis, SMA and IMA
B. PATHOLOGY
   1. Recite the most common histologies of esophageal cancer and their relative frequency
   2. Recite risk factors for each of the two major histological subtypes
C. STAGING
   1. Describe the TNM staging system for esophageal cancer
   2. Describe the role of each of the following techniques in the diagnosis, staging and preoperative evaluation of patients with esophageal cancer
   3. Clinical Staging
1. History
2. Physical Examination
3. Chest x-ray
4. Barium swallow
5. CT
6. PET/CT
7. MRI

4. Diagnosis and Pathological Staging
   1. EGD
   2. EUS-FNA
   3. Laparoscopic staging

D. TREATMENT
   1. Recite the indications for neoadjuvant and adjuvant chemotherapy
   2. Recite the indications for neoadjuvant and adjuvant radiation therapy
   3. Recite the indications for esophagectomy
   4. List the potential conduit options and the relative indications for each
   5. Recite the steps of an esophagectomy
   6. Recite the complications of esophagectomy and the management of those complications

E. PROGNOSIS
   1. Describe the prognosis of esophageal cancer based on TNM staging.

B. Patient Care

1. Weekly patient care case evaluation: Choose 1 case per week to perform a thorough history and physical exam, assessment with decision-making, and development of care plan, to be reviewed with an attending. Patients with the following diagnoses should be rotated as are available:
   - Solitary pulmonary nodule
   - NSCLC
   - Pleural effusion
   - Malignant pleural mesothelioma
   - GERD
   - Esophageal perforation
   - Esophageal carcinoma

C. Manual Dexterity

1. Identify and learn the use of the following laparoscopic and thoracoscopic instruments:
   - Types of graspers
   - Endostitch
   - Laparoscopic needle holders
   - Harmonic scalpel
   - Mediflex liver retractor
   - Carter-Thomas port closure device

2. Verbally outline the expected or routine steps in:
   - Mediastinoscopy
   - Thoracoscopic wedge resection of a pulmonary nodule
   - Talc pleurodesis
   - Nissen fundoplication
   - Esophagectomy
3. Function as an effective first assistant in the following advanced, thoracic and foregut surgeries:
   - Pleurectomy/decortication and extrapleural pneumonectomy for MPM
   - Lobectomy
   - Esophagectomy
   - Nissen fundoplication.

4. Perform portions or all of the following procedures:
   - Bronchoscopy
   - Mediastinoscopy
   - EGD with biopsy or dilatation
   - Thoracotomy
   - Thoracoscopic wedge resection of a pulmonary nodule (all)
   - Talc pleurodesis (all)
   - Laparoscopic port establishment, and set-up for minimally invasive foregut surgeries (all)
   - Nissen fundoplication (portions)
   - Laparoscopic jejunostomy (all, if skills permit)
   - Esophagectomy (portions)

D. Practice-Based Learning and Improvement

1. Identify own learning needs or goals at the onset of the rotation.

2. Following a procedure debrief with faculty what went well and what could be improved.

3. Access the literature to address at least one, case-based question of interest a week

4. Identify one facet of patient diversity (e.g., race, gender, ethnicity, culture) about which you need to learn more in order to provide ethical and respectful treatment, and pursue greater knowledge through reading or other means.

5. Explain to medical students (if rotating on the service) the fundamentals of your job, as well as their job.

6. Diagnose personal learning needs associated with any medical errors, complications, or “near misses” that occurred during your watch

7. Use feedback gained from others, and the experience gained on this rotation, to formulate future learning goals and steps.

E. Interpersonal Skills and Communication

1. Communicate patient information clearly to other health providers in written notes and oral presentations.

2. Apply appropriate communication skills with patients and families (i.e. effective listening, awareness of nonverbal cues, and use of open-ended questions).

3. Convey the results of an operation to the family in the immediate postoperative period with faculty present.

4. Counsel and educate patients and families on their treatment options, surgical outcomes and prognosis, and home care needs – with faculty and fellow supervision.
F. **Professionalism**

1. Adhere to patient privacy and informed consent policies at all times.

2. Adhere to Baylor College of Medicine behavior policies (e.g., sexual harassment, duty hours, dress code) at all times.

3. Demonstrate respect, compassion, integrity, and honesty in all interactions with patients, families, and other health care providers.

4. Demonstrate personal responsibility for patient welfare.

5. Articulate ethical issues underlying clinical decisions made for at least one complex case seen during this rotation.


G. **Systems-Based Practice**

1. Know when to call for help from attending physicians.

2. Provide timely and pertinent consultation when asked by other physicians, nurses, or page operators, and other health care personnel.

3. Estimate the costs and x-ray exposure of chest CT, chest X-ray, PET scan.

4. Consider patient characteristics (e.g., age, race and ethnicity, family support, socio-economic status, type of insurance) in evaluating treatment options and developing an appropriate care plan.

5. Diagnose any “systems issues” associated with medical errors, complications, and “near misses” that occurred during this rotation *(portfolio)*.

5. **Resident Assessment**

Residents will be evaluated through the following means:

- Observations during rotation by faculty.
- Mid-rotation feedback meeting with faculty.
- End-of-rotation chart-stimulated oral exam by faculty.
- Global evaluations submitted at the end of the rotation.
- Monitoring of attendance at M+M and grand rounds.
- Compliance with faculty and rotation evaluation (see below).

6. **Rotation Evaluation**

Residents will evaluate the rotation by submitting the following forms:

- Evaluation of faculty
7. Weekly Reading Assignments

I. WEEK 1: ANATOMY AND PREOPERATIVE EVALUATION
   A. Chest, 2013 May;143(5 Suppl):e1665-905

II. WEEK 2: PULMONARY NODULES AND LUNG CANCER

III. WEEK 3: MALIGNANT PLEURAL MESOTHELIOMA
   A. Adult Chest Surgery, Chapters 99, 102-103

IV. WEEK 4: PLEURAL EFFUSIONS AND PNEUMOTHORACES
   A. Adult Chest Surgery, Chapters 106-108

V. WEEK 5: BENIGN FOREGUT
   A. J Gastrointest Surg, 3 (1999), pp. 292–300
   B. J Gastrointest Surg, 13 (2009), pp. 1539–1549

VI. WEEK 6: ESOPHAGEAL CANCER
   A. NEJM. 2011. 365 (15): 1375-1383
   B. NEJM. 2012. 366 (22): 2074-2084
Duration: 3 Months

Supervising Faculty/Location:
- Dr. Faisal Bakaeen
- Dr. Lorraine Cornwell
- Dr. Shuab Omer

Level of Resident:
- PGY-6
- PGY-7

Goals:
Upon completion of the rotation on the Cardiothoracic Surgery at VAMC, the residents will achieve a broad base of knowledge in the preoperative, operative and postoperative care of the cardiothoracic surgical patient in a large VA Hospital.

Objectives:
1. To participate in all phases of care including preoperative work-up, the operative, postoperative care including outpatient follow-up.
2. To cover patients in the intensive care unit and gain the knowledge of critical care.
3. To attend and present patients as appropriate at the educational conference at the hospital.
4. To lead rounds on service patients daily.
5. Achieve a broad base of knowledge concerning the preoperative and postoperative care of the cardiothoracic surgical patient.
6. Be able to evaluate and formulate treatment plans for elective cardiothoracic surgical patients.
7. Have a wide exposure to, understanding of, and ability to treat a variety of postoperative conditions and/or complications.
8. Be able to demonstrate an understanding of pathophysiology of cardiothoracic surgical disease.
9. Be able to identify, resuscitate, and provide definitive treatment, both operatively and non-operatively, all emergency surgical patients.

Medical Knowledge
Demonstrate established and evolving medical knowledge in anatomy, physiology, and pathology in a wide variety of cardiothoracic diseases.

Interpersonal and Communication Skills
1. Apply interpersonal skills in a team environment composed of peers, nurses, students, staff and supervising faculty.
2. Listen and communicate effectively with patients and families.
3. Develop leadership role in facilitating patient care with nurses and physician assistants.

Professionalism
1. Practice with high standards of ethical principles in clinical care and patient confidentiality
2. Demonstrate progressively mature behavior and leadership skills; accept constructive criticism
3. Respond to the needs of the patient and the medical and professional community
Practice-Based Learning and Improvement
1. Demonstrate practice-based learning, especially in basic surgical procedures, emergency procedures and perioperative care of the cardiothoracic surgery patient; demonstrate commitment to improving patient care
2. Develop maturity and autonomy in patient care through graduated responsibility.

Systems-Base Learning
1. Apply knowledge to practice cost effective quality patient care.
2. Understand and function within a large managed VAMC health care system.

Scholarly Activity
1. Engage in discussion and participate in case presentations at educational conferences.

Supervisory Lines of Responsibility
The team consists of a Chief resident in Cardiothoracic surgery, a first year Cardiothoracic surgery resident, three physician assistants, one nurse practitioner and one nurse coordinator. This team reports directly to the supervising faculty.
1. CARDIOTHORACIC SURGICAL SERVICE ROSTER

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<th>PAGERS</th>
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<tr>
<td>Faisal Bakaeen</td>
<td>713-841-0448</td>
<td>27515</td>
<td>832-489-3202 (C)</td>
</tr>
<tr>
<td>Shuab Omer</td>
<td>281-551-0183</td>
<td>25352</td>
<td>419-260-7301 (C)</td>
</tr>
<tr>
<td>Loraine Cornwell</td>
<td>713-841-0657</td>
<td>28040</td>
<td>212-717-0123 (C)</td>
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<tr>
<td>Anthony Riffel</td>
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<td>Antonio Delgado</td>
<td>713-841-5280</td>
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<tr>
<td>James Swann</td>
<td>281-551-0307</td>
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<tr>
<td>Casiano Chi</td>
<td>*5 2165</td>
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<tr>
<td>Amy Miclat</td>
<td>281-551-0599</td>
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<td>OCL FAX #</td>
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<td>PA Office Fax #</td>
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2. ADMISSIONS:
All transfers and admissions need to be discussed with staff attending. Each patient needs a complete set of computer orders. The PAs will assist in writing the admission orders during weekdays. The resident on call will handle admissions on weekends. Patients need to be seen and examined and orders entered at the time of admission. H&P is required within 24 hours of admission. All H&Ps and notes must identify the attending physician and comment on staff concurrence, and have the attending as cosigner on the note (because attending note also must be signed within 24 hours).

3. PRE-OP GUIDELINES:
The operating resident will have seen and examined the patient, and reviewed the chart and studies. Make sure IMED consent is signed and in CPRS (outpatients consented by attending and PA; inpatients will require resident for IMED computer consent). Make it a general practice to discuss the procedure and risks with the patients’ family and establish a rapport with the family prior to the operation.

The resident is expected to know all details of the patient and present the case to the attending staff with a proposed plan. The operating resident should write a pre-op note in the computer the day before surgery, confirming that all is ready.

Clinic on Monday afternoons 1 pm on 5C includes preops, postops, and surveillance follow-up patients. All pre-ops seen in the clinic must be seen and approved by one of the staff.

CABG
• Standard Labs to Include: CBC, CMP, UA, PT/PTT/INR, Blood type, cross for 4/4/4
• Recent PA-L CXR
• EKG
• Transthoracic Echo (TTE)
• PFT
• Carotid Dopplers
• Cardiac Cath

AVR
• Standard Labs
• Recent PA-L CXR
• EKG
• Transthoracic Echo (TTE)
• PFT
• Carotid Dopplers
• Dental Consult
• Cardiac Cath (Left & Right)

MVR/MV REPAIR
• Standard Labs
• Recent PA-L CXR
• EKG
• Transesophageal Echo (TEE)
• PFT
• Carotid Dopplers
• Dental Consult
• Cardiac Cath (Left & Right)

AORTIC ROOT
• Standard Labs
• Recent PA-L CXR
• EKG
• Transesophageal Echo (TEE)
• PFT
• Carotid Dopplers
• Dental Consult
• Cardiac Cath (Left & Right)
• CT chest and abdomen

**THORACOABDOMINAL ANEURYSMS (TAAA)**
• Standard Labs
• Recent PA-L CXR
• EKG
• Transthoracic Echo
• PFT
• Carotid Dopplers
• Cardiac Cath (if appropriate)
• CT chest and abdomen
• Dobutamine Stress Echo (or cath if appropriate)

**LUNG RESECTION**
• Standard Labs
• Recent PA-Lat CXR
• CT (CT within 3 Mos.)
• EKG
• Dobutamine Echo / P Thall nuclear stress (if appropriate)
• PFT (w/RA ABG, and DLCO, or functional testing, if appropriate)
• Brain MRI if >stage I (if appropriate)

**ESOPHAGECTOMY**
• Standard Labs
• Recent PA-Lat CXR
• EKG
• Dobutamine Echo / P Thall
• PFT
• CT chest and abdomen
• EGD
• EUS
• PET/CT scan

4. **ASSIGNMENT OF SURGICAL CASES:**
The first year resident is generally responsible for the general thoracic surgical cases. The second year resident will be responsible for the cardiac and thoracic aortic procedures. The case assignment should be discussed between the residents the day before. These are only guidelines; case assignment could vary depending on resident experience and interests.

5. **SCHEDULING AND POSTING:**
Most of procedures on our service are electively scheduled as outpatient through the clinic. The PAs will maintain an updated list of the current status of the cardiac and thoracic outpatients. The TAVR coordinator maintains the TAVR list. The PAs will coordinate the OR schedule with the attendings for elective cases. Many consults are referred from IFC (interfacility consults), and so their travel must be arranged in advance. Usually those patients travel on Sunday and stay in the area for Monday clinic.

The PAs and residents will be responsible for making sure the patients are ready for surgery. Posting deadline is 12:00 noon the day prior to surgery for all elective operations (the PAs post the cases in ORC computer system, unless urgent add-on). Residents will be informed of the final OR schedule for the next day on afternoon rounds. Residents will need to post emergency cases on OR slips at the front desk. The cardiothoracic surgery service has one OR room from Monday to Friday and 2 rooms on Tuesday, Wednesday, and Friday.
OPERATING ROOM:
The patient will be brought to the OR between 7:15 and 7:30 am on weekdays, or at ~8:15 am on Wednesdays (late start day). The operating resident should be present at the time of anesthetic induction and during the placement of the Swan-Ganz catheter and positioning. If the resident is unable to be there, the staff should be notified in advance. Chest tube removals and extubations in the ICU should be done prior to the cases, so that no additional chores would delay your presence in the operating room. The resident assigned to the case is responsible for the positioning and draping of the patient as well as securing the perfusion lines.

Time out: Time out is a mandatory patient safety tool. The patient ID, site of surgery and the proposed operation will be reviewed with the team by the operating surgeon on entry into the OR, and a form is signed. Another time out is done immediately prior to skin incision by the operating resident, with the same information.

Briefing (Preop and Postop): After induction, the operating surgeon will review with the anesthesiologist, perfusionists, OR nurses and techs the plan for the operation. This should include preoperative antibiotics, plan for airway, plans for conduct of the operation, technical aspects of cardiopulmonary bypass, special instruments, and required prosthetics. At the conclusion of the case, the operating surgeon will debrief the team on team performance, equipment issues, anesthetic management and any other intraoperative issues that needs to be corrected for future cases.

Cardiac Cases: The operating resident will open the sternum and harvest the internal mammary for CABG cases. Please notify staff when the patient is ready for cannulation. NO heart cannulation will be done without attending supervision. The PAs will harvest the saphenous vein. Radial harvest will be discussed in advance. Intraoperative coagulopathy must be corrected in the OR prior to transfer to the SICU. We have a routine of measuring chest tube output every 5 minutes, and 3 “counts” should be less than 20ml before breaking down the perfusion lines. Inform the attending if the counts are higher.

Thoracic Cases: The operating resident will be present in the operating room for induction of anesthesia and ensure correct positioning of the double lumen endotracheal tube. Double lumen endotracheal tube position should be verified with the bronchoscope before scrubbing. Patients undergoing pulmonary resection will be evaluated with preoperative bronchoscopy in the operating room to assess resectability. Patients undergoing esophagectomy will be evaluated with flexible esophagoscopy and bronchoscopy in the room to assess resectability and conduit quality. Postoperative bronchoscopy will be performed for pulmonary toilet as needed. Any central lines should be placed on same side of the thoracotomy to prevent risk of pneumothorax on the contralateral lung. Central line is not usually needed for thoracic cases unless specified. Please notify staff when the patient is being positioned.

SICU:
The operating resident is expected to participate in the patient's transfer from the operating room to the ICU and to always be available. The resident is expected to stay at the bedside until all the monitoring lines and all the drips have been transferred from anesthesia to ICU.

A consult to cardiac rehab / PT will be entered into CPRS for all patients undergoing major cardiothoracic surgery on admission to the SICU.

Orders: There are 8 standardized computer order sets in CPRS.
1. Postoperative cardiac order set for the SICU
2. Postoperative thoracic order set for the SICU
3. Cardiac transfer order set for 5A Step-down
4. Thoracic transfer order set for 5A Step-down
5. Postoperative TAVR order set for the SICU
6. TAVR transfer order set for 5A Step-down
7. Postoperative Esophagectomy order set for the SICU
8. Esophagectomy transfer order set for 5A Step-down

These are found under the ORDER tab, under the CARDIOTHORACIC section in CPRS. Note that all patients admitted to the SICU require activation of the mandatory SICU order set for critical care issues. The order sets are general guidelines to help you with your orders, but should not dictate your postoperative care. Please adjust them as you see fit for each patient. Let us know if there are obsolete orders or if the set should otherwise be updated or improved.

8. TRANSFER FROM SICU TO STEPDOWN UNIT
The patients will be transferred to the 5A Cardiothoracic Surgery Step-down Unit. Generally this occurs on POD #2, but depends on the patient’s status. Notify the NP/PA's about transfers and specific instructions. The residents or NP should write transfer orders from the SICU to the Step-down Unit before 7AM in order to avoid delays in the OR schedule. The PA's will assist in care of the 5a Step-down patients including writing routine progress notes and discharge summaries, but on weekends, the resident is responsible for those tasks.

9. AFTERNOON ROUNDS:
Daily afternoon teaching rounds with attendings, residents, students, NPs and PAs will be at 4-5pm or when all service duties are completed. Residents are responsible to have all the information and studies on the patients ready for afternoon rounds. Please bring up topics that you would like to discuss about recent patient care.

10. DISCHARGES:
No patient will be discharged without the approval of the attending staff. The discharge orders are generally written by PA or NP, and should be written early, prior to 9am on the day of discharge in order to facilitate the transfer of patients from the SICU.
The PAs are expected to write DC summaries on anyone discharged during the week. The residents may be asked to dictate weekend DC summaries and any not completed by the PA on the day of DC.
When patients are D/C after surgery they will need a F/U appointment to cardiothoracic surgery clinic in 2-3 weeks with a pre-clinic CXR, which can be written for in the orders for D/C. Also all medications and the prescriptions for the medications must be entered into the computer.
Travelling Patient:
All patients that are traveling to distant VA sites must have their discharge & travel arrangements made at least 48 hours in advance. It must include their medication & prescriptions for them, whether a travel attendant is necessary (or family member is OK) and the accepting doctors name at the other VA sites. The chart must be signed off completely on the day of travel before the patient can leave. Please involve the social worker well in advance.

11. THORACIC ONCOLOGY:
Preoperative considerations: Consider split lung function test (if pneumonectomy is considered). Please obtain metastatic workup (MRI brain, PET/CT scan) for all high-risk patients.
Staging EBUS is liberally used for evaluation of possible mediastinal metastasis, done by interventional pulmonary. It will be performed for any CT adenopathy (>1cm), mass >3cm or central, or if extended pulmonary resection is considered.
All patients with esophageal cancer and patients with stage IIIA lung cancer will be considered for neoadjuvant protocols. All patients with postoperative lung cancer stage IB (T2) or greater will be referred for consideration for postoperative adjuvant chemotherapy.
Follow up/ Cancer surveillance: We follow NCCN guidelines for cancer surveillance, and this should be documented in the postop notations. Lung cancer patients will be scheduled for follow-up with CT scan every 4-6 months for the first 2 years, then annually thereafter. The follow-ups may be performed with outlying clinics or oncology or primary care physicians if detailed discussion is made with the patients and careful documentation for the follow-ups is made in the progress notes. Residents and PAs will ensure that timely proper follow-ups are made with oncology and radiation therapy if adjuvant treatments are appropriate.
Pulmonary Conference: Multidisciplinary tumor board conference for pulmonary disease is held every Tuesday at 1:00 pm on 4th floor in the Cancer Center. Participation in MDTB is strongly encouraged. If the residents are not in the OR, they should be in conference. All surgical cases from the previous week should be presented at the Tuesday conference. A list of cases to be presented must be provided to Dr. Linda Green (pager 1341, Ext. 7266) by Friday before the
conference for preparation of the pathology slides. Tony Riffel, PAC helps with preparation for MDTB; please discuss with him which case will be presented.

**General Tumor Board:** Multidisciplinary oncology conference is held every Wednesday at noon in the 4th floor cancer center. Esophageal cases are often reviewed at the general tumor board. If residents are not in the operating room, tumor board participation is encouraged.

12. **DICTATION:** Operative dictations will be completed on the day of surgery. To ensure that you are credited with the dictation, the 6 digit code for the dictation should be included in the written CPRS brief operative note. Contact transcription to set up user ID for dictation. Operative privileges can be taken away for failure to dictate in a timely way. Residents should not sign the operative reports in the CPRS system; the attendings will need to edit and sign the reports. Some staff prefer to dictate their own notes (discuss after the case).

13. **CHARTS/PROGRESS NOTES:** Progress notes, Clinic notes, Consult notes, H&Ps, Discharge Summaries, and operative notes must document appropriate staff participation such as: ”The patient was seen with staff and he agrees with plans”, or ”Staff was present and assisted during all the principal parts of the operation”.

All verbal or telephone orders to the nurses need to be countersigned within 24 hours.

All patients require a pre-operative note, brief operative note, postoperative note, and daily progress note by residents in the medical record. The template for CTS progress note includes the required performance measures. Glucose level should be documented in the post-cardiac patients as part of the note.

14. **WEEKLY CONFERENCE and CLINIC SCHEDULE**

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<th>MONDAY</th>
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<td>CT SURGERY TEAM</td>
<td>7:30 TAVR conference</td>
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a. **CT Surgery Meeting:** Weekly CT Surgery Team meeting will be held every Monday morning at 8 a.m. in room 5B-170D. The residents will review the in-patients. The clinic list and preop lists will be discussed. Scheduling issues, research updates, as well as clinical and administrative issues will also be discussed in this meeting.

b. **Pulmonary Conference:** The first year thoracic resident is responsible for presenting the post-op cases in the pulmonary conference. Dr. Linda Green can be notified at VA pager 1341 as to which cases will be presented so that she can prepare the pathology slides. Attendance at this conference is mandatory.

c. **Morbidity and Mortality Conference:** Morbidity and mortality cases are discussed in this weekly conference on Wednesday at 4pm. The resident will submit brief write-ups on all complications to the surgical office by Monday morning for the week prior, and prepare a brief power point presentation as per Baylor format. These should be reviewed and discussed with the attending before submission.

15. **CLINIC RESPONSIBILITIES:**

Thoracic Surgery Clinic starts at 1:00 p.m. on Mondays on 5C. Residents should participate in clinic unless they are in the OR. Patient encounter forms need to be completed on the computer on every patient since these forms are part of the tracking mechanism for assessing our workload. Put the attending as co-signer on all notes.
16. **NON-OR INVASIVE PROCEDURES:**
All invasive procedures that require a consent AND is not being performed in the OR needs to be tracked for Q&A purpose. An “Invasive Procedure Note” should be done for all of these type of procedures (central line, thoracentesis, chest tube), using the CPRS template, which includes all of the required elements (such as correct site, time-out). It is the responsibility of the residents who performed the procedure to give this list to Clara Kistner, RN or Oscar or Leticia (Q&A person) on a weekly basis, usually during the Monday 8am team meeting.

17. **NP/PA GUIDELINES:**
NP/PA’s will be responsible for care of the floor patients and their notes. Consults: Residents are responsible for notifying PAs of all new consults on the same day they are received. If a resident is not available for timely evaluation of a new consult, a PA will evaluate that patient. The PAs will maintain follow-ups on patients transferred to rehab services. The PA’s scope of practice does not include operating independently in the OR. PA’s will be supervised by the thoracic resident or attending staff when performing procedures and in the OR.

18. **ATTENDING NOTIFICATION**
Please notify appropriate attending physician when a patient is admitted, when an urgent consult is requested, or when an inpatient condition deteriorates. It is better to let the on-call attending know about any consult right away in case OR schedules will need to be adjusted. Transfers from other VA facilities or local hospitals must be accepted by an attending physician. Please direct these issues to staff.

19. **VACATION TIME**
The residents are allowed a one-week period of vacation during their rotation at the Houston VAMC. The residents will be expected to submit their vacation request to the Thoracic Residency Coordinator (Jaye Chambers) prior to the rotation for planned vacations.

20. **VA PAGERS, KEYS, AND PARKING PASS**
VA pagers, keys and parking passes for the residents will be issued at each rotation. At the end of the resident’s rotation, all VA property will be returned.

21. **PATIENT CARE : Routines and Tips**
- **Consults-** Always check first with attending if a patient needs consultation with other services. Although you can call for nutrition, speech pathology, cardiac rehab, PT/OT and social services

- **Vent Management**
  - Check ABG 30 minutes after vent change, change in mental status or respiratory distress
  - Extubate on POD # 1
  - Neb treatments with albuterol, xopenex and atrovent q 6 hours
  - BIPAP 10/5 q HS and prn naps if patient has OSA or borderline hypoxemia
  - Correct any acidosis quickly—(with Bicarbonate if metabolic acidosis, increased ventilation if respiratory acidosis)

- **Pressors/inotropes**
  - Titrate pressors to keep SBP> 110 MAP> 70. If history of HTN or CVA, keep BP higher.
  - Vasopressin drip first choice for Dr. Cornwell

- **Anemia**
  - Check with staff prior to transfusions. Consider a Hgb>=8 adequate if patient 65yo and asymptomatic
  - Repeat stat H&H if patient symptomatic (orthostatic/fatigued)? Tachycardic?
  - All stools should be checked with guaiac testing for blood
  - Initiate ulcer prophylaxis if not currently on it (Protonix 40 mg IV/PO daily or Omeprazole 20mg po daily
  - Ferrous Gluconate 325 mg PO BID
  - Thiamine 100mg PO BID
  - Folic acid 1 mg PO daily
Epogen 10,000 units 3x per week—not used much anymore—check w staff

- **Antibiotics**
  - DC antibiotics on after 47 hours(cardiac) and 23 hours(thoracic)--
  - Cefepime 1 gm q 8 hours and Vancomycin 1 gm q 12 hours for cardiac
  - Cefoxitin 1gm q12 and Vancomycin 1 gm q12 for Esophagectomy patients
  - Cefazolin 1gm q 8 hours x 23 hours for thoracic patients

- **Extubation**
  - Get weaning parameters and ABG on CPAP. Then extubate in amPOD#1

- **Coumadin**
  - Start after pacing wires removed
  - Keep INR 2.5- 3.5 for mechanical valve, 2-3 for afib

- **Arrhythmias**
  - V-tach-
    - Check Mg, Ca, Phos, and K levels
    - Attach defibrillator pads and turn machine on
    - Think Amiodarone or Lidocaine but be aware of QT and QT corrected levels
  - A-fibrillation-
    - Amiodarone drip for Dr. Cornwell’s patient in the ICU. Amiodarone should not generally be given by PIV (use central line) Use Metoprolol and PO Amiodarone in 5a stepdown

- **TAVR**
  - Watch for vascular issues in legs
  - Watch for bradycardia. Worry about heart block and always have Cordis and do transcutaneous venous placement via Cordis.
  - If the patient has aortic insufficiency-keep them with permissive tachycardia and no beta blockade. Also after-load reduction with Lasix and milrinone
  - Keep MAP 65, SBP= 110-130

- **Transfer to 5a step-down**
  - Usually Transfer on POD # 2—use transfer template. Start home meds.

- **Transfer back to SICU**
  - Always notify staff

- **Discharge**
  - Follow up appt 2-4 weeks after discharge home

- **DVT prophylaxis**
  - Start Lovenox 40mg SC daily when Plt count >80 and if creatinine < 2.0
  - Heparin 5000 units SC q 12 hours if creatinine > 2.0

- **Foley catheter**
  - DC Foley catheter before 12noon–day of transfer to 5a step-down

- **GI prophylaxis**
  - Protonix 40 mg IV daily while NPO
  - Omeprazole 20mg PO daily
  - Or Ranitidine 150mg PO or JT BID (use elixirs only for jtube—crushed meds tend to cause clogs)

- **Hypotension**
  - Give crystalloid (NS or plasmalyte), or 5% albumin if preload is the issue
- Correct acidosis with bicarbonate
  - Correct hypocalcemia

- **Home medications**
  - Resume home medications when appropriate
  - Make sure to reconcile outpatient medications

- **Lab and imaging studies**
  - Daily CBC, BMP, Mg, Phos, PCXR in SICU
  - Daily CBC, BMP, Mg, Phos x 3 days and CXR PA/LAT in 5a stepdown.

- **Low EF**
  - Use Coreg instead of Metoprolol
  - Discuss ?EP consult if EF<35%, lifevest/ AICD

- **Chest tube**
  - Remove chest tubes POD # 2 when chest tube output < 200 past 24 hours(post pump case)
  - Chest tube to water seal POD# 1 for Thoracic patients, and check CXR on waterseal prior to transfer out of SICU
  - Digital chest drain—Medela Thopaz, for lung resection patients only. Start at -20 cm H20 suction, then to -8 cm H20 on POD1

- **Pacing wires**
  - Remove TPW’s on POD # 3-4 once cleared with attending surgeon, before starting anticoagulation. Lovenox or other anticoag may need to be held. The transfer orders should have Lovenox timing at 5 pm so this may not be an issue. If anticoag is necessary, TPWs may need to be cut.

- **POD# 1**
  - Get weaning parameters and ABG on CPAP. Then extubate if ok.
  - Start PCA morphine
  - Start Lasix q12H if appropriate
  - Start in low dose beta blocker BID
  - Remove Swan Ganz
  - Start clear liquid diet
  - Start Coreg for low EF instead of Metoprolol
  - Transition Regular Insulin drip to SSI

- **POD# 2**
  - DC antibiotics
  - Remove chest tubes
  - Start oral pain meds
  - Start lovenox 40 mg SC daily at 1700 if platelet count >100 after the Chest tubes out
  - Transfer to floor. Foley d/ced upon transfer order. (in am please)
  - Advance diet -Regular or low fat or diabetic diet
  - Consult Physical therapy
  - Start stool softeners

- **Pneumothorax**
  - Insert chest tube to -20cm suction
  - PCXR daily while CT in

- **Sedative/Narcotic**
o Assess wakefulness prior to starting Fentanyl or Propofol immediately post-op
o Fentanyl drip while intubated
o Propofol drip while intubated
o PCA morphine once extubated
o Norco 5/325 1-2 tabs PO q 4 hours prn
o Tylenol 1000mg IV q 6 hours x 24 hours
o Tramadol 50mg PO q 6 hours prn (if allergic to Hydrocodone)
o NO Toradol for Dr. Omer’s patient

• Activity
  A. Patient needs to be encouraged to get out of bed BID to chair while in SICU if hemodynamically stable.
  B. Patient to be on bed rest if one of the following
     O Unstable vital signs
     O Patient complains of weakness or vertigo (place on fall precautions!!)
     O Patient has any other reason that makes it unsafe for him/her to get out of bed
  C. The following are NOT reasons to be on bed rest
     O Patient has chest tube
     O Patient “does not want to” unless has one of above reasons

• Staples /Sutures
  o Staples and suture removed during follow up appointment

22. RESIDENT EXPECTATIONS:
  • Conference- Attend all mandatory conferences (Mon team meeting, Tues Pulmonary MDTB, Wed Teaching conference, Morbidity and Mortality)
  • Clinic- Resident should be present in the clinic on Mondays to help evaluate patients. This is a requirement in residency training for your learning experience. All pre-ops seen in the clinic must be approved by one of the staff and then sent for pre-op testing.
  • Pre-op- Expected to know all the details of the patient and present the case to the attending staff with a proposed plan. The operating resident should write a pre-op note in the computer the day before surgery. Patient must be seen, examined and consented (IMED consent unless unavailable—then write an email to Dr. Bakaeen with explanation).
  • Consents- Responsible for making sure informed consent is obtained from the patients prior to surgery date. Make it a general practice to discuss the procedure and risks with the patients’ family and establish a rapport with the family prior to the operation.
  • OR-It is expected that all residents participating in a procedure read about the case ahead of time and understand the indications, technical anatomy, and possible complications for all elective cases. Patients must be seen, evaluated and marked as indicated. Always update H&P prior to case. The operating resident must be present at the time of anesthetic induction and during the placement of the Swan-Ganz catheter. If the resident is unable to be there, the staff should be notified prior to that time. The resident assigned to the case is responsible for the positioning and draping of the patient as well as securing the perfusion lines.
  • Dictations -Operative reports must be dictated immediately after the case is completed, and the reference number should be attached to the brief op note.
  • Attitude- Always maintain a positive and professional demeanor
  • Attire-Report to work clean and presentable at all times.
  • Education- Residents are expected to participate in the education of medical students and are expected to welcome them to the rotation, show them the ropes, teach and foster their education.
• Consults- Residents are expected to see and evaluate all inpatient consults, and notify on call attending immediately. Residents are responsible for notifying PAs of all new consults on the same day they are received. If a resident is not available for timely evaluation of a new consult, a PA will evaluate that patient.

• Hospital admission- On call attending should be notified of any transfer/admission. Do not accept transfers. All transfers are only approved by attending.

• Transfer to Stepdown – SICU patients will be transferred to the 5a Stepdown Unit. Notify the NP/PA’s about transfers and specific instructions. The residents must write transfer orders from the SICU to the Stepdown Unit early in the day, in order to avoid delays.

• SICU- The operating resident is expected to participate in the patient's transfer from the operating room to the SICU, watching for potential problems or complications, assisting the nurses and anesthesiologists, and to always be available. The resident is expected to stay at the bedside until all the monitoring lines and all the drips have been transferred from anesthesia to SICU. Also, the resident is expected to perform daily management of patients and write progress notes, and perform any necessary ICU procedures. Chest tube removal and extubation should be done early so that no additional chores would delay presence in the operating room.

• On-call - If all service patients are stable, the Houston VA call is from home. However, if any patients are unstable, the on-call resident may be expected to be in-hospital for close monitoring of the patient. The following are possible criteria for in-house call: ECMO/ LVAD, significant mediastinal drainage (more than 200 mls per hour), marginal respiratory status and potentially will require intubation, hemodynamic instability, possible need for re-exploration. Please discuss need for in-house availability with the attending surgeon. We expect residents to follow the working hours regulations and inform us if they are going over the hours. The resident should consider remaining in-house at least for several hours after significant mediastinal drainage has ceased. This is to assure that the patient is not simply collecting the drainage inside his chest and is at risk for cardiac tamponade. If the nurses call for severe hemodynamic abnormalities or if the resident judges the need to start a new inotropic support, the resident is expected to physically assess the situation. The resident is also expected to notify the attending physician in case of significant developments in the patient's condition, i.e. bleeding, significant hemodynamic instability or need for further inotropes.

• ATTENDING NOTIFICATION: Notify attending of any major/significant change in patient’s condition which includes the following:
  o Arrest/death
  o Unstable hemodynamics
  o Unplanned intubation
  o Sudden or severe hypoxia, or the requirement of 100% face mask or BIPAP
  o Severe acidosis PH< 7.2 or BE >-8
  o Stroke/TIA/seizure/paralysis/LOC/ syncope/ or sudden change in mental status (& stroke code should also be called)
  o Loss of pulses or doppler signals
  o Chest tube bleeding > 100c/hr or significant drop in Hgb or any bleeding from any source (urine, stool, NGT, lines)
  o Arrhythmia (VT, VF, SVT, severe bradycardia- especially with instability)
  o Any abrupt change or unstable vital signs- i.e. need to increase vasopressors in order to maintain MAP> 70 or SBP >110

• Notes- Progress notes, Clinic notes, Consult notes, H&Ps, Discharge Summaries, and operative notes must document appropriate staff participation. Please add the attending as a signer in CPRS for all notes except daily progress notes. Medication reconciliation is required on the H and P. An “OCL update” on the H and P is required the morning of surgery, and also documents that the med reconciliation was double checked. All patients require a pre-operative, operative, postoperative, and daily progress notes. We expect that the CTS templates will be used to help ensure compliance with the performance measures.
• Rounds- Be ready for morning and afternoon rounds. Morning rounds are work rounds with the students and NP, and attendings should be updated on their patients’ status. Afternoon rounds are with the whole team, and the student should present one patient each afternoon rounds.

• Continuing education- On non-OR days, please pursue further educational experiences. Cardiology has stated that CTS residents are welcome in the cath lab. There is a bronch simulator in bronch lab on 3rd floor, and Lap Sim in STAR LAB in library on 4th floor. Residents are welcome to assist Dr. Casal with EBUS or rigid bronch procedures. Ask the attendings to introduce you/ facilitate your experience, when you are ready to do this.

• Final tips
  o Call staff early- staff would rather be contacted for the great majority of things if you are concerned
  o Stay calm in a crisis. There will be crises, this is heart surgery.
  o Teamwork is key. Trust no one outside your team, or at least trust yet verify
  o Keep track of who you speak with in radiology, lab, pathology etc.
  o Try to get along with the nurses- they can make your day easy
  o Sleep when you can, eat when you can and laugh when you can!
Overview:
The professional position/job of a fellow in the Congenital Heart Surgery Section of the Michael E. DeBakey Department of Surgery at Baylor College of Medicine includes a combined learning/teaching approach in accordance with the recommendations and requirements from the American Board of Thoracic Surgery, Residency Review Committee, and the ACGME. Training components include patient care, education, and research.

Congenital Heart Surgery is a difficult and highly specialized field. State-of-the-art results are only obtained in centers dedicated to the ideal that the treatment of children with complex heart defects requires consistency, accuracy, and diligence. We are committed to your development of proficiency in the diagnosis and treatment of diseases of congenital arterial, venous, and lymphatic circulatory systems, including those components intrinsic to the heart.

The faculty and staff of Congenital Heart Surgery at Texas Children’s Hospital are dedicated to ensuring all house staff have a quality educational experience. Fellows are provided learning and teaching opportunities with attending faculty mentorship, guidance, and supervision in accordance with the ACGME requirements. The curriculum is designed to assure well rounded didactic and clinical experiences to develop the competence of fellows in the six areas of Core Competencies outlined by the ACGME: Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice.

Specific Duties and Expectations:
Each Post Graduate Year (PGY), or level of training, includes specific competency and duty expectations, and fellows undertake progressively more responsibility (graduated levels of responsibility) in patient care and educational activities. The following are PGY level goals/objective and service expectations of the house staff rotating with Congenital Heart Surgery at Texas Children’s Hospital.

PGY 6 Residents
Residents in their sixth postgraduate year of Thoracic Surgery training rotate on the Congenital Heart Surgery Service for a three month rotation. During the rotation they are under the supervision of faculty and are expected to participate and/or develop specific procedure capabilities and competences. It is anticipated the residences will develop and execute patient care plans, demonstrate technical ability, use information technology, and evaluate diagnostic studies. Residents are expected to know and understand current medical information and critically evaluate the scientific information. Further, it is necessary that they demonstrate the ability to practice lifelong learning, analyze personal practice outcomes, and use information technology to optimize the care of their patients. It is anticipated that they would have increasing capabilities with regards to communication with other healthcare professionals, counsel and educate patients and families and maintain appropriate records documenting practice activities and outcomes as well as to function as a team member and/or leader.
### GOALS
**PGY-6**

- Expose the resident to Congenital Heart Surgery and transplantation in a setting of optimum patient care.
- Educate the fellow in the diagnoses and management of patients with congenital cardiac disease including pre and post-operative assessment, surgical consultation, and inpatient care.
- Expose fellow to a minimum of 75 major congenital cardiac surgery procedures as required by the ACGME.
- Educate the fellow in the anatomy and physiology of the majority of congenital cardiac lesions while providing a basis of surgical technical proficiency for common, uncomplicated congenital cardiac defects.
- Develop a broad knowledge in the diagnoses and treatment of patients with congenital heart defects in preparation for the ABTS Subspecialty Board Examination in Congenital Heart Surgery.
- Ensure fellow conducts himself in a professional manner with patients, families, and other health care partners.
- Expose the fellow to challenges and benefits of working in various health care setting and systems.
- Educate the fellow on the value and importance of outcomes and continuous learning.
- Introduce the fellow to data management and monitoring patient outcomes.
- Introduce the resident to the business of healthcare management.
- Introduce the fellow to AMA ICD-9 and CPT coding.

### OBJECTIVES
**PGY-6**

- Understand the embryology of the heart and great vessels as it relates to normal anatomy of the heart, and the development of congenital cardiac anomalies.
- Gathers essential and accurate information about the patients.
- Integrates clinical data to generate appropriate differential and management plans.
- Appropriately follows-up on patient's clinical status and progress toward management goals.
- Identifies and adapts to changing clinical conditions.
- Performs all essential technical procedures competently, asking for help when appropriate.
- Demonstrates an up-to-date knowledge and application of disease path physiology, diagnosis, and treatment.
- Creates and sustains a therapeutic relationship with patients and their families, displaying sensitivity to age, gender, culture, and socio-economic class.
- Interacts appropriately and effectively with all members of the multidisciplinary team.
- Interacts appropriately and effectively with primary surgical team and consultants.
- Prioritizes tasks and manages time efficiently.
- Practices cost-effective medical care.
- Prepares for rounds and conferences.
- Constructs clinical questions and consults the critical care literature for answers.
- Accepts constructive criticism/admits errors.
- Mentors medical students.
• Acts in a professional manner (arrives on time, dresses appropriately, completes tasks when assigned, and utilizes time wisely.

<table>
<thead>
<tr>
<th>CORE COMPETENCIES</th>
<th>PGY-6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td>Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of the knowledge to patient care.</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td>Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals: 1) Identify strengths, deficiencies, and limits in one's knowledge and expertise. 2) Set learning and improvement goals. 3) Identify and perform appropriate learning activities. 4) Systemically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. 5) Incorporate formative evaluation feedback into daily practice. 6) Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems. 7) Use information technology to optimize learning. 8) Participate in the education of patients, families, students, residents, and other health professionals.</td>
</tr>
<tr>
<td><strong>Practice-based Learning &amp; Improvement</strong></td>
<td>Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals: 1) Identify strengths, deficiencies, and limits in one's knowledge and expertise. 2) Set learning and improvement goals. 3) Identify and perform appropriate learning activities. 4) Systemically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. 5) Incorporate formative evaluation feedback into daily practice. 6) Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems. 7) Use information technology to optimize learning. 8) Participate in the education of patients, families, students, residents, and other health professionals.</td>
</tr>
<tr>
<td><strong>Interpersonal &amp; Communication Skills</strong></td>
<td>Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. 1) Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds. 2) Communicate effectively with physicians, other health care professionals, and health related agencies. 3) Work effectively as a member of leader of a health care team or other professional group. 4) Act in a consultative role to other physicians and health professionals. 5) Maintain comprehensive, timely, and legible medical records.</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Resident must be able to demonstrate the following: 1) Compassion, integrity, and respect for others. 2) Responsiveness to patient needs that supersedes self-interest. 3) Respect patient privacy and autonomy. 4) Accountability to patients, society, and profession. 5) Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.</td>
</tr>
</tbody>
</table>
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

1) Work effectively in various health care delivery settings and systems relevant to their clinical specialty.
2) Coordinate patient care within the health care system relevant to their clinical specialty.
3) Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-bases care as appropriate.
4) Advocate for quality patient care and optimal patient care systems.
5) Work in inter-professional teams to enhance patient safety and improve patient care quality.
6) Participate in identifying systems errors and implementing potential systems solutions.

Fellows and residents will be expected to demonstrate cost-effective health care delivery without compromising quality of care.
Fellows and residents will be afforded the opportunity to explore the possibility of a future career focused in congenital heart surgery, having observed performance expectations in this multi-disciplinary clinical setting.
University of Texas M. D. Anderson Cancer Center  
Thoracic Surgery Residency Program  
Goals & Objectives

Goals:

Patient Care:
The fellow will be able to present a cohesive plan for the evaluation and management of surgical diseases of the thorax. This will involve all phases of care including preoperative assessment, intraoperative decision-making, technical performance, immediate postoperative care, and long-term follow-up. Education in Patient Care is specific to each of the three disciplines represented in cardiothoracic training (acquired adult cardiac, congenital, and general thoracic).

Medical Knowledge:
The fellow is expected to achieve a broad base of knowledge and skills concerning the diagnosis and treatment of disorders commonly seen in the cardiothoracic surgical patient.

Practice-based Learning and Improvement:
The fellow should be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and continually strive to improve their patient care practices.

Interpersonal and Communication Skills
The fellow should be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates.

Professionalism
The fellow must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Professionalism is based on the principles of primacy of patient welfare, patient autonomy, and social justice. It involves all of the following responsibilities: competence, honesty, patient confidentiality, appropriate relations with patients and coworkers, improving quality of care, improving access to care, just distribution of finite resources, commitment to scientific knowledge, maintaining trust by managing conflicts of interest, and a commitment to professional responsibilities.

Systems-Based Practice
The fellow will appreciate the wide variety of disciplines involved in the delivery of modern medical care and be able to effectively utilize those systems to provide quality and cost effective health care.

Objectives:

Patient Care
The objectives for patient care have been adapted from the TSDA Comprehensive Cardiothoracic Curriculum and correlate with the learner objectives presented in each unit (http://www.tsda.org/curriculum/Blue_Book_Curriculum_2004.pdf).

It is unlikely that every fellow will be exposed to all the clinical scenarios listed in the objectives below during their rotation. However, it is expected that each fellow will capitalize on every clinical scenario that does become available during each rotation. The performance of more complex techniques and a greater responsibility of the patient’s care will be based on the fellows’ performance and frequency of exposure to a particular clinical scenario rather than on the time spent at a particular institution or their PGY level.
Medical Knowledge

I. Chest Wall
   - Anatomy, Physiology and Embryology
   - Acquired Abnormalities or Neoplasms
   - Congenital Abnormalities and Thoracic Outlet Syndrome

II. LUNGS AND PLEURA
   - Anatomy, Physiology, Embryology, and Testing
   - Non-Neoplastic Lung Disease
   - Neoplastic Lung Disease
   - Congenital Lung Disease
   - Disease of the Pleura

III. Trachea and Bronchii
   - Anatomy, Physiology, and Embryology
   - Congenital and Acquired Abnormalities
   - Neoplasms

IV. MEDIASTINUM & PERICARDIUM
   - Anatomy, Physiology, and Embryology
   - Congenital Abnormalities of the Mediastinum
   - Acquired Abnormalities of the Mediastinum
   - Congenital and Acquired Abnormalities of the Pericardium

V. DIAPHRAGM
   - Anatomy, Physiology, and Embryology
   - Acquired Abnormalities, Neoplasms
   - Congenital Abnormalities

VI. ESOPHAGUS
   - Anatomy, Physiology, and Embryology
   - Congenital Abnormalities
   - Acquired Abnormalities
   - Neoplasms

VII. CONGENITAL HEART DISEASE
   - Embryology and Anatomy
   - Physiology and Physiologic evaluation
   - Cardiopulmonary Bypass for Operations on Congenital Cardiac Anomalies
   - Left-to-Right Shunts
   - Cyanotic Anomalies
   - Obstructive Anomalies
   - Miscellaneous Anomalies
   - Principles of Postoperative Care

VIII. ACQUIRED HEART DISEASE
   - Coronary Artery Disease
   - Myocarditis, Cardiomyopathy, Hypertrophic Obstructive Cardiomyopathy, Cardiac Tumors
   - Abnormalities of the Aorta
   - Cardiac Arrhythmias
   - Valvular Heart Disease

IX. THORACIC TRAUMA
   - Trauma of the Chest Wall
   - Tracheobronchial and Pulmonary Trauma
   - Esophageal Trauma
   - Diaphragm Trauma
   - Cardiovascular Trauma

X. TRANSPLANTATION
   - Cardiac Transplantation
Lung Transplantation

Heart-Lung Transplantation

XI. EXTRACORPOREAL BYPASS AND COAGULATION-BLOOD PRODUCTS

- Physiology of Extracorporeal Bypass
- Techniques of Extracorporeal Bypass
- Mechanical Support
- Fundamentals of Coagulation Management and Blood Component Therapy

XII. MINOR PROCEDURES

- Bronchoscopy
- Esophagoscopy
- Tube Thoracotomy

Practice-Based Learning and Improvement

1) Given a question regarding appropriate management of a clinical condition the fellow will be able to use readily available resources to identify literature that is current, relevant, and has the highest level of evidence, interpret the findings, and formulate an answer to the question.

2) Given a common complication associated with the treatment of a cardiothoracic patient under the care of the fellow, the fellow will be able to research the complication, reflect on his role in the development of the complication, and offer appropriate solutions to diminish its occurrence in the future.

3) Given constructive criticism on their performance the fellow will be able to incorporate that criticism into their daily performance and demonstrate improvement in that area.

4) Utilize the departmental database to monitor surgical outcomes.

Interpersonal and Communication Skills

1) Listen and communicate effectively with all members of the health care team including...
   a. nurses, patient care technicians, social workers, therapists (physical, occupational, respiratory, etc.)
   b. mid-level providers (advanced practice nurses, physician assistants)
   c. housestaff
   d. faculty
   e. consulting physicians

2) Listen, gather information, and communicate effectively with patients and their families when...
   a. evaluating patients for the first time
   b. discussing treatment plans and obtaining consent
   c. administering postoperative inpatient care
   d. evaluating patients during follow-up as an outpatient

3) Perform clear, effective and efficient hand-off of patient care at the completion of clinical duties each day.

4) Verbally present new and consultative cases to the faculty and perform written documentation in a clear, comprehensive, and efficient manner.

5) Verbally present a treatment plan to the faculty and perform written documentation in a clear, comprehensive, and efficient manner.

Professionalism

1) Given a clinical scenario the fellow will be able to discuss any issues regarding diagnosis or treatment in a compassionate, respectful, and honest manner.

2) Given a procedure to accomplish the fellow will obtain an appropriate ethical consent and acknowledge any issues regarding the patient’s age, gender, culture, and/or disabilities.

3) During all interactions with faculty, allied health-care providers, patients, and patients’ families the fellow will be committed to providing the best possible service they can, well groomed, punctual, respectful, and trustworthy.

4) When an error regarding behavior or performance in any of the other 5 competencies is identified the fellow will take responsibility for their role in the issue and report the event to their supervising physician.

5) Given confidential patient information the fellow will never divulge the information to anyone other than involved providers.
6) Given a patient with clearly defined opinions on end of life issues the fellow will always respect these issues, bring them to other’s attention, and ethically withhold medical or surgical care when appropriate.

**Systems-Based Practice**

1) Given a clinical scenario with equivalent treatment option in terms of outcome the fellow will list the cost differences of each treatment arm.

2) Given a clinical scenario that requires the assistance of other allied health specialists…
   a. Speech, physical, respiratory, and occupational therapists
   b. Social workers
   c. Nutritionists
   d. Hospital administrators
   e. Chaplain
   f. Etc.

   …the fellow will identify the appropriate group to involve and effectively integrate their plan into the care of the patient.

3) Given a clinical scenario the fellow will order tests only with a clearly defined need to practice cost effective and safe medical care.
<table>
<thead>
<tr>
<th>Date</th>
<th>Thoracic Surgery Curriculum</th>
<th>Cardiovascular Topics</th>
<th>Required Readings</th>
<th>Presenter</th>
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| 07/09/2014  | CV 1-4 CV 5-6               | Cardiac Surgery General Management I-IV Cardiopulmonary Bypass/Myocardial Protection/Circulatory Support I & II | Chapter 1: Page 1-66 (Vol.I)  
Chapter 2&3: 67-162 (Vol.I)                                                      |           |
| 07/16/2014  |                             | Coronary Artery Anomalies, Definition of normal, classification, the clinically important anomalies, mechanism of ischemia, treatments (lecture & quizzes) | Chapter 46: Page 1643 (Vol.2)                                                    |           |
| 07/23/2014  | CV 7                        | Ischemic Heart Disease I- Coronary Artery Disease                                      | Chapter 7: Page 353-428 (Vol.I)                                                   |           |
| 07/30/2014  | CV 8 & 9                    | Ischemic Heart Disease II- PCI Hybrid Approaches Ischemic Heart Disease III-CABG       |                                                                                   |           |
| 08/06/2014  | CV 10                       | Ischemic Heart Disease IV- Complications of IHD                                        | Chapter 8 (LV aneurysm) & 9 (Post-Infarction VSD)                                 |           |
| 08/13/2014  | CV 11 & 12                  | Heart Valve Disease I- Aortic Valve Anatomy, AS, & Heart Valve Disease II             | Chapter 12 (Aortic Valve Disease)                                                 |           |
Chapter 11: Page 473-540 (Vol.I)                                              |           |
| 08/27/2014  | CV 15 & 16                  | Heart Valve Disease V- Tricuspid & Pulmonic Valves & VI Endocarditis                  | Chapter 14: Page 656-671 (Vol.I)  
Chapter 15: Page 672-697 (Vol.I)                                              |           |
| 09/03/2014  | CV 17                       | Heart Valve Disease VII- TAVR                                                         |                                                                                   |           |
| 09/10/2014  | CV 18 & 19                  | Great Vessel Disease I & II- Acute Aortic Dissection                                  | Chapter 25: Page 941 (Vol.I)                                                     |           |
| 09/17/2014  | CV 20                       | Great Vessel Disease III- Thoracic & Thoracoabdominal Aortic Disease                  | Chapter 26: Page 973 (Vol.I)                                                     |           |
| 09/24/2014  | CV 21                       | Great Vessel Disease IV- Thromboembolic Disease, Pulmonary Vasculature Diseases       | Chapter 27: Page 1025 (Vol.I)                                                     |           |
| 10/01/2014  | (pending)                   | TEE                                                                                   |                                                                                   |           |
| 10/08/2014  | CV 22 & 23                  | Cardiac Conduction System Disorders I & II                                            | Chapter 5: Page 197                                                             |           |
| 10/15/2014  | CV 24 & 25                  | Diseases of the Pericardium and Myocardium I- Pathophysiology Diagnosis and Imaging & II- Cardiac Tumor | Chapter 23: Page 900  
Chapter 18: Page 749                                                             |           |
| 10/22/2014  | CV 26                       | Disease of the Pericardium & Myocardium III- HOCM                                    | Chapter 19: Page 769  
Chapter 20: Page 793                                                             |           |
Chapter 98: Page 1241 (Vol.I)                                                     |           |
| 11/05/2014  | CV 29                       | Heart Failure and Cardiace Transplant III                                            | Chapter 22: Page 873 (Vol.1)                                                     |           |
| 11/12/2014  | CV 31-33                    | Cardiothoracic Trauma I, II, & III                                                   | Chapter 17: Page 742 (Vol.I)  
Chapter 24: Page 917 (Vol.I)  
Chapter 73: Page 891 (Vol.I)  
Chapter 146: Page 1851 (Vol.2)                                                  |           |
| 11/19/2014  | Anesthesia                  | Anesthesia for Cardiovascular Surgery: Operative Monitoring                           | Chapter 4: Page 163-188 (Vol.I)                                                  |           |
| 11/26/2014  | Anesthesia                  | Anesthesia for Cardiovascular Surgery                                               | Chapter 4: Page 163-188 (Vol.I)                                                  |           |
### November 19th 2014-January 28th 2015
**Concetual Section**
TCH West Tower Building, Taussig Auditorium
19th Floor, Room: B19536

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<tr>
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<th>Electronic Thoracic Surgery Curriculum</th>
<th>Reading Chapters</th>
<th>Required Readings</th>
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<td>CD 4</td>
<td>11 &amp; 13</td>
<td>PDA / ASD / PAPVR</td>
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<td>14 &amp; 21</td>
<td>VSD CAVC</td>
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<td>12/10/2014</td>
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<td>12, 18, &amp; 27</td>
<td>AS / ACo / IAA / LVOTO</td>
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<td>Aortic Coarctation, Interrupted Aortic Arch, TAPVR, Cor Triatriatum</td>
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<td>01/21/2015</td>
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<td>CD 10</td>
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<td>Topic</td>
<td>Reading Chapter</td>
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<tr>
<td>Anatomy, Physiology, Risk assessment--BACKGROUND READING Benign lung tumors</td>
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<td>Lungs</td>
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<td>Screening for Lung Cancer: Challenges for Thoracic Surgery Solitary Pulmonary Nodule Diagnosis and Staging of Lung Cancer</td>
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<td>Chest Wall Tumors Chest Wall Reconstruction Chest Wall Deformities Thoracic Outlet Syndrome</td>
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<td>Embryology and Anatomy of the Diaphragm Pacing of the Diaphragm Diaphragmatic Paralysis and Eventration of the Diaphragm Congenital Diaphragmatic Hernias and Other Hernias of the Diaphragm Foramen of Morgagni Hernia Tumors of the Diaphragm Diaphragmatic Injuries</td>
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<tr>
<td>TS35: Management of Benign Esophageal Disorders IV</td>
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</tbody>
</table>
17. Appendix 2- Educational Compact

Michael E. DeBakey Department of Surgery
Compact between Teachers, Learners, and Educational Staff

Learners pursuing a professional career at Baylor assume responsibility to develop in-depth knowledge, acquire and apply special skills, and demonstrate professionalism. Teachers guide and educate learners, and model appropriate attitudes, interpersonal skills and professional behaviors. Core educational staff members support both learners and teachers. This Compact serves both as a pledge and a reminder to teachers, learners, and educational staff that moral, ethical, and professional behavior by all BCM personnel is essential to the basic principles of this institution.

Guiding Principles of the Educational Compact

**Duty**
All participants in the education mission have the duty to sustain a learning environment conducive to maintaining the knowledge, attitudes, and skills necessary for providing contemporary standards of professional behavior.

**Integrity**
All education participants/parties will behave in a manner that reflects individual and institutional commitment to intellectual and moral excellence.

**Respect**
Fundamental to the ethic of professions is respect for every individual. Mutual respect between learners, as newer members of the profession, and their teachers, as experienced professionals, is essential for nurturing that ethic. In addition to individual respect, all educational parties must respect and follow established professional policies.

As a teacher, I pledge to:
- Maintain currency in my professional knowledge and skills
- Ensure excellence of the educational curriculum
- Be a model of professionalism in all of my interactions with faculty, learners, patients, colleagues, and staff
- Respect all faculty, learners, patients, colleagues, and staff as individuals, without regard to gender, age, race, national origin, religion, or sexual orientation; and oppose observed disrespect or bias
- Nurture learner commitment to achieve personal, family, and professional balance
- Recognize and acknowledge expressions of professional attitudes and behaviors as well as the achievement of quantifiable academic excellence
- Respond vigorously to unprofessional behavior and indications of abuse or exploitation of faculty, learners, patients, colleagues, or staff
- Create a safe environment in which individuals can communicate any concern about breaches of this compact
- Accept responsibility for instilling these attributes in learners and faculty for whom I have responsibility

As a learner, I pledge to:
- Acquire the knowledge, skills, attitudes, and behaviors necessary to fulfill all established educational objectives
- Embody the professional virtues of integrity, empathy, altruism, compassion, respect, honesty, courage, and trustworthiness
- Respect as individuals, without regard to gender, race, national origin, religion, or sexual orientation, all patients, peers, faculty, and staff
- Uphold the highest professional standards and conduct myself accordingly in all interactions with patients, peers, faculty, and staff
- Assist my fellow learners in meeting their professional obligations, while fulfilling my own obligations as a professional
• Help create a safe environment in which individuals can communicate any concern about breaches of this compact

**As an educational staff member, I pledge to:**

• Maintain currency in my professional knowledge and skills
• Help ensure excellence of the educational curriculum
• Embody professionalism in all of my interactions with faculty, learners, patients, colleagues, and staff
• Respect all faculty, learners, patients, colleagues, and staff as individuals, without regard, to gender, age, race, national origin, religion, or sexual orientation; and oppose observed disrespect or bias
• Help create a safe environment in which faculty, learners, and staff can work and can communicate any concern about breaches of this compact

_We gratefully acknowledge the inspiration for this Compact provided by Jordan J. Cohen, M.D., President of the Association of American Medical Colleges through his “Compact between Faculty and Learners,” published November 4, 2001._
RESIDENT NAME: _____________________

Please initial on each line and sign the last page.

_____ The term of my employment is for one year, from 7/01/2015 through 6/30/2016.

_____ I understand that I am expected to maintain the highest ethical and moral character at all times.

_____ I will be responsible for my professional work to the Program Director.

_____ I will check and read my BCM e-mail daily with the understanding that there may be important communications that need my attention.

_____ I agree to stay current in procedural and administrative tasks, particularly completing medical records in a timely manner, submitting QA and M&M documentation, and maintaining up-to-date health assessments as these are a reflection of my professionalism as a physician.

_____ I agree to complete medical records and all documentation requested by all program-affiliated hospitals promptly and in accordance with the policies and recommendations of the program.

_____ I will be responsible for developing a personal program of self-study and professional growth, and I will seek the assistance and supervision of the teaching staff of the Michael E. DeBakey Department of Surgery and its affiliated hospitals in meeting these goals and expectations.

_____ I have read and understand the Overall Competency-Based Goals and Objectives for the Thoracic Surgery Residency Program.

_____ I will read the competency-based goals and objectives pertinent to each clinical rotation at the start of each rotation and review these objectives as well as expectations and responsibilities with the Rotation Director.

_____ I will participate fully in the clinical and educational activities of the Residency Program and affiliated hospitals, and especially in those relating to quality management, patient care review activities, and the appropriate use of resources.

_____ I will round twice daily on all inpatients with members of the surgical team of which I am a part.

_____ I will attend, and actively and meaningfully participate in the mandatory weekly Resident Core Curriculum Conferences and other teaching conferences, including Surgical Grand Rounds, all of which are intended to benefit my education. I commit to attending and signing in to at least 75% of each conference’s session for the academic year, understanding that bona fide vacation or active on-call responsibilities are the sole reasons excusing participation from these activities.
I will complete the weekly reading and study assignments pertinent to the Resident Core Curriculum Didactic Conferences and to the cases presented at the weekly M&M Conference which I attend.

I will (co-)facilitate the Resident Core Curriculum Didactic Conferences under the guidance of attending faculty moderators as assigned.

I will complete all paperwork/clerical work before leaving the service to maintain current documentation.

I understand that I may be subject to weekly testing, coincident with my core curriculum reading assignments. My performance on these examinations will demonstrate my commitment to learning and to becoming a competent surgeon.

I will assume an appropriate level of responsibility for teaching and supervising other residents and medical students.

I understand that I must be ACLS and ATLS certified by December of the academic year listed above and remain current in my certification status thereafter.

I understand that it is my responsibility to ensure that my pager is operable at all times, and that I must respond appropriately and in a timely manner to my pages.

I understand that my surgical rotations may take place at any of the hospitals affiliated with the residency program, or at other defined hospitals, at the discretion of the Program Director, as they provide comprehensive educational experiences deemed consistent with the educational mission of the Program.

Commensurate with my level of training and advancement, I will participate in safe, compassionate, and effective patient care under general supervision as determined by the Program Director.

I will be prepared to participate in the operating room by having a thorough knowledge of the patient’s history, of the pathophysiology of the disease, and of technical aspects of the procedure.

I will keep my operative log up to date. [https://www.acgme.org/ResidentDataCollectionNet/ACGME/ResidentCaseLogs/Login.aspx]

I will endeavor to develop an understanding of ethical, socioeconomic, and medical/legal issues affecting medical care and practice, as well as to utilize review measures in the provision of patient care.

I understand that I am expected to deal with patients and their families as if they were my own.

I understand that I must accept and deal with authority appropriately.
I understand that I must demonstrate genuine dependability, good clinical judgment, and the ability to interact in a professional manner with attending staff, nursing staff, mid-level and ancillary medical practitioners, as well as with fellows, resident colleagues, and students.

I understand that I must use all my vacation time in the current academic year as vacation time is not carried over to the following academic year. I understand also that the American Board of Surgery considers vacation time to be a part of my training.

I will notify the Program Director if I receive a summons, complaint, subpoena, or court paper of any kind relating to my activities in connection with the Department, the affiliated hospitals, and the residency program.

I have read and understand the ACGME/TSBME duty hour regulations. I will adhere to these regulations and will record my hours worked on a weekly basis.

I have been advised that the policies and procedures affecting the Michael E. DeBakey Department of Surgery residents are available in the GME Office, the Surgical Education Administration Office, and on E*Value [https://www.e-value.net/].

I understand that each year, all residents and fellows in the Michael E. DeBakey Department of Surgery are expected to submit an abstract for presentation at the June Research Day. Faculty mentors are available to assist residents and fellows on projects in preparation for Research Day. Residents and Fellows should begin their planning at the start of every new academic year (June/July) with their faculty mentor. All residents and fellows are required to attend the Research Day event.

Surgical Resident Signature   Date   Surgical Resident Name [PRINTED]

Program Director or Date
Associate Program Director Signature
I acknowledge that I have received the Thoracic Surgery Residency Program Handbook electronically and have been made aware of the educational expectations I must meet, as described during the Michael E. DeBakey Department of Surgery’s annual orientation. By signing below, I agree to abide by the policies of Baylor College of Medicine and the Michael E. DeBakey Department of Surgery and commit to making my best effort to meet the educational standards of the College and Department.

________________________________________  
Surgical Resident Signature

________________________________________  
Date