Guidelines for the Surgery B Service

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I. Clinics

A. Faculty responsible for the clinic

Tuesday PM – Kimbrough  
Friday AM – Evers  
Friday PM – M Trahan / Marx

B. Assigning patients to the appropriate clinic

Patients should be assigned to one of the faculty listed above. All future follow-ups should be scheduled in that attending’s clinic slot. If Dr Evers operates on a patient, that patient should be assigned to return to his clinic on Friday mornings. In order for this to happen, this information must be entered in the appropriate place on the yellow-bordered discharge sheet for all hospital admissions and day surgeries and on the clinic note for all clinic visits.

C. First visits

After a patient is seen for the first time in the surgery clinic, all subsequent visits should be with the same attending. If a patient is to follow-up only as needed, the note should read something like “follow-up PRN with Dr Kimbrough on a Tuesday afternoon.”

D. Scheduling operations

Any patient who is being considered for operation should be presented to the responsible faculty while the patient is still in the clinic to discuss operative indications and schedule a date. When an operative plan and date are agreed upon, the patient’s label should be placed in the Faculty surgical scheduling book. The procedure, responsible faculty, and posting resident should be listed on the label for future planning. There should never be a case posted without this information clearly documented. The chief resident’s book may also be used for reminders, but the official Faculty surgery schedule is kept in the clinic conference room.

E. Clinic Notes

Clinic notes are obviously intended to provide an accurate representation of the physician-patient encounter. These notes often serve a valuable purpose when trying to get quick information regarding a patient previously seen in our clinic. In order for the clinic notes to serve their intended purpose they must be thorough, accurate, and legible. Each note should have the physical exam and decision-making documented by the resident. Medical students may (and should) write clinic notes but these do not substitute for a note written by a medical doctor. All treatment options and recommendations should be written in the notes. If there were pertinent labs or radiographs involved in the decision-making, the results of these should also be listed. If the patient has selected an option other than what we recommend, that decision and the risks involved must be documented. There should be a clearly written diagnosis and signature on each note and billing sheet. The attending responsible for each clinic will read and sign these notes. The notes will be returned for correction if there is any missing or illegible information.

F. Chief resident responsibilities
The chief resident is responsible for everything that happens in the clinic. (S)he should be informed of every scheduled operation, every complication and every patient visit. All patients should be discussed with the chief resident before the disposition is made or the patient is presented to faculty. When the chief resident is out for the day, the next highest ranking resident assumes the responsibilities. Upon returning, the chief should be informed of all important events occurring while (s)he was away.

G. Preoperative conference

There is a preoperative conference every Friday morning at 11:30 a.m. All team members are expected to be there – residents and students. The purpose of this discussion is to set the operative schedule for the next 4 OR days (Monday, Wednesday, Thursday, and the following Monday). If run efficiently it should only take 15-20 minutes. Somebody at the meeting should be familiar with each case to provide a general synopsis of the patient, diagnosis, and indications for the operation. If no one remembers the patient we will need to spend extra time sifting through the clinic files to obtain this information. The chief residents should have assigned the residents and students to each case based on the available residents’ abilities. A call schedule should be available at the meeting to predict which residents will be absent on each particular operating day. Having this operative plan ahead of time allows all team members to be familiar with their responsibilities and opportunities for the coming week. It also gives everyone ample time to read and prepare for the cases.

H. Continuity of care

For optimal educational experience as well as most effective patient care, we should establish some continuity of care between the patients and residents. As mentioned above, the resident who sees a patient in clinic should be the one who participates in the operation. The same principle should apply to follow-up care. The operating resident should check and know the results of all pathology studies. These results should be discussed with the chief resident and attending. Patients should be scheduled to return to clinic on a day that the involved resident is available to see them.

I. Complications

Complications are often not found until patients return for follow-up in the clinic. The chief resident and surgical attending should be notified of all complications at the time of their discovery.

J. Special considerations

1. Certain operations require involvement of other services. The most common ancillary procedures are the wire-localized breast biopsy (breast imaging) and the sentinel node biopsy (nuclear medicine). The resident who posts these cases must call to schedule these procedures at the time that the operative date is set. The operative surgeon must call to confirm the procedure as the operative date approaches. These operations are impossible to do without the patients being transported to the respective department before coming to the holding area. It is the responsibility of the operating resident to ensure that all the required procedures have been done before the patient reaches the operating room.

2. All patients with newly diagnosed breast cancer, a previously undocumented recurrence of breast cancer, or considering prophylactic mastectomy are to be referred to the Multidisciplinary Breast Cancer clinic in the department of
radiation oncology coordinated by Dr Sunny Hatch. This also includes patients with ductal carcinoma in situ.

3. All patients with gastrointestinal cancers should be presented at the GI Tumor Conference. Contact Sedonia in Dr Evers’ office with the patients’ information.

4. The Department of Surgery has several faculty who routinely perform basic and advanced endoscopic procedures. Before consulting Gastroenterology, the appropriate Surgeon should be contacted to request any endoscopic procedures. The ladies in the residents’ office usually know which surgical attending is to be consulted on any given day. The decision to contact Gastroenterology should be made only by the responsible surgical endoscopist or service attending.

II. Operating Room

A. Posting

1. Responsibilities

The chief resident is responsible for posting the operations for the B service.

2. Timing

At the time of pre-op evaluation in the clinic, the posting form should be completed and faxed to the posting office. The posting should be confirmed shortly after the Friday morning meeting. The operating room has strict posting requirements. It is the responsibility of the chief resident to be familiar with these criteria and adhere to them. Most notably is that all elective cases are to be posted no later than by noon, 2 business days before the date of the procedure. There are very few exceptions to this rule. Neglecting to post by the deadline usually results in canceling all cases scheduled for that day.

3. Equipment and supplies

Any special equipment (stirrups, retractors, scopes, Neo-probe, fluoroscopy, etc) or supplies (type of mesh, cholangiogram catheter, Port-a-cath, etc.) needed for the case should be listed on the posting sheet to avoid delays on the day of surgery.

B. Resident participation

1. Responsibilities

Ideally the resident who sees a patient in the clinic would be the resident who performs the operation. This is often not possible due to case complexity, work hour restrictions, service changes, and call schedules. It is imperative, however, for the resident to have examined each patient (s)he plans to operate upon prior to that patient’s arrival to the operating room. This is easiest to do in the clinic, but it can also be done in the day surgery unit or holding area as a last resort. The operative indication and plan must be clear before the patient leaves the holding area for the operating room. Additionally, DSU patients should be examined in the holding area prior to going to the operating room. The patient should be examined by the operating surgeon to confirm lumps, hernias, etc. There is no excuse for operating on the wrong site, performing the wrong procedure, not being able to find a breast mass, etc. The only way to prevent these errors is for the operating team to have examined the patient and clarified
all this information before anesthesia is induced. If there are any questions or concerns about a posted case the attending should be contacted.

2. Timing

Residents should be in the operating room before or shortly after the patient arrives. The first case should start at 7:30 (except on Wednesdays it is 9 am) and in order for that to happen, the resident should be in the operating room at 7:15. This gives time to position the patient, hang the appropriate radiographs, and get any additional equipment and instruments that may be needed. There may be other delays by anesthesia or nursing, but no case should be delayed due to inability to locate a surgeon.

3. Bowel Preparation

Faculty often differ in their method of bowel preparation. The Surgery B attendings have agreed upon most aspects of the prep. Specifically:

a. Dr Evers uses a mechanical bowel prep, 45cc of phosphosoda given at noon and 8 pm, followed by systemic antibiotics for prophylaxis (usually 1 gram Cefotetan) just prior to starting the operation. No luminal antibiotics are given with Dr Evers’ Prep.

b. Drs Kimbrough, Trahan and Marx use 45cc of phosphosoda given at noon and 8 pm, plus 1 gram of Neomycin and 1 gram of erythromycin base given at 1 pm, 2 pm, and 11 pm, and finally 1 gram of Cefotetan given IV just before starting the operation.

c. Intravenous fluids should be given to most inpatients getting mechanical bowel cleansing to avoid hypovolemia, which may present itself upon induction of anesthesia.

d. The phosphosoda should be given with large volumes of clear fluids by mouth.

4. Thrombosis prophylaxis

Nearly all patients will require prophylaxis against deep venous thrombosis and pulmonary embolism. Clarification about indications for this standard of care should be made before the patient is anesthetized.

5. Preoperative note

There must be a preoperative note by the operating surgeon on every patient that goes to surgery. This note should include: a) Indications for operation (this usually means a short narrative of the preoperative problem and how the diagnosis was made), b) All pertinent and recent laboratory exams, c) How much blood is typed and crossed for the operation (this should also be confirmed with the Blood Bank). Also, it should be noted that the risks and complications were discussed with the patient and operative consent obtained. If this is a fairly complicated procedure, then at times a diagram may be helpful for the patient’s permanent record.

6. Antibiotics
Antibiotics can be classified in two ways, either prophylactic or for treatment of some definable source of infection. If used for prophylaxis, the antibiotic should be started just prior to surgery and, depending upon the antibiotic, several doses may be given postoperatively but then stopped. If the antibiotics are being used to treat a source of infection, then the source must be clearly defined and appropriate antibiotic coverage used. Antibiotics for treatment are usually discontinued in 5-10 days after initiating treatment.

7. **Faculty notification**

Faculty notification is required prior to anything being done in the operating room, no matter how minor the procedure may seem to be. Our department, as well as some even higher powers, requires an attending statement of presence for each operative procedure. This is only possible if the attending is notified as the case is being started. Minor procedures done at the bedside also require faculty notification prior to starting.

8. **Operative reports**

Operative reports must be dictated promptly after completing the operation. The responsible faculty and departmental chairman are notified if this is not done. This is a very simple task that causes much frustration when it is neglected. Residents that fail to dictate on time will lose operating privileges.

9. **Family notification**

The patient’s family must be sought shortly after completing the operation to discuss the operative findings, procedure, complications, and patient status. The operating resident should know how and where to contact the family members. This must be done for even the simplest procedures, as we would all expect for doctors operating upon our own family members.

### III. Inpatient service

#### A. Progress notes

1. **Responsibilities**

Every inpatient should have a full progress note written daily by a medical doctor. The note and the signature should be legible. It should be an accurate summary of the events of the preceding night with appropriate mention of vital signs (especially Tmax) and pertinent I’s and O’s. This should not be a simple co-signing of the students’ notes.

2. **Students**

Medical students may (and should be encouraged to) write notes, but these do not substitute for the residents’ notes. The student notes should be read and corrected with appropriate feedback given. They are purely for the students’ educational benefit.

#### C. Consults

1. **Faculty notification**
All consults should be presented to faculty the same day of their receipt. Adequate space should be left on the consult sheet for the faculty to write their note. The consult should be signed by the responsible faculty and then faxed to the billing office at 77302.

2. After business hours

Consults seen overnight by the call team are then referred to the inpatient service the next day. The service attending should see these patients on rounds this next day.

3. Students

The senior medical students should be encouraged to see the consults and helped to formulate a plan of treatment. They may write a note, but this note is not to substitute for a full consult written out by a medical doctor.

4. Residents

Unless there is a shortage of residents, the junior residents should see the consults rather than interns. After formulating a plan the resident should then discuss the case with the chief resident who then will discuss it with the responsible faculty member.

5. Follow-up

If the surgical service is to follow a consult, the patient should be seen and a note written daily by the residents. The faculty does not necessarily need to see the consults everyday but should be kept up to date on their progress.

6. Sign-offs

A sign-off note should be written for consults that no longer have the need for daily surgical follow-up. The note should include legible information on how to contact the surgical service if additional surgical evaluation is needed.

7. Bedside procedures

In order for our hospital to bill appropriately for all procedures, a faculty member must be present for the key portions. A resident planning a bedside procedure, even something as simple as a line exchange over a wire or drainage of an abscess, must notify a faculty member prior to starting that procedure.

D. Discharges

1. Responsibilities

The discharging resident should dictate the discharge summary as soon as the discharge order is entered and discharge sheet is completed. There is no reason to wait any longer to dictate. Residents that fail to dictate on time will lose operating privileges.

2. Timing

All discharge orders are to be placed before 10 am. This is an institutional and departmental policy.
3. Discharge sheet

This document should list the diagnoses, procedures, medications, and follow-up accurately.

E. Deaths

1. Death Summaries

The death summary should be dictated by the chief resident and given to the residents’ secretaries within 24 hours of the patient’s death.

2. Postmortem examination (Autopsy)

These should be requested on all patients expiring on our service or within 30 days of an operation. The appropriate time to approach the family takes some judgment but should be soon after they are notified of the death. It cannot be overemphasized that postmortem examinations are invaluable to our knowledge of what went wrong and how we could possibly improve our practice. A great deal of educational benefit can be derived if the responsible resident (usually the Chief resident) is present for the autopsy.

F. Faculty notification

1. Daily patient care

Faculty should be located soon after the business day begins to be informed of the status of the patients on the service (“run the list”). It is very frustrating for the attending to be approached by a patient or patient’s family to inquire about an event or new treatment that the attending knew nothing about (see the next item). On weekends the responsible faculty should be called after rounds are completed.

2. Problems

If there is a problem with a patient on the service, the attending should be notified of the problem so the treatment plan can be discussed. This means any change in a patient's condition that is considered significant enough to require diagnostic steps or a change in management must be reported to faculty at that time. If an attending does not respond promptly to paging after the usual business hours, an attempt should be made to call that attending at home or by mobile phone. If this is still unsuccessful for private patients, the service attending should be contacted. In the almost unimaginably rare circumstance that the service attending is not available, the on call surgery attending should be notified for emergencies.

a. Evers 744-1495
b. Kimbrough 740-1831
c. Trahan (281) 614-5481
   (local mobile) 771-1759
d. Marx 737-1867
   (local mobile) 761-0014
Private patients

The attendings will frequently admit patients to the General B Service and plan to follow those patients personally for a variety of reasons. The care for these patients should be directed by the respective attending not the General B Service attending unless other arrangements have been made at the faculty level. The above guidelines (III.E.1. and III.E.2.) apply in this situation also.

G. Special Considerations

1. Thrombosis prophylaxis

All inpatients should receive prophylaxis against deep venous thrombosis and pulmonary embolism. Any decision to stop prophylactic measures or exclude a patient from the order entry protocol must be discussed with the responsible faculty. Medication lists must be checked daily to assure compliance.

2. Fluids

Ringer’s lactate is an excellent resuscitative fluid and should be used for the resuscitative phase of a patient sustaining a traumatic injury or bowel obstruction, and should also be used in the immediate postoperative period following laparotomy. D5 1/2 normal saline is a maintenance fluid and should not be used for resuscitation.

3. Antibiotics

For indicated diseases, antibiotics should be selected based upon the UTMB susceptibility profile or the specific profile report by the lab. The UTMB susceptibility profile should be carried by everyone on the service for quick reference in selecting empiric antibiotics.

4. Lasix

Lasix should be reserved only for specific indications. The junior resident should check with either the Chief Resident or attending before giving Lasix to the patient and there must be clear-cut indications (for example, an elevated wedge or central venous pressure, or chest x-ray consistent with pulmonary edema). Lasix should not be given simply for a low urine output.

5. Intensive Care Unit

Our patients in the Intensive Care Unit are our responsibility. All orders should be cleared by our team on our patients. The ICU team may make recommendations, but ultimately the orders must be approved by a member of our team.

6. Cancer Staging Form

This document must be completed on all patients with cancer of any type. Disease specific forms are available for printing on My UTMB (Clinweb). After looking up the patient, click open the “E-forms” folder at the bottom of the menu, and find the diagnosis under the “View/Print” tab. Print the form, complete it, and sign it.
7.  The List

Someone on the service should be responsible for making the patient list using the format saved on the computers in the resident’s office. The list should be updated after morning rounds and delivered to Dr Evers’ and Dr Kimbrough’s offices before 9 am.

IV. Conferences

The residents on the B service should make every effort to attend all of these important conferences and be on time. To arrive late is rude, inconsiderate, and unprofessional. Faculty will monitor this and failure to comply will be noted on resident evaluations. The chief resident should ensure that all members (residents as well as students) of the team are available for all conferences unless urgent patient care is needed elsewhere.

A. GI Tumor conference - Every other Tuesday at 5 pm in the surgery library
B. GI Med-Surg conference – Mondays at 12 in the GI conference room (4th floor McCullough)
C. Grand Rounds – Every Wednesday at 7:30 am (or 8 am once a month)
D. Morbidity and Mortality – Every Wednesday at 4:00 pm
E. Preoperative conference – Friday at 11:30 am in the clinic conference room
F. Resident conference – Wednesdays at noon in McCullough 6.106

V. Resident work hours (also apply to students)

The rules as spelled out by the ACGME and our Department of Surgery should be followed without exception. The rules are not negotiable. Residents should learn to budget their time and patient care responsibilities in order to comply with the rules. The team should work together to make sure all team members are in compliance with the rules and that no one is suffering from the hazards of sleep deprivation. Problems with complying with the regulations and residents showing signs of sleep deprivation should be brought to the attention of the attending as soon as possible.

A. 80-hour rule

No resident may work more than 80 hours in any one week. If someone is scheduled for 3 calls in one week and assuming they work only 24 hours each day on call, they have only more 8 hours to work that week. Each resident must keep a log of their hours worked and budget their time appropriately considering the number of calls they are assigned.

B. 30-hour rule

No one may be in the hospital for more than 30 consecutive hours for any reason. After conclusion of the resident’s post-call duties they may remain in the hospital to complete patient care on the service, perform operations, and see clinic patients. However, they may not stay or be asked to stay past the 30-hour time period. Again each resident is personally responsible for making sure this rule is followed.

C. 24-hour rule (or 1 in 7 rule)
Everyone must get at least one 24-hour period off each week. The post-call day may not be counted as the 24-hours off. Rounding until 9 AM on Saturday and returning at 9 AM to round on Sunday is allowable and counts as 24 hours off.

D. 10-hour rule

Everyone must get 10 hours off after each day of regular duty. If a resident stays late until 10 pm, (s)he must not return until 8 am the next day.

VI. Medical students

Third year students are not to arrive any earlier than 6 am and are not to be kept in the hospital later than 6 pm. They are to be released from duties on the day after their nights on call. Their small groups are to take precedence over other clinical duties. They should be encouraged to attend these important educational opportunities and be on time. Additionally, they should not be asked to cover more than 2 or 3 patients at a time. These and other rules can be found in the third year student clerkship manual, which all residents should read and follow. No student should feel like they are hurting their grade or “letting the team down” when they are following the institutional rules.

The students are an integral part of the team and they should at all times be treated with respect. We would hope that the residents would take some time to teach the students, either at the bedside, the operative table or the breakfast table. In addition, the students should be called for cases seen in the Emergency Room and should be a part of the operation.