

Resident Guide

A. General Policies and Principles

1. Patient care is the first priority. The welfare of the patients and quality of medical services are a combined responsibility of the attendings, residents and students.
2. Education is a vital part of the everyday operation of the service. Each of us is responsible for the education of ourselves, other staff, patients, and patient families.

B. Organization and Administration

1. Stanford Faculty Attendings:
 - **Acute Care Surgery/Trauma:** Drs. Badger*, Browder, Gregg, Maggio, Marks*, Spain, Staudenmayer, Weiser
 - **Colorectal-Red:** Drs. Shelton and Welton
 - **Colorectal-White:** Drs. Kin and Kirilcuk
 - **Hepatopancreatobiliary (HPB):** Dr. Visser
 - **Minimally Invasive Surgery (MIS):** Drs. Azagury, Hawn, Lau, Morton, Rivas
 - **Surgical Oncology 1:** Dr. Norton
 - **Surgical Oncology 2:** Dr. Poultsides
 - **Surgical Oncology 3:** Drs. Cisco and Lin
 - **Breast Service:** Drs. Dirbas, Jeffrey, Wapnir, & Wheeler

*denotes PAMF staff surgeon
2. All patient care is supervised by the surgery staff. The senior/chief resident on each service has overall responsibility for the service including inpatient and outpatient care in the clinic. Junior residents, interns and medical students assigned to the service are the primary physicians responsible for executing all aspects of the surgical patient's evaluation and treatment. Treatment plans must be communicated to the chief resident prior to being put into action.

C. Admissions

1. Admissions may come from clinic, telephone referrals, hospital transfers and emergency admissions. Direct admissions to the floor need to be reported to the senior resident upon arrival.
2. History and physical exam must be recorded in the chart within 12 hours of admission. This should include an assessment and treatment plan and is the primary responsibility of the intern or consult resident to ensure its timely completion. Medical students notes do not count and cannot be cosigned.

D. Discharges

1. All patient discharges need the approval of the attending surgeon. Discharges should be anticipated and well-planned. Tentative decisions for discharge should be made the night before. Patients should be discharged before 11am whenever possible as per institutional goals. Planning for discharge includes:
 - Making an appointment for the appropriate clinic
 - Completing discharge prescriptions
 - Diet and activity limitations
 - Wound care and bathing instructions, and provision of dressing supplies
 - Coordinating primary care or other outpatient follow-up
 - Ensuring that the patient's social needs have been addressed
2. A dictated or written discharge summary must be completed by the discharging resident at the time of discharge. If there are any changes in the patient's status prior to discharge, the chief resident should be notified. If a patient is being discharged to a skilled nursing facility or transferred to another hospital, the discharged summary must be completed and in the chart prior to the patient leaving.

E. Conferences

1. Mandatory Conferences
 - QI M&M Conference: Mondays, M114, 7:00-8:00am
 - Grand Rounds: Tuesdays, LKSC, 7:00-8:00 am
 - Core Course: Tuesdays, LKSC, 8:00-9:30 am
2. Service Specific Conferences:
 - Please note specific service teaching conferences, preoperative conferences, tumor boards, and multidisciplinary conferences and prepare accordingly