GUIDE TO THE R1 YEAR

STANFORD GENERAL SURGERY

2017-2018
Welcome to Stanford Surgery

- History of and Present Day Stanford Surgery
- Expectations
- Intern Ward Duties/Patient Care
- Night Service
- Duty Hours
- Schedule
- Conference Schedule
- Chiefs’ Journal Club
- Chiefs’ Rounds and Social Events
- Balance in Life
History of Stanford Surgery

Emile F. Holman, M.D.
Chair 1926 – 1955
Halsted’s last resident
Brought surgery west

Norman E. Shumway, M.D.
Cardiac 1958 – 1993
Father of heart transplantation
“Best first assist”

Thomas M. Krummel, M.D.
Chair 1999 – 2015
ECMO, Innovation, Biodesign
6 Divisions, >60 faculty
Department of Surgery – Present Day

- 6 Divisions
- More than 60 faculty; 130 adjunct/affiliated clinical faculty
- Continued growth/upward trajectory
  - New Adult (2018) and Children’s hospitals (Summer 2017)
  - Development of Surgery HSR Program
  - Actively recruiting new faculty across all divisions
Division of General Surgery

- **Acute Care Surgery/Trauma:** Drs. Badger*, Browder, Maggio, Spain, Staudenmayer, Weiser, Nassar
- **Breast:** Drs. Dirbas & Wapnir
- **Colorectal Red / White:** Drs. Shelton, Morris, Kin & Kirilcuk – division TBD
- **Hepatopancreatobiliary (HPB):** Drs. Dua & Visser
- **Minimally Invasive Surgery (MIS):** Drs. Azagury, Lau, Morton, & Rivas
- **Surgical Oncology 1:** Dr. Norton
- **Surgical Oncology 2:** Dr. Poultsides
- **Surgical Oncology 3/Endocrine:** Drs. Cisco, Lin, Wheeler
Other Surgical Divisions

- **Pediatric General Surgery**: Drs. Bruzoni, Chao, Fuchs, Hartman, Krummel, Lund, Mueller, Powell, Sylvester, Wall

- **Abdominal Transplantation**: Drs. Bonham, Busque, Concepcion, Esquivel, Gallo, Melcher

- **Vascular Surgery**: Aalami, Chandra, Dalman, Harris, Lee, & Mell

- **Plastic & Reconstructive Surgery**

- **Clinical Anatomy**
Additional training sites

- Lucille Packard Children’s Hospital (LPCH)
- Palo Alto Veterans Hospital (PAVA)
- Valley Medical Center (VMC)
- Kaiser (R2-R5 only)
Stanford Surgery

- Grounded in the Halstedian tradition of clinical excellence and education (embodied by Shumway)
- Dedicated to the future (sits in a very forward-looking Silicon Valley)
  - Opportunities are plentiful (clinical, academic, industry...)
- YOU are part of this future

Mark and Krummel, Arch Surg 2004
Expectations

- Patient care is **always** first
  - Honor and privilege to care for our patients
  - Patients will be incredibly thankful (some just have unique ways of showing it)
  - How would you want your family member treated?

- Honesty is required (with your colleagues, patients, and yourselves)

- Be dependable
  - Come early and come prepared (“Fortune favors the prepared mind.” – Louis Pasteur)

- Be professional
  - Treat others with respect, support your colleagues, ”dress for success”, complete your work hours/case logs/evaluations/etc. in timely manner
Patient Care

- What you do matters...
Variation in Hospital Mortality Associated with Inpatient Surgery

Amir A. Ghaferi, M.D., John D. Birkmeyer, M.D., and Justin B. Dimick, M.D., M.P.H.

- Difference in hospital quality based on “rescue” from complications (“Failure to rescue”)
- You are our eyes and ears, our first responders
- Answer is always to evaluate the patient

(you have minimal experience ➔ not ready to trust telephone/RN/EM evaluation)
Intern Ward Duties

- Sign-in, pre-rounding (numbers)
- Lead AM rounds
- Orders
- Discharge patients
- Call consultants
- Documentation
- Answer pages
- Make independent rounds and Lead PM rounds
- Maintain the list/census
- Sign-out
Sign-in and Pre-rounding

- Arrive early enough
  - Get thorough sign-out from night intern
  - Prepare census
  - Get numbers (vitals, I/O, labs, imaging) – discuss with your chief what should be written down / format
  - Photocopy list for remainder of team
  - Bottom line: YOU need to know what’s going on with your patients

- Medical students expected to help – it’s your job to help them help you
Lead AM Rounds

- Have a plan for leading rounds efficiently
- Notify Chief of any urgent issues from the start
- Patient presentation
  - Concise, accurate, clear – remember, we are surgeons
  - Make an assessment and present a plan (this is how your learn)
Write Orders

- 1\textsuperscript{st} priority is to institute plan from AM rounds
  - Orders – talking to people still matters
    - Get them in EPIC
    - Run the list with Charge RN or bedside RN
    - TPN $\rightarrow$ Discuss with pharmacy
    - Imaging $\rightarrow$ \textbf{Discuss with radiologist every time} to ensure scan performed to our liking
    - PICC $\rightarrow$ Discuss with PICC RN to ensure it gets done
  - MDR (~10am with Charge RN, CM, SW, Dietician, etc.)
Discharges

- Goal: before 11am
- Can set-up day before with “Conditional Discharge”
- Discharge Orders
  - Know which home meds to resume, which to hold, what requires new Rx
    - Plan ahead – ask your chief about this the night before or on AM rounds so it doesn’t hold things up
    - Confirm discharge pharmacy with patient
    - Rx (triplicate) must be accurate (avoids unnecessary phone calls, long drive back to hospital for patient/family)
  - Know activity, dietary, bathing restrictions; wound care; follow-up plan
Discharge Summaries

- Discharge Summaries
  - Not a summary of every event during their hospital stay
  - Can serve as progress note for the day if it includes a physical exam
  - Summary of events you would care about when evaluating that patient at follow-up
    - Surgery, Complications, Recovery (final “CYA” line), Final path, Follow-up, Physical exam
    - Use a template
Consultations

- Call early
  - Be respectful, but okay to be firm – if your chief asked you to call the consult, the answer is YES, we do want them to actually see the patient and leave a note. No debate.
  - Know the patient and specific question before calling
Documentation

- Every patient requires a note from a physician (or APP) every day
  - Must include PE and A/P
  - Medical student notes DO NOT count; nor does a cosigned student note
  - Students CANNOT write under your account (illegal as this is Medicare fraud)

- Use templates (can “steal” from other residents in Epic)

- Must be done in a timely fashion (but patient care come first)

- Copy-forward function is dangerous; best to avoid

- Update the Problem list
Documentation

- Be specific
  - Billing/Coding folks will message/call/page (frustrating but the future of medicine)
  - e.g., ”CKD” → “CKD, Stage 4”

- Document Quality Metrics – these actually help us help patients!
  - Urinary catheter (if yes, then reason)
  - Central line (if yes, then reason)
  - Antibiotics (indication, length, end date)
  - VTE prophylaxis (or why not)
Answering Pages

- You are our eyes and ears while we operate
- This is a team effort
  - BE PROFESSIONAL. Anything else is unacceptable.
  - Play well with others; Do not throw sand in the sand box; *All I Really Need to Know I Learned in Kindergarten*
  - Be respectful, be prompt; “kill them with kindness”
    - Not knowing the answer is not an acceptable reason to ignore the page
    - Answering the page with “let me run it by the chief” better than ignoring...
  - You represent your team, your attending, your program, and Stanford Hospital
Follow-up Daily Tasks and Lead PM Rounds

• Use a system that works for your (check boxes, etc.)

• Ensure that labs, imaging, studies, etc. are completed in timely fashion (again – talking to people in person is best for this)

• Keep your Chief updated with the results
  ◦ come to OR and/or text

• Make independent rounds if Chief in OR late into evening (and update Chief), or

• Prepare for PM rounds each afternoon
Maintain the Census

- Keep the list updated
- Summary line important for covering intern/team
Sign Out

- ACGME Requirements:
  - Minimize transitions of care
  - Monitored signout (by service Chiefs/Fellows)
  - Documented process to ensure effectiveness of transitions

- IPASS System
<table>
<thead>
<tr>
<th>I</th>
<th>Illness Severity</th>
<th>• Stable, “watcher,” unstable</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Patient Summary</td>
<td>• Summary statement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Events leading up to admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hospital course</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ongoing assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plan</td>
</tr>
<tr>
<td>A</td>
<td>Action List</td>
<td>• To do list</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Time line and ownership</td>
</tr>
<tr>
<td>S</td>
<td>Situation Awareness and Contingency Planning</td>
<td>• Know what’s going on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plan for what might happen</td>
</tr>
<tr>
<td>S</td>
<td>Synthesis by Receiver</td>
<td>• Receiver summarizes what was heard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asks questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Restates key action/to do items</td>
</tr>
</tbody>
</table>
I – Illness severity
- Stable, “Watcher”, Unstable

P – Patient summary
- “44M w/ HTN, CAD s/p CABG, HLD now POD0 from his distal gastrectomy. He has an epidural for pain (managed by pain) and should be strict NPO with his NGT to lcws; do not manipulate his NGT.”

A – Action list
- “POC around 8pm, follow-up his labs, text chief when they’re back”

S – Situation awareness and contingency planning
- “If pain control inadequate, call pain service. If blood pressure low, text chief.”

S – Synthesis by receiver
- Ask questions, reiterate plan
Postoperative Checks

- Requirement for every postoperative patient (within 4-8 hours)
- Must document (if no note in chart, did not happen)
  - Does not need to be a novel!
Patient Care - Summary

- Call for help: call early (trust your gut; error on side of patient safety)

- Never hesitate to call your chief
  - Keeping your chief in the dark is NEVER acceptable
  - Text messages are free (but if no response, assume not received). Text → Call → Page

- Do not call your chief in the OR; come to the OR (unless patient too unstable to leave the bedside)
  - If too unstable, chief occupied → call or page SICU chief/fellow or call RRT/Code Blue
  - RRT gets you Crisis RN and RRT; Code Blue gets you the Code Team

- Document events/your decision-making (brief SOAP note suffices)

- ANY JUNIOR OR SENIOR RESIDENT SHOULD HELP YOU IF YOU ASK – YOU ARE NEVER ALONE!!!
Night Service

- Stanford roster at night: R4, R2-Consult, R2-SICU, R1 x 2
- Safety Net (in addition to Chief at home)
  - Use the R4 at night (R4/R5 on Sat)
    - R4 is the first stop at night
  - Seems minor and R4 in OR → Consult R2 or SICU R2
Night Service

Intern Responsibilities at Night

Trauma Intern – “Triple Ts”

- Covers ACS (trauma), thoracic, transplant
- Runs / documentation for all minor traumas (97), helps with major traumas (99)
- Obtain face-to-face signout each night
- Complete assigned tasks (POC, studies, etc)
- Manage all direct admissions (eval, H&P, staff with Chief, etc)

Onc/CRS/... Intern – “the 9s”

- Covers Breast; Colorectal (x2); HPB; MIS; Surg Onc 1, 2, & 3, Vascular
- Helps with minor (97) and major (99) traumas
- Obtain face-to-face signout each night
- Complete assigned tasks (POC, studies, etc)
- Manage all direct admissions (eval, H&P, staff with Chief, etc)
Night Service

Pearls to live by:

- Be concerned. Assume the worst.
- Understand how your best plan will fail.
- See the patient. In person. DON’T BE LAZY.
- Communicate early and as often as needed.
- Ask for help.
- It is better to wake up the chief overnight than to be woken up by the chief the next day... Trust us.
Trauma

• It’s a team effort
• On nights and weekends, BOTH interns should have trauma IDs turned on and plan on helping with new trauma activations unless otherwise detained (run traumas, scribe, etc)
• The more you watch, the more you learn
• Master the primary and secondary survey!
• ATLS: get the book / app / podcast – whatever it takes
• Trauma manual
“Conservative management of SBO” → Nonoperative management

“Outside hospital” → Referring facility (hopefully has walls/roof)

“Gallbladder pain” → Biliary colic, symptomatic cholelithiasis...

- Gallstones with RUQ pain can be biliary colic, cholecystitis, choledocholithiasis, cholangitis, biliary pancreatitis...

“Pain on exam” → Pain is a symptom, tenderness is a sign

Do NOT auscultate bowel sounds (if you do, please do not share with anyone)

No silly noun-verbs (e.g., Coumadinize, surgerize)

No adding –wise to the end of organ systems (e.g., Respiratory-wise, Neuro-wise)
OR

- Come to OR early and often
- We will involve you as much as we can
- You can learn a ton watching surgery
- Stepwise progression... (prove you can walk before we let you run)
  - Practice, practice, practice
  - OR is not the place to practice your knot throwing, how to palm a needle driver...
Duty Hours

• Duty hours
  ◦ 100% compliance is NOT a goal, it is a requirement (reality, MedHub, ACGME survey)
  ◦ Your education matters
  ◦ In reality, there is no reason to be over the 80-hours, 6 days per week limit

• Identify problems early → consult with chief early
  ◦ A text message Friday night that you will be over hours is poor planning
  ◦ If you are struggling with hours and service chief not helping → email admin chiefs
  ◦ This is a shared responsibility that takes communication and planning!!
Duty Hours

- 80 hours per week, averaged over 4-week period
- 1 day free of duty every week, averaged over 4-week period
  - 1 day = 24 hours
  - Allows golden weekend and black weekend as long as it averages out
  - Vacations mean everything averaged over 3 weeks instead
- PGY1: Able to do 24h shifts
- PGY1: Should have 10 hours, must have 8 hours free of duty between duty periods
- PGY1: No home call
Schedule

- Know both **Call schedule** and **Rounding schedule**
- Call schedule available on Amion (via Scalpel homepage)
- **Amion schedule is final**
- We will try to complete these well ahead of time (help us out...).
Resident Resources

QUICK LINKS

ON CALL  EHR  OTHERS

- Stanford On Call
- VA On Call
- SCVMC On Call
- PD On Call
- VA-PD Moonlighting

EDUCATION

Core Course Schedule (view Resident Calendar)
SCORE Portal & TWIS Quiz
Schedule – Your Responsibility

- Know your schedule and identify any errors or potential conflicts
  - Review your block schedule when it is posted → identify errors early
  - Spend about ~10 minutes; help us out (we are trying hard to help you by getting it done early)
  - Email us if you see a real problem (e.g., working week of vacation, working 36 straight days...)

- Anticipate issues and troubleshoot – and COMMUNICATE
  - Examples: Transition from night service or a night call, vacation interfering with rounding requirements...
  - Email next service chief EARLY to warn them you are coming off nights

- DO NOT email us with the problem:
  
  **Identify the problem, offer a solution, and then email us**
• To meet duty hour requirements, you **must** have 1 day off every 7 days (averaged over 4 weeks)
  ◦ If 1 week of vacation, then average over 3 weeks (you do NOT get credit for vacation week)
  ◦ 1 day off = 24 hours
  ◦ If you are on call Sat night and rounding Sunday:
    • You must leave the hospital early enough on Fri night to have 24 h off → NO EXCEPTIONS
## Schedule Example

### Week 1

<table>
<thead>
<tr>
<th>Event</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Event 1</td>
<td>Event 2</td>
<td>Event 3</td>
<td>Event 4</td>
<td>Event 5</td>
<td>Event 6</td>
<td>Event 7</td>
</tr>
</tbody>
</table>

### Week 2

<table>
<thead>
<tr>
<th>Event</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>Event 4</td>
<td>Event 5</td>
<td>Event 6</td>
<td>Event 7</td>
</tr>
</tbody>
</table>

### Week 3

<table>
<thead>
<tr>
<th>Event</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>Event 7</td>
</tr>
</tbody>
</table>

### Week 4

<table>
<thead>
<tr>
<th>Event</th>
<th>Monday</th>
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<th>Friday</th>
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</thead>
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<tr>
<td>Example</td>
<td>Event 1</td>
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<td>Event 3</td>
<td>Event 4</td>
<td>Event 5</td>
<td>Event 6</td>
<td>Event 7</td>
</tr>
</tbody>
</table>

## Call Schedule

<table>
<thead>
<tr>
<th>Week</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Event 1</td>
<td>Event 2</td>
<td>Event 3</td>
<td>Event 4</td>
<td>Event 5</td>
<td>Event 6</td>
<td>Event 7</td>
</tr>
</tbody>
</table>

### Rounding Schedule

<table>
<thead>
<tr>
<th>Service</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>Event 5</td>
<td>Event 6</td>
<td>Event 7</td>
</tr>
</tbody>
</table>

## Underlying Basis Rules

1. **Underlying Basis Rules**
   - **1:** Rules that govern the underlying basis of the schedule.
   - **2:** Rules that govern the underlying basis of the schedule.
   - **3:** Rules that govern the underlying basis of the schedule.

## Table 1: Master List

<table>
<thead>
<tr>
<th>Service</th>
<th>Day off</th>
<th>Weekday Shift</th>
<th>Weekend Shift</th>
<th>Total Work</th>
<th>Work Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Event 1</td>
<td>Event 2</td>
<td>Event 3</td>
<td>Event 4</td>
<td>Event 5</td>
</tr>
</tbody>
</table>

## Table 2: Holidays

<table>
<thead>
<tr>
<th>Service</th>
<th>Day off</th>
<th>Weekend Shift</th>
<th>Total Work</th>
<th>Work Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Event 1</td>
<td>Event 2</td>
<td>Event 3</td>
<td>Event 4</td>
</tr>
</tbody>
</table>

### Instructions

1. **1:** Implement the new system.
2. **2:** Update the existing system.
3. **3:** Implement the new system.
4. **4:** Update the existing system.

---

[Note: The table and schedule are placeholders and should be replaced with actual data or content relevant to the context of the document.]
Scheduling changes

- Assume the answer is NO.

- That said, certain things come up during residency. We get through this together

  ① Email us for approval (include dates, reason, and plan for coverage → we expect to you problem-solve)
    
    - This means you will have emailed the involved parties to work out a solution
    
    - Unless it’s an emergency, this should be done ONE WEEK IN ADVANCE

  ② Admin Chiefs will review the switch

  ③ If approved, we will email all involved parties as well as the administration
Scheduling changes

- About rotations or vacations: admin chiefs
- Emergencies: admin chiefs and service chiefs
- Day to day schedule requests (ONE WEEK IN ADVANCE)
  - Stanford: service chiefs for ROUNDING, admin chiefs for CALL
  - LPCH: R3
  - VA: R4
  - VMC: Tanya Johnson and service chiefs (R4/R5)
Duty Hours and Other Regulations

• MedHub (online timecard)
  ◦ Must be filled out every week → no excuses
  ◦ Allows us to identify problems early (though the hope is problems identified before this point)
  ◦ Must be filled out honestly

• ACGME survey
  ◦ Not our opportunity to identify duty hour problems (should be fixed via personal accountability and then via MedHub)
Scheduling Step 3

- You will take Step 3 during your R1 year
- Paid for by GME office (go to their website for details)
- Schedule your test based on your service and obligations. For example:
  - If on Ortho, ENT, Cardiac, Vascular: schedule while on Anesthesia
  - Breast or MIS (especially when there is an R3/R5 doing an elective) > Surg Onc/CRS
  - UNACCEPTABLE TIME TO SCHEDULE:
    - ACS Day/Night
    - When R1-R5 on service is on vacation
QI M&M, Grand Rounds, and Core Course

• Absences are rarely excused

• Tardiness is rarely excused

• For Grand Rounds: Sitting in the back row is acceptable if the front rows are filled

• For Core Course/Journal Club: Sit in the front rows
  ◦ Come prepared

• For Subspecialty services: You may attend Gen Surg Core Course OR your subspecialty conference (not both)

• Do NOT delay your return to off-site services
Sign-in Sheet for QI M&M

- Monday mornings
- Breast Intern vs MIS Intern
- YOUR responsibility to be sure it is there by 6:55, no later, NO EXCUSES
- If vacation, find coverage
Logistics

- Use Stanford email only
- Add SECURE: to subject of any email including patient information
  - e.g., “SECURE: patient update for weekend rounds”
Feedback

- Provided to you (resident) **real time**, monthly (MedHub evals), and during twice-yearly feedback sessions with PDs

- You (resident) provide feedback after every rotation
  - **Anonymous** (collated by GME, faculty only sees after 6 months or certain “n” reached)
  - Meaningful (changes made every year based on resident feedback)
  - Be honest, critical, but professional

- Part of the ACGME survey ➔ so if not sure re: process, ask!
Tips and Tricks to Succeed

- The answer is always “yes”
  - Cases, clinic, consult, presentation, tumor board
  - This will make your life easier, your chief’s life easier, and your attending’s life easier

- Do not burn bridges
  - You represent our department and our attendings
  - Kill ‘em with kindness... or just “do what you get paid for”
  - As chiefs, we are not interested in cleaning up your interpersonal messes. BE PROFESSIONAL.

- Read...
Reading Habits of General Surgery Residents and Association With American Board of Surgery In-Training Examination Performance

Jerry J. Kim, MD; Dennis Y. Kim, MD; Amy H. Kaji, MD, PhD; Edward D. Gifford, MD; Christopher Reid, MD; Richard A. Sidwell, MD; Mark E. Reeves, MD, PhD; Thomas H. Hartranft, MD; Kenji Inaba, MD; Benjamin T. Jarman, MD; Chandrakanth Are, MD; Joseph M. Galante, MD; Farin Amersi, MD; Brian R. Smith, MD; Marc L. Melcher, MD, PhD; M. Timothy Nelson, MD; Timothy Donahue, MD; Garth Jacobsen, MD; Tracey D. Arnell, MD; Christian de Virgilio, MD

Figure 1. Residents’ Level of Satisfaction With Primary and Secondary Study Sources

Table 4. Factors Associated With ABSITE Performance

<table>
<thead>
<tr>
<th>Factor</th>
<th>Effect (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive correlation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>USMLE 1 score, per 1-point increase</td>
<td>0.1 (0.02 to 0.14)</td>
<td>.03</td>
</tr>
<tr>
<td>USMLE 2 score, per 1-point increase</td>
<td>0.3 (0.19 to 0.44)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>MCAT score, per 1-point increase</td>
<td>1.2 (1.3 to 2.0)</td>
<td>.002</td>
</tr>
<tr>
<td>Having an equal study focus on ABSITE and patient care</td>
<td>11 (7 to 15)</td>
<td>.009</td>
</tr>
<tr>
<td>Daily studying for patient care or clinical duties</td>
<td>13 (4 to 23)</td>
<td>.02</td>
</tr>
<tr>
<td>Surgical textbook as study source</td>
<td>11 (6 to 16)</td>
<td>.02</td>
</tr>
<tr>
<td>Level of satisfaction with study material (Likert scale)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Opinion of ABSITE significance (multiple choice)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Negative correlation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior ABSITE remediation</td>
<td>−26 (−36 to −16)</td>
<td>.002</td>
</tr>
<tr>
<td>Lack of study</td>
<td>−12 (−21 to −9)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>SCORE questions as primary source</td>
<td>−14 (−19 to −9)</td>
<td>.01</td>
</tr>
<tr>
<td>Internet search engine as source</td>
<td>−21 (−30 to −13)</td>
<td>.04</td>
</tr>
<tr>
<td>Primary focus on patient care when studying</td>
<td>−9 (−14 to −5)</td>
<td>.009</td>
</tr>
</tbody>
</table>

Table 5. Predictors of ABSITE Performance on Multivariable Analysis

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Effect (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>USMLE 2 score</td>
<td>0.4 (0.2-0.6)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>MCAT score</td>
<td>0.6 (0.2-1.0)</td>
<td>.003</td>
</tr>
<tr>
<td>Equal study focus on ABSITE and patient care</td>
<td>6.1 (0.6-11.5)</td>
<td>.03</td>
</tr>
<tr>
<td>Opinion of ABSITE significance (responses 1-4)</td>
<td>9.2 (6.9-11.6)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
Chiefs’ Journal Club

- Organized by Drs. Mazer and Brubaker
- ALL residents participate, during core course time
- Categorical General Surgery R2 Residents will present
- Critical analysis of the studies with powerpoint slides
  - R2 will present, followed by discussion
- Followed by ongoing ‘discussion’ on Tuesday evenings – not at work!
Social Events

- Post- Journal Club Tuesday evenings
- Stanford Football Tailgate(s)
- Holiday Parties
- Annual BIL retreat
- Resident vs. Faculty softball game
- Resident Appreciation Day (Graduation day)
- Graeme Rosenberg (PD resident)
Professionalism Curriculum

• Topics range from:
  ◦ Financial Planning
  ◦ Time Management
  ◦ Dress for Success
  ◦ Resiliency in Residency and Career
  ◦ Transition from Residency to Practice
  ◦ Contract negotiation
Balance in Life

- Class and whole program sessions
- Evolving each year

- End of the day: We are a family
- Life keeps happening during residency
- Look out for each other, support each other
- Mental and physical health needs active management and care
“It doesn’t matter what you say you believe – it only matters what you do.” - Robert Fulghum

“Science isn’t one success after another. It’s mostly one success in a desert of failure.” - Judah Folkman, MD


“Opening of the abdomen is not to be advised with too light a heart. The dextrous hand must not be allowed to reach before the imperfect judgment.” - Sir Zachary Cope

“The man who can drive himself further once the effort gets painful is the man who will win.” - Roger Bannister