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, Gregg, Maggio, Marks Spain, Staudenmayer, Weiser
- **Breast**: Drs. Dirbas, Jeffrey, Wapnir, & Wheeler
- **Colorectal Red**: Drs. Shelton & Welton
- **Colorectal White**: Drs. Kin & Kirilcuk
- **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
Other Surgical Divisions

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

- **Plastic & Reconstructive Surgery:** Drs. Chang, Curtin, Fox, Gaudilliere, Girod, Gurtner, Helms, Hentz, Kahn, Khosla, Lee, Longaker, Lorenz, Nazerali, Nguyen, Sen, Wan

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

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

- **Clinical Anatomy**
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...)
- Intern class of 2016-2017 is 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)
  - Photocopy list for remainder of team
- Medical students expected to help
Lead AM Rounds

- Have a plan for leading rounds efficiently
- Notify Chief of any urgent issues from the start
- Patient presentation
  - Concise, accurate, clear
  - Off assessment and plan (this is how your learn)
Write Orders

- 1st priority is to institute plan from AM rounds
  - Orders
    - Run the list with Charge RN or bedside RN
    - TPN → Discuss with pharmacy
    - Imaging → Discuss with radiologist to ensure scan performed to our likeness
    - PICC → 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”
  - Earn $5 gift cards by getting discharges done in timely fashion
- Discharge Orders
  - Know which home meds to resume, which to hold, what requires new Rx
    - 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
    - Ask your Chief if unsure
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
    - Build a template
Consultations

- Call early
  - Be respectful, but okay to be firm
  - Know the patient and specific question before calling
Every patient requires a note from a physician (or APP) every day

- Must include PE and A/P for billing purposes
- 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 from former interns (can ”steal” in Epic)

Must be done in a timely fashion

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
  - 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
  - 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
- Keep your Chief updated with the results
  - Text message and/or come to OR
- 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</td>
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<td></td>
<td></td>
<td>admission</td>
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<td></td>
<td>• Hospital course</td>
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<td></td>
<td>• Ongoing assessment</td>
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<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</td>
<td>• Know what’s going on</td>
</tr>
<tr>
<td></td>
<td>Awareness and</td>
<td>• Plan for what might happen</td>
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<tr>
<td></td>
<td>Contingency</td>
<td></td>
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<tr>
<td></td>
<td>Planning</td>
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<tr>
<td>S</td>
<td>Synthesis by</td>
<td>• Receiver summarizes what</td>
</tr>
<tr>
<td></td>
<td>Receiver</td>
<td>was heard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asks questions</td>
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<tr>
<td></td>
<td></td>
<td>• Restates key action/to do</td>
</tr>
<tr>
<td></td>
<td></td>
<td>items</td>
</tr>
</tbody>
</table>
Sign Out - IPASS

- 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)
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)
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**
- Covers ACS (trauma), thoracic, transplant
- Runs 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**
- Covers Breast; Colorectal; HPB; MIS; Surg Onc 1, 2, & 3
- 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)
Surgeon Talk

- “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)
• Come to OR early and often
• We will involve you as much as we can
• 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
Duty Hours

- FIRST trial (*NEJM*, 2016) published but no changes yet...
  - 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: Duty period must not exceed 16 hours
  - PGY1: Should have 10 hours, **must have 8 hours**, free of duty between duty periods
  - PGY1: No home call
Schedule

- Emailed out by JoAnn: Know both **Call schedule** and **Rounding schedule**
  - Excel spreadsheet emailed in advance
- Call schedule available on Amion (via Scalpel homepage)
- **Amion schedule is final**
- Great effort this year to complete in 4-month blocks (help us out...)
Schedule – Your Responsibility

- Know your schedule and identify any errors or potential conflicts
  - Review your block schedule when it is emailed out → identify errors early
  - Spend about ~10 minutes; help us out (we are doing you a favor by getting it done in 4-month blocks)
  - Email us if you see a real problem (e.g., working week of vacation, working 36 straight days...)
- Anticipate issues and troubleshoot
  - 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
Schedule Intricacies

- 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 (5pm) and rounding Sun AM (until 8-9am):
    - You must leave the hospital by 9 am Sun (16-hour maximum) → NO EXCEPTIONS
    - You must leave the hospital by 5 pm Fri (1 day off) → NO EXCEPTIONS
## Schedule Example

### Call Schedule

<table>
<thead>
<tr>
<th>Week</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
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### Rounding Schedule

<table>
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<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
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</table>

### Underlying basic rules

1. Dispatch the unit.
2. Enter the data in the Blank line.
3. Repeat for the next 3 days.
4. Ensure the date on the top right is 3 days.
5. Ensure the data is entered correctly.
6. Enter the data in Table 2.
7. Enter the data in Table 1.
8. Enter the data in Table 3.
9. Adjust the call schedule table in the next 3 days.
10. Ensure that every row has a day.

### Table 1 - Master List

<table>
<thead>
<tr>
<th>Service</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
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<th>Sun</th>
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### Table 2 - Vacations

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### Table 3 - Table

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### Table 4 - Table

<table>
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<th>Service</th>
<th>Mon</th>
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<th>Thu</th>
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</tbody>
</table>
Scheduling changes

• Assume the answer is NO...

• That said, certain things come up during residency and as a family, we must support each other

  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

  ② Admin Chiefs will review the switch

  ③ If approved, we will email all involved parties as well as the administration
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
  - If you schedule on ACS day/night, we (you) will have major problems (i.e., this is UNACCEPTABLE)
  - If you schedule on a service while your colleague (R1-R5) is on vacation, we (you) will have major problems (i.e., this is also UNACCEPTABLE)
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 & Grand Rounds

- Breast Intern vs MIS Intern
  - Block 1: K. Perrone (MIS) or I. Chang (Breast)
- YOUR responsibility to be sure it is there by 6:55, no later, NO EXCUSES
- If vacation, find coverage
Logistics

• Use Stanford email only
  ◦ We will ignore any correspondence from Gmail, Yahoo, etc.

• 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”

• Read...
Table 3. Reading Strategies Pertaining to ABSITE

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How prepared were you for ABSITE?</td>
<td></td>
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<tr>
<td>Did you follow a year-round ABSITE reading schedule?</td>
<td></td>
<td></td>
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<tr>
<td>What is your opinion of the ABSITE results?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Four respondents did not report this variable.

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>c</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Opinion of ABSITE significance (multiple choice)</td>
<td>c</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Negative correlation</td>
<td></td>
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<tr>
<td>Prior ABSITE remediation</td>
<td>-26 (-36 to -16)</td>
<td>.002</td>
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<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>
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</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>
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<tr>
<td>MCAT score</td>
<td>0.6 (0.2-1.0)</td>
<td>.003</td>
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<tr>
<td>Equal study focus on ABSITE and patient care</td>
<td>6.1 (0.6-11.5)</td>
<td>.03</td>
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<tr>
<td>Opinion of ABSITE significance (responses 1-4)</td>
<td>9.2 (6.9-11.6)</td>
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<tr>
<td>Subtitle</td>
<td>Plan’s The ABMS Review</td>
<td>ABMS Major</td>
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<td>----------------------------------------------</td>
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<tr>
<td>Acquired Heart Disease - Coronary Insufficiency</td>
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<tr>
<td>Transplantation of Abdominal Organs</td>
<td></td>
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<tr>
<td>Hiatal Hernia and GERD</td>
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<tr>
<td>Chest Wall and Pleura</td>
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<tr>
<td>Colon and Rectum</td>
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<tr>
<td>Venous Disease</td>
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<tr>
<td>Acute Abdomen</td>
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<tr>
<td>Biliary System</td>
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<td>Hand Surgery</td>
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<td>Burns</td>
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<tr>
<td>Inflammation and Cytokines</td>
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<td>Head and Neck</td>
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<td>Parathyroid</td>
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<td>Breast</td>
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<td>Thoracic Surgery</td>
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<td>Fluids/Electrolytes/Nutrition</td>
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<td>Legal/Ethics</td>
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<td>Review of Surgery for ABSITE and Boards</td>
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<td>Molecular and Cell Biology</td>
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<td>Breast Reconstruction</td>
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<td>Ethics in Surgery</td>
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<td>ABSITE</td>
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<td>Appendix</td>
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<td>Blood Products</td>
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<tr>
<td>Neurosurgery</td>
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<td>Adrenal</td>
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<td>Trauma - II</td>
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<td>Liver</td>
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<td>Hepatobiliary Surgery</td>
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<td>Trauma - II</td>
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<td>Pediatric Surgery</td>
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<td>Skin/Soft Tissue</td>
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<td>Reconstructive Surgery</td>
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<td>Alimentary Tract</td>
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<td>ABSITE</td>
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</table>
Chiefs’ Journal Club

- 4th or 5th Tuesday each month, starting in July
- Categorical General Surgery R2 Residents will each present 2 times
- Must be from index journals (*NEJM, JAMA, Lancet, Annals, JAMA Surg*)
- Critical analysis of the study with powerpoint slides
  - R2 will present and then moderate the discussion (pimping encouraged)
- Paper will be emailed out 1 week prior
Chiefs’ Rounds

- Beers and burgers
- 4\textsuperscript{th} or 5\textsuperscript{th} Tuesday each month, starting in June
  - Inaugural Chiefs’ Rounds: June 30
- 7pm, meet at Dutch Goose
- Department funded (“continuation of journal club”)
  - Admin Chiefs will also chip in
Social Events

- Graeme Rosenberg (R2 → PD resident)
  - Monthly Chiefs’ Rounds (4th/5th Tuesday)
  - Faculty Social Event (monthly, 2nd Tuesday vs Thursday, Dr. Cindy Kin)
  - Stanford Football Tailgate(s)
  - Holiday Parties
  - Annual BIL retreat (ropes course, dinner)
  - Resident vs. Faculty softball game
  - Resident Appreciation Day (Graduation day)
Professionalism Curriculum

- New curriculum starting this July
- 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

- End of the day: We are a family
- Look out for each other, support each other
- Mateo’s chin lac
“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