Prevocational Training Term Description: General Surgery

Date of term description version	April 2024
Date term last accredited	March 2021

Term Details

Facility	Canberra Health Services				
Term name*	General Surgery				
Term specialty*	General Surgery				
Term location	Canberra Hospital				
Classification of clinical experience in term* (Highlight a maximum of 2)	Un-differentiated illness patient care	Chronic illness patient care	Acute critical illness patient care	Peri-operative/ procedural patient care	Non-direct clinical experience (PGY2 only)
Is this a service term? Service term is a term with discontinuous learning experiences including limited access to education program or limited access to regular within-unit learning activities or less/ discontinuous overarching supervision (e.g., relief term or nights with limited staff).				Yes	No

Term duration (weeks)*	12-14 weeks (depending on term dates)		
Term accredited for	PGY1 and PGY2		PGY2 Only
Total number of prevocational training places	**8**	**Limitations/conditions** In some terms, the CRMEC will make limitations (e.g. skills mix or minimum numbers)	JMOs must be assigned to a team and term supervisor prior to commencement of the term

Term Supervision

Term Supervisor (name and position) Term supervisor is responsible for conducting term orientation, discussing the PGY1/2's learning needs with them, and conducting and documenting a midterm and end-of-term assessment. Term supervisors must complete mandatory training and commit to a code of conduct outlining their responsibilities.	<u>Endocrine/Head and Neck/General Surgery (Team 1):</u> Dr Philip Chia <u>Colorectal/General Surgery(Team 2):</u> Dr Ram Ganesalingam <u>Upper GI/HPB/General Surgery (Team 3):</u> Dr Soon Lau

		Trauma (Team 4) Dr. Sean Chan
Clinical team supervision	**Primary/Immediate Clinical Supervisor (name and position)** Clinical supervisor is a consultant or senior medical practitioner (PGY3+) with experience in managing patients in the relevant discipline. They are readily accessible for support, provide education, conduct EPAs and contribute to assessment.	Endocrine/Head and Neck/General Surgery (Team 1): Dr Philip Chia Dr Janaka Balasooriya Dr. Xiaoming Liang Dr Mike He Dr. Ailene Fitzgerald Dr Amir Butt Dr Thembe Ncube Colorectal/General Surgery(Team 2): Dr. Usama Majeed Dr. David Rangiah Dr. James Lim Dr. Ram Ganesalingam Dr. Rebecca Read Dr Alisha Azmir Upper GI/HPB/General Surgery: Dr Soon Lau Dr James Fergusson Dr Charles Mosse Dr Phil Jeans Dr Sivakumar Gananadha Dr Edwin Beenen Dr Christopher Lim Trauma (Team 4): Dr. Sean Chan Dr Thembekile Ncube Dr Philip Chia Dr Ailene Fitzgerald Dr. Janaka Balasooriya Dr. David Lamond Dr. James Falconer Dr Gerrard Marmor
	Additional Clinical Supervisors (positions) Position of others (PGY3+) responsible for day-day clinical supervision, including after-hours supervisors.	Any of the consultants listed will be happy to answer questions or provide urgent advice. There are also surgical registrars and fellows to provide day to day clinical supervision. These rotate on a semi-annual basis.
	EPA Assessors Name and position of others (PGY3+) who have completed training to undertake EPA assessments.	All consultants and fellows in this term can undertake EPAs. Registrars and allied health who have undertaken EPA training may also complete EPA's with JMOs.

Clinical Team Structure* Highlight the team model, identify and describe the clinical team structure including how PGY1/2s are distributed amongst the team.	Ward Based	Team Based	Other
	Each PGY doctor will be allocated to a clinical team. In this term, PGY 1/2 medical officers will be managing the day to day needs of all patients under the above consultants depending on their clinical team allocation. The lists of patients under this team can be obtained from DHR. A separate list of consults (patients requiring general surgical input but under other clinical teams) can also be generated from DHR. The first point of call for assistance and advice will be the clinical teams general surgical team accredited registrar followed by the General surgery team fellow. The JMO is encouraged to contact the relevant consultant directly if the registrar or fellow is uncontactable. The PGY1/2 JMO will accompany the registrar and consultant on ward rounds, carry out tasks as directed for patient care, including assisting in theatre when required.		

Commencing the Term

Requirements for commencing the term* If there are any specific requirements (e.g., courses, procedural skills or e-learning requirements) provide details of how the prevocational doctor will receive this training/will be assessed.	No specific extra skills related to this position are required. Before commencing the term, it's expected that interns have a foundational understanding of basic surgical skills, including aseptic technique, surgical instrument handling, and wound care. Additionally, some familiarity with gastrointestinal anatomy and common surgical pathology would be beneficial. It is expected that JMOs understand how to identify the sick patient. We encourage interns to review relevant textbooks or online resources to ensure a smooth transition into the unit.
Orientation Include detail regarding the arrangements for orientation to the term, including who is responsible for workplace orientation and any additional resource documents such as clinical policies and guidelines required as reference material. **The term supervisor is responsible for orienting the JMO to the term requirements and clinical expectations within the first week of starting the term**	The Term supervisor will meet and provide a term orientation to the incoming JMO within the first week of term. The JMO will be given a description of the term timetable including consultant operating, scope and clinic sessions. They will be directed to the intranet folders for existing surgical standard operating procedures (SOPs). Further information will be provided at handover meeting on the first day of term.

Overview of the Unit

The role of the unit and range of clinical services provided, including an outline of the patient case mix, turnover and how acutely ill the patients generally are	**Role of the Unit** • Provide high quality general surgical services to ACT and surrounding geographic regions of NSW; • Ensure that services provided meet with the highest standards of care and are given with compassion, kindness and courtesy; • All health care providers in the department should be aware of the cost-effectiveness of all investigations and treatment and aim to ensure optimal use of resources; • ensure good working relationships with all staff to provide optimal patient care and experience; • To provide training for Surgical Registrars in accordance with RACS expectations; • To provide training to JMOs around diagnosis and management of common surgical conditions which may extend to all ward staff and students including nursing; • To participate in other hospital activities through conferences and seminars to educate medical doctors and colleagues on surgical patients; • To participate through various Community groups such as the Breast Support Group and Colostomy Association, to support patients in the community; • Health and well-being advocacy for patients and staff; and • Active participation and promotion of teaching and research opportunities related to subspecialty areas.
Clinical responsibilities and tasks of the prevocational doctor Provide an overview of the routine duties and responsibilities	**Consultant Specific Requests** • Every consultation to the unit requires a specialist opinion. The consultant must be contacted and typically reviews the consult within 24 hours. Please refer to individual consultant preferences regarding the specific process of consultations. **Ward Rounds and Ward Work** • It is expected that the Inpatient Team (Intern/RMO and Registrar) round on every patient every day. This should include any patient for whom there is clinical involvement irrespective of whether they are under the Unit bed card or not. The patient list should include these patients in this daily review. • Enter a written note on every inpatient every day into the DHR. • Prior to rounding, the Nurse in Charge of the relevant ward should be given the opportunity to round with the Unit. • Should the Nurse in Charge elect not to round then at the completion of the round on that ward the Nurse in Charge should be briefed on patient care plans. • Medical Students attached to the Unit are considered integral members of the team and should participate as a Pre-Intern, including in patient examination and medical chart entries. Every medical student entry or test request must be counter-signed by a medically qualified team member. • It is expected that on ward rounds with consultants that the intern/resident will be familiar with all patients and may be asked to present a concise summary of the patients progress up to that point in time, including an assessment or problem list and management plan. The Registrar will contribute any additional management plans or dilemmas.

- Consultation to other inpatient units can only be made after discussion with the Registrar who will inform the consultant of the problems for which additional opinions are being sought.
- After rounding on Intensive Care Unit patients, it is mandatory that the Intensive Care Medical Staff be consulted and a conjoint appraisal of the patient's progress made..

Outpatient Sessions

- Both registrar and resident are expected to attend the outpatient sessions if workload and space permits. In the clinic all new patients must be seen by a consultant.
- The registrar or consultant will be responsible for theatre case requests and informed consent.
- Medical students are encouraged to see new patients as long cases prior to the consultant.
- The resident's responsibilities in the outpatient clinic are principally to follow up reviews. Returning patients to their regular GP is encouraged.
- Each change in management, progress or prognosis requires a letter to the patient's GP.
- All patients seen in an outpatient setting by a JMO must be discussed with the clinical supervisor.

Operating Room

- Participation in all operating room sessions is mandatory for the unit Registrar; the RMO and/or intern are strongly encouraged to attend where ward work permits.
- The unit Registrar and any assisting JMOs should be in the Operating Room at least 10 minutes prior to the operating list commencing to review any concerns and check the patient prior to anaesthetic commencing.
- Team time out is essential.
- At the completion of every operation the following must be checked and completed and is the responsibility of the principal surgeon:
  - An operation report
  - Detailed post operative orders;

Any required orders placed. and any other request forms

Presentations

- Residents attached to the Unit are encouraged to consider participation in clinical research projects while attached to the Unit.

Hours of Work

- Generally, it is expected that most work will be completed in the hours rostered. Any uncompleted tasks should be handed over to the incoming evening JMO;
- Should all team duties be completed, collaboration with other surgical teams is encouraged to share the workload before pursuit of other educational activities, such as library reading and research;

	• If at any time the JMO is unable to respond expeditiously to a page (e.g. because they are in protected teaching) then covering arrangements need to be in place; • Should the JMO or Registrar wish to leave the hospital during normal rostered hours of duty then appropriate cover must be in place and the consultant should be aware; and • Please note the Unit Timetable. Prior to leaving the unit it is incumbent on the JMO to contact the incoming JMO and orientate him/her to the appropriate surgical wards and any current inpatients who will be the responsibility of the new JMO.
Work Routine Provide an overview of the work routine	Work routine and tasks are outlined above and in more detail in the JMO Handbook. All JMO positions within Teams 1-3 are allocated by General Surgery Unit, however Trauma RMOs are allocated by MOSCETU. All JMOs will be informed of the specific term supervisor prior to commencing by Medical Education Unit.
Clinical handover procedure Provide an overview of the handover procedure and expectations in this training term	Handover is at 0700hrs in building 2, level 3, conference room 1 and all teams are invited to attend. However, depending on the specific team's commitments for the day, there may be a requirement to be rounding with the consultant or registrar at this time prior to theatre, in which case any patients needing to be handed over will be done early in the day at an opportune time.
Safety	OH&S, occupational violence and safety in pregnancy are covered in the JMO Handbook. The General Surgery Department supports Speaking Up For Safety of patients and staff.
Opportunities for Indigenous Health	Aboriginal and Torres Strait islander peoples may present as patients within this term and JMOs will be able to engage the support of the Aboriginal Liaison Officer as required for patients and their families and improve their knowledge, and skills around cultural safety.

Education, Learning and Assessment

Term Learning Objectives
List the term-specific learning objectives*
	CLINICAL MANAGEMENT
	The JMO should strive to become familiar with the following by the end of this Term:
	Clinical:
	• Abdominal pain and its common surgical causes
	• Pre-operative assessment and investigations
	• Principles of informed consent
	• Patient and relatives' counselling skill development
	• Common surgical procedures relevant to the subspecialty term and follow-up
	• Diagnosis and management of common postoperative complications:
	  ○ Atelectasis
	  ○ Pneumonia
	  ○ Common arrhythmias
	  ○ Pulmonary Emboli (and prophylaxis)
	  ○ Wound complications including drain management
	  ○ Fluid and electrolyte disturbances
	• Efficient and high quality clinical handover – all JMOs are expected to prepare well for daily handovers including weekends.
	• Be familiar with the Enhanced Recovery after Surgery (ERAS) protocol after colorectal surgery.
	•
	Procedural:
	• IV placement Insertion of urinary catheters.
	• Draining and packing superficially infected abdominal wounds.
	• VAC dressing- application and removal.
	• Procedures relating to general surgery including time out, managing the aseptic field and assisting in theatre
	• Wound debridement and closure techniques;
	• Excision of skin lesions; and
	• Depending on opportunities, tube thoracostomy, central venous catheterisation, lumbar puncture, and abdominal paracentesis.
	Educational:
	• Participate in Wound Management Skills Workshop.
	• Familiarity with and participation in Audit process.
	• Early Management of Severe Trauma course (EMST).
	
	Interpretative:
	You should be familiar with interpretation of the following:
	• Fluid and electrolyte disturbance
	• Renal function and liver function tests
	• Medical Imaging:
	  ○ Chest X-ray
	  ○ Plain abdominal film
	  ○ CT Scans

<table>
<tr><td>Detail education and research opportunities and resources <u>specific to this training term</u> that will be available to the JMO during the term.
Formal education opportunities should also be included in the unit timetable</td><td colspan="4">General Mandatory Education
All interns are expected to attend the mandatory Tuesday afternoon teaching program. This is a requirement of CRMEC. The period from 1430-1600 on Tuesdays is protected time for PGY1.
Mandatory RMO (PGY2) teaching is Thursdays from 1300-1400. This time is protected for PGY2 JMOs.
Non mandated, non protected JMO teaching also occurs at 1300 on Mondays as part of the ‘Monday Shorts’ teaching program.
Venue and topics are confirmed by email earlier in the day.
Other team members, including registrars or JMOs are to continue the clinical work required in the absence of the attending JMO to prevent delay from completion of their clinical shift due to attending teaching.
Grand Rounds:
All JMOs are encouraged to attend Grand Rounds on Wednesdays.
Term-Specific Training
AMO Teaching: Dr Majeed, Dr Lim and Dr Rangiah, Dr. Ram Ganesalingam, Dr. Rebecca Read and Dr. Thembe Ncube.
Registrar Teaching: General surgery registrar teaching – Week 1 and 3 - Wednesday 5.30 – 6.30pm.
Trauma JMO teaching: On-duty specialist weekly – Thursday 2.30pm – 3.30pm.
Educational Resources
A comprehensive range of reference material is held in the hospital library and is available on the Intranet.
• In addition to the teaching timetable, participation in the following is encouraged:
Wound Management Skills Workshop
Familiarisation with and participation in Audit process
Burns Education Day
Early Management of Severe Trauma course (EMST).</td></tr>
<tr><td>During this term prevocational doctors should expect opportunities to complete the following EPAs* (Highlight all that apply)</td><td>EPA 1
Clinical Assessment</td><td>EPA 2
Recognition and care of the acutely unwell patient</td><td>EPA 3
Prescribing</td><td>EPA 4
Team communication – documentation, handover and referrals</td></tr>
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Term/Unit Timetable and Indicative Duty Roster*

Include the **start time** and **finish times** of the shifts the prevocational doctor will be rostered to. Show the activities that the prevocational doctor is expected/rostered to attend – these include all **education opportunities** (both training facility-wide and term specific), ward rounds, theatre sessions, inpatient time, outpatient clinics, shift handover, morning handover from hospital night team, afternoon handover to hospital's after hours team. Please include the approximate times of activities wherever possible. If there are extended shifts or evening shifts attach four weeks of rosters for the whole team.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0700 Handover 0730 Consultant/registrar ward round Operating theatre sessions occur on a 4-weekly cycle. Check timetable in 10A doctors' room 1300 – Non mandated 'Monday Shorts' JMO teaching	0700 Handover 0730 Consultant/ registrar ward round 1430-1600 mandatory Intern teaching session	0700 Handover 0730 Consultant/registrar ward round 1200 – Grand Rounds	0700 Handover (Upper GI radiology meeting John James Hospital) 0730 Consultant /registrar ward round 14.00 – 15.00 Trauma teaching 1300-1400 mandatory RMO teaching session	0700 Handover 0730 Consultant /registrar ward round	As per Surg Pod 1 roster	As per Surg Pod 1 roster

Patient Load Average Per Shift	10-15	
Overtime	Rostered overtime hours/week	2.5
	Unrostered overtime hours/week	2.5
After hours roster Does this term include participation in hospital-wide afterhours roster? If so advise: • Frequency of after-hours work, including evenings, nights and weekends (hours/week and weekends/month) • Onsite supervision available after hours If the JMO will be working outside this term on afterhours roster, provide details of the after-hours work and a four-week roster. The designated after-hours supervisor should be listed in the supervisory team.	Each week one of the JMOs will be rostered on the discharge summary shift, which allows for finalising the discharge summaries. This is a shift that will include additional time from 1630 to 1730 each day. PGY1/2 will be expected to work on the after-hours roster. The General Surgery term forms part of Surgical Pod 1. All rostered overtime over weekends or late shifts during the week fall under this Pod. Surgical Pod 1 encompasses: • General Surgery Team 1 (Endocrine/Head and Neck/ General Surgery); • General Surgery Team 2 (Colorectal /General Surgery); • General Surgery Team 3 (Upper GI/Hepatopancreaticobiliary/General surgery); • Trauma Surgery; • Acute Surgical Unit; • Cardiothoracic Surgery; • Urology; and • Relief positions. Whilst in a Pod you will have a direct term supervisor as outlined by the individual term description as well as an over-riding Pod supervisor to facilitate the co-ordination of the working unit. Within your Pod you may have one or more weeks of evening shifts and a week of night shifts. As an evening PGY1/2 you may be called to commence work earlier in the day should the patient load require it. A week of night shifts may also occur during your term. The standard process is 7 nights rostered, followed by 7 days off – however the JMO is on call for days 6 and 7, unless taking annual leave after the days. Alternatively, arrangements can be made to allow for leave provided adequate warning is given. JMOs will also be expected to do approximately three to five Surgical Pod 1 weekend/public holiday shifts throughout the term. • Note: The rostering of a routine JMO (SP 2.1) and an extra (SP 2.2 A&D) on Saturdays is different to the rest of the after-hours rostering for Surg Pod 2. SP 2.1 will cover all SP2 units (SP1 will continue to cover SP1 units) and SP 2.2 will be responsible for all admissions and discharges for both	

	SP1 and SP2, meaning SP1 and SP2 will not be responsible for admissions and discharges on Saturdays. • On Sundays, the SP1 and SP2 will cover their respective units (including covering admissions and discharges without an extra, as is currently the case). By working after hours shifts, you will be part of a team providing 24-hour care for patients within your Pod. You will also be more aware of the specialist and registrar plans as you will be working in a small unit of specialties on a day-to-day basis. You will participate in more focused handover and utilise relevant electronic discharge/case mix information more efficiently and you will be able to follow up relevant investigations and consultations more closely with a working Each Pod works as a functional unit allowing all JMOs within it to attend the teaching sessions provided by each of the sub-specialties when able as well as your own specialties' teaching programme. All interns are expected to attend mandatory intern teaching sessions held every Tuesday afternoon and all RMOs are expected to attend mandatory RMO teaching on Thursday afternoons.

List Other Relevant Documentation
Intern job description RMO job description JMO Handbook