Prevocational Training Term Description: General Surgery

Date of term description version	January 2024
Date term last accredited	April 2022

Term Details

Facility	North Canberra Hospital (NCH)				
Term name*	General Surgery				
Term specialty*	General Surgery				
Term location	6 W and Theatres				
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). Note: this will be determined by CRMEC based on how whether this is discontinuous supervision and education experience within the term				Yes	No

Term duration (weeks)*	One term (12-14 weeks)		
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)	• Two JMOs must be assigned on each surgical team at any one time • All JMOs will be assigned to one term supervisor for 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.		General surgery 1: Dr David Rangiah General Surgery 2: Dr Rebecca Read General Surgery 3: Dr Amir Butt General surgery 4: Dr Kieran Hart
	Primary/Immediate Clinical Supervisor (name and position)	General surgery 1 Team : Dr Siva Gananadha

Clinical team supervision	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.	Dr James Lim Dr Edwin Beenen Dr Mike He Dr Charlie Mosse Dr Chris Lim General Surgery 2 Team: Dr Frank Piscioneri Dr Mike He Dr Ailene Fitzgerald Dr James Lim Dr Krish Naidu Dr Jandaka Balasooriya General Surgery 3 Team: Dr Phillip Jeans Dr Xiao Liang Dr Thembekile Ncube Dr Krish Naidu Dr Usama Majeed General Surgery 4 Team: Dr Daniel Gilbourd Dr Hodo Haxhimolla Dr Mohammed Kahloon Dr Simon McCredie Dr Hin Fan (Rex) Chan Dr Anton Maré
	Additional Clinical Supervisors (positions) Position of others (PGY3+) responsible for day-day clinical supervision, including after-hours supervisors.	Each team's consultants or registrars also supervise the JMOs and facilitate ward activities. There is usually one surgical registrar per team and one or two surgical fellows. When rostered afterhours, JMOs are supervised by: • Surgical Registrar who can be contactable by pager or through switch is onsite till 2130 Monday to Friday, (partake in a 24-hour on call roster, and are available to be on-site whilst on call) • Obstetrics and Gynaecology Registrar who is contactable by pager or through switch is onsite 24/7 • Mental Health registrar who is contactable by pager or through switch (partake in a 24-hour on call roster and are available to be on-site whilst on call). • The afterhours Medical Senior Staff who are available in the ED, ICU and Anaesthesia if required, these departments also operate as the Medical Emergency Team.

	EPA Assessors Name and position of others (PGY3+) who have completed training to undertake EPA assessments.	Clinical supervisors, registrars and allied health members who have completed EPA training can par-take in completing EPA.		
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 unit has 5-6 consultants, one registrar and one junior doctor. Senior members will help JMO complete day to day activities. Team registrar usually will be the first point of contact followed by the fellow or consultant. Morning ward rounds will be led by the registrar or fellow with assistance for the JMO. Consultants will also round on their patients with the registrar and JMO. Plans formulated during the round will be executed by JMO with assistance from registrar. JMOs are encouraged to attend the theatre and outpatients clinics after completing ward activities (ideally at least a half day theatre list and clinic each week).			

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.	There are no prerequisites for commencing this term; however, JMOs will need to attend a Basic Life Support (BLS).This can be organised through Learning and Development. 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.
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.**	Start of term Orientation delivered by Medical Administration. Mandatory ward orientation with CNC of the department. Orientation is organised in the first week for Theatres which includes scrubbing and gloving techniques. Orientation about the term is provided to the junior doctors on their first day of their rotation. It will be delivered by the registrar and fellow. JMOs should attend theatre or an outpatient clinic during the first week of the term to meet their supervising consultant if they have not already met them on the ward.

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; • Ensure that adequate ward and operating facilities are always available for elective and emergency surgery; • In close co-operation with Nursing Staff, maintain optimal care and efficiency of utilisation in the wards to maximise usage of resources; • To provide training for Surgical Registrars along the guidelines lay out by the R.A.C.S.; • To provide training to Residents and Interns, rotating through the department to enable them to cope with the diagnosis and management of patients with surgical conditions; • To provide continuing Medical Education through ward teaching, seminars, lectures and discussions to nursing staff and nursing students; • To participate in other hospital activities through conferences and seminars to educate medical doctors and colleagues on surgical patients; • To participate through various non-medical groups such as the Breast Support Group and Colostomy Association, to support patients in the community; • Where possible, to promote health through the prevention of disease by changes in lifestyle; and • Research, both clinical and basic, in surgical diseases are pursued to better understand mechanisms of disease and improve health care. Surgical Team provides elective and acute care for a range of general surgical conditions. A wide range of procedures are performed covering a full range of general surgical problems particularly upper GI bariatric surgeries, colorectal, breast, surgical oncology, urological & hernia surgery, endocrine surgeries as well as others. Acute conditions are admitted through the Emergency Department, particularly appendicitis, bowel obstruction, gall bladder disease, urinary retention, perianal abscesses etc. Trauma and cardiothoracic surgery are performed at Canberra Hospital Health Services.
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** • Consultant led ward round twice in a week and daily with registrar. • 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 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 at the end of each workday.

Outpatient Sessions

- Both registrar and resident are expected to attend the outpatient sessions if workload permits. In the clinic all new patients must be seen by a consultant.
- No patient can be added to the unit waiting list without a co-signing of the request for admission form by a consultant.
- 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 things must be checked and completed: ➢ An operation report (a dictated report is the responsibility of the principal surgeon); ➢ Detailed post-operative orders; ➢ Pathology request forms completed with an appropriate history and for those patients being discharged that day prepare a unit contact card; and ➢ Follow up appointment and medical certificates. **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 covering resident; • Should all duties be completed then pursuit of other activities, such as library reading and research activities, is encouraged; • 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 • Please note the Unit Timetable. **Handover (every day and at last day of term):** Attend 0700 hrs morning along with the registrar and consultants. Prior to finishing the term it is incumbent on the JMO to contact the incoming JMO and orientate him/her to surgical unit and inform them any current inpatients who will be the responsibility of the new JMO.
Work Routine Provide an overview of the work routine	Daily morning round commences at 7:00 am with both registrars and PGY 1/2 staff. The rounds are consultant-lead twice weekly. Following the round, the registrar and resident staff divide the work depending on patient numbers, clinical condition, and theatre commitments. The surgical service operates very much as a team. Junior staff are encouraged to assist each other if there is a difference in clinical load between the teams.
Clinical handover procedure Provide an overview of the handover procedure and expectations in this training term	Handover is supervisor by the senior registrar and fellow. The night JMO and registrar will hand over to the day team at 0700 in the doctor's office on the surgical ward. New patients and any issues from overnight will be discussed.

	The PGY1/2 is responsible for the effective handover at the end of the term to the incoming JMO on rotation.
Opportunities for Indigenous Health	Aboriginal and Torres Strait islander patients may present 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*
	By the completion of the term the JMO are expected to acquire the following skills and knowledge:
	Clinical:
	• Abdominal pain and its common surgical causes
	• Pre-operative assessment and investigations
	• Principles of informed consent
	• Patient and relatives' counselling skill development
	• Colorectal surgery procedures and follow-up
	• Diagnosis and management of postoperative chest conditions:
	  ○ Atelectasis
	  ○ Pneumonia
	  ○ Common arrhythmias
	  ○ Pulmonary Emboli (and prophylaxis)
	• Fluid and electrolyte disturbance
	• Wound Assessment:
	  ○ Cellulitis
	  ○ Infection
	  ○ Dehiscence
	• Management of drains
	• Efficient and high quality clinical handover – all JMOs are expected to prepare written and verbal handovers every day including weekends.
	• Be familiar with the Enhanced Recovery after Surgery (ERAS) protocol after colorectal surgery.
	
	Advantages and disadvantages of various types of:
	• Dressings
	• Wound Antiseptics
	• Common cure of antibiotics
	
	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.
	
	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
	
	Communication learning objectives
	• To be able to explain to patients and their relatives what is happening, what to expect and to listen and be able to address their concerns.
	• To be able to communicate with external medical and paramedical personnel, including GPs, especially regarding postoperative care.
	• To communicate effectively with hospital staff involved in the patients' care including the registrars and consultants.
	• To be able to communicate effectively via the written medical record with appropriate documentation of clinical findings, test results and the clinical plan.
	• Be able to communicate with nursing staff regarding the clinical plans for each patient.
	• To have sound written communication skills.
	
	Professionalism learning objectives
	• To show enthusiasm and initiative for learning and research.
	• To demonstrate a desire for self-directed learning.
	• To be willing to teach and assist other staff.
	• To be punctual, reliable and honest and to behave in an ethical manner to patients and other staff.
	• To be prompt and efficient in the management of work and with good prioritisation of tasks.
	• To understand and model the institutions policy on bullying in the workplace.

Detail education and research opportunities and resources <u>specific to</u>	JMOs are encouraged to attend as many educational events as possible.

<table>
<tr><td><u>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">The following general education is available:
• Tuesday afternoon Education Session 1300-1600hrs. This is protected time. This is a requirement of CRMEC.
• Wednesday lunchtime Grand rounds.

The following term-specific education is available:
• There are many opportunities for term specific education during ward rounds, theatre lists and outpatient clinics. Interested JMOs can attend surgical registrar teaching if they are available and interested (often Monday at 1300) and the monthly research meeting (held on the Wednesday of week 3 at The Canberra Hospital campus at 1730 pm.</td></tr>
<tr><td>During this term prevocational doctors should expect opportunity 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>
</table>

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 are 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 Morning Round AM:Theatre List Dr Lim 1530 Handover	0700 Handover Morning Round 1300-1530 Education Program 1530 Handover	0700 Handover Morning Round AM: Theatre List Dr Gananadha 1200 Grand Rounds PM: Theatre List Dr Gananadha 1530 Handover	0700 Handover Morning Round AM: Theatre List Dr Lim and Dr He PM: Theatre List Dr He 1530 Handover	0700 Handover Morning Round AM: Theatre List Dr He PM: Theatre List Dr He 1530 Handover	0730 Handover Morning Round 2130 Handover	0730 Handover Morning Round 2130 Handover

Patient Load Average Per Shift	Maximum 25 patients	
Overtime	Rostered overtime hours/week	Approximately 13 hours including weekend and long shifts
	Unrostered overtime hours/week	Average of 3 hours per fortnight which can change due to seasonal changes or activity.
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.	JMOs participate in the Surgical POD afterhours rotation covering Surgical Wards, OPMHU, Acacia, Maternity and first on call for theatre. Afterhours JMO shifts are as per the roster distributed by the Medical Administration. PGY1: • Day shifts (0645-1615) • Surgical evening shifts (1300-2130) • Surgical nights (2100-0700) • Surgical weekends (0730-213 PGY2+: • Day shifts (0645-1615) • Surgical evening shifts (1300-2130) • Surgical nights (2100-0700) • Surgical weekends (0730-2130) JMO's are supervised by surgical registrars and medical registrars during the after-hours and weekend periods. Bedside case-based education is occasionally carried out by the registrars and consultants over the weekend and in afterhour's sessions.	

List Other Relevant Documentation

Intern job description
RMO job description
Scope of Practice