**GA Rotations Goals and Objectives**

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The goal of the **First GA Rotation** is for the resident to move from being a

**Novice**  (A novice knows little about the subject, and rigidly adheres to rules with little situational perception. He/she does not feel responsible for outcomes. )

To

**Advanced Beginner** (The advanced beginner is still dependent on rules, but can adapt rules to changing circumstances. However, all attributes of a situation tend to be given equal importance, and there is still little feeling of personal responsibility for outcomes.)

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| **First Rotation Goals** | **First GA Rotation Objectives** |
| **Medical Knowledge**  Acquires knowledge of the pathophysiology and laboratory manifestations of common conditions; knows where to access information. | The resident will acquire knowledge about (please see GI, liver, and pancreaticobiliary online learning outlines for detailed outline):   * The gross and microscopic anatomy of the gastrointestinal tract, liver, and pancreaticobiliary tract * Common inflammations of the esophagus, stomach, and intestines * Common acquired abnormalities, such as Barrett’s esophagus, common polyps, diverticular disease; ischemic injuries * Common tumors of esophagus, stomach and colon * Viral hepatitis, fatty liver disease, autoimmune hepatitis and PBC * Gross and microscopic changes of cirrhosis * hepatocellular carcinoma and benign bile duct tumors * Common patterns of gallbladder disease * Pancreatic ductal adenocarcinoma and PanIN   The resident will learn to access the standard textbooks available in the signout room, and will review the relevant online learning modules. |
| **Patient Care**  Is able to perform procedures necessary to generate laboratory information, gather clinical information needed to establish a diagnosis, and make observations relevant to the clinical situation. | With appropriate supervision (see below), the resident will   * Be able to gross common gastrointestinal tract, liver, and pancreatic specimens as directed in the grossing manual * Become proficient at taking good quality gross photographs that help to illustrate the important findings. * Dictate cogent gross descriptions, and select appropriate tissues for microscopic examination. * Begin to recognize when more information from the submitting physician is need to adequately perform gross dissections. * Obtain clinical history from the EMR when none is provided * Review prepared slides and dictate preliminary reports in the correct format, correlating histologic findings with endoscopic findings. * Order additional studies after discussion with faculty, and keep pending cases organized until completed * Keep incomplete cases organized until completed |
| **Practice-based Learning and Improvement**  Uses feedback and evaluations to generate or modify learning plan and improve skills. | The resident:   * Uses faculty critiques and personal assessment of gross descriptions and sampling to improve and refine gross dissection and sampling of similar specimens. * Uses feedback from preliminary diagnostic errors to improve diagnostic accuracy * Asks questions and seeks guidance in building medical knowledge and improving patient care skills * Accesses learning sources (textbooks, medical literature, online resources) to fill gaps in medical knowledge that come to light during case discussions * Develops increasingly efficient case management |
| **Interpersonal and Communication Skills**  Establishes collegial interactive and communication skills in dealing with others; structures reports that are clear, succinct, and follow templates; listens to and fulfills requests from other providers. | The resident will   * Interact in a collegial way with technical staff, including histotechnologists, pathology assistants, and transcriptionists, with goal of providing optimal patient care * Volunteer his/her opinion of cases to faculty, using correct terminology * Dictate diagnoses that use accepted terminology, are easy to understand, and that relay the information important to patient management * With direction, notify treating physicians of unexpected diagnoses |
| **Professionalism**  Is honest, compassionate, and respectful of others; complies with laws and regulations; fulfills patient care and educational responsibilities faithfully. | The resident:   * Is present and ready for signout at the agreed time * Admits errors or omissions and takes steps to correct them * Protects patient privacy * Is sensitive to issues of race, gender, ethnic background, religion, sexual orientation and other social factors in dealing with patient care and in interactions with other providers and other learners * Treats colleagues at all levels with respect |
| **Systems-based Practice**  Identifies issues related to error, cost, and the need for interdisciplinary collaboration in the delivery of health care. Conducts handoff at the conclusion of rotation with care and thoroughness. | The resident:   * Is vigilant regarding possible specimen, slide, or identification errors and takes steps to investigate and resolve potential errors * Accurately assigns billing codes and quality codes to cases, and understands the role of these codes * Discusses the cost-effectiveness in the selection of ancillary studies. * Understands the value of intradepartmental consultation and collaboration with other departments and specialties in delivering optimal patient care. |

The goal of the **Second and Third GA Rotations** is for the resident to move from being an

**Advanced Beginner** (The advanced beginner is still dependent on rules, but can adapt rules to changing circumstances. However, all attributes of a situation tend to be given equal importance, and there is still little feeling of personal responsibility for outcomes.)

To

**Competent** (The competent learner grasps the relevant facts, can sort information by relevance, can bring his/her own judgment to each case, and solve problems. Guidelines are adapted to unexpected events. He/she feels accountable for outcomes because of increasing decision-making.)

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| **Second and Third Rotation Goals** | **Second and Third GA Rotation Objectives** |
| **Medical Knowledge**  Acquires knowledge of less commonly-encountered conditions and laboratory techniques; critically evaluates knowledge sources and uses evidence-based approach to acquire new knowledge. | The resident will acquire knowledge about (please see GI, liver, and pancreaticobiliary online learning outlines for detailed outline):   * Uncommon inflammatory and acquired conditions of the gastrointestinal tract * Polyposis syndromes * Benign and malignant lymphoid infiltrates of the gastrointestinal tract * Gastrointestinal endocrine disorders * Mesenchymal proliferations, including neoplasms, of the gastrointestinal tract * Neoplasms of the appendix and anus * Other uncommon gastrointestinal neoplasms, and uncommon variants of common neoplasms. * Uncommon hepatitidies, PSC, hepatic iron storage, Wilson’s disease, vascular disorders, transplant pathology, benign hepatocellular neoplasms * Cholangiocarcinoma * Gallbladder adenoma, papilloma, dysplasia and carcinoma * Pancreatic serous, mucinous cystic, intraductal, endocrine, and other neoplasms |
| **Patient Care**  Is able to perform procedures necessary to generate laboratory information, gather clinical information needed to establish a diagnosis, and make observations relevant to the clinical situation. Uses laboratory data and own observations to generate accurate diagnoses and differential diagnoses; suggests appropriate ancillary studies as needed; responds to requests for consultation. | With appropriate supervision (see below), the resident will   * Be able to adapt grossing techniques to uncommon specimens from the gastrointestinal tract, liver, and pancreatic specimens * Dictate gross descriptions, photograph, and select appropriate sections from complex specimens, asking for guidance as needed. * Obtain clinical history from the EMR when the provided information is needed to make accurate diagnosis * Review prepared slides and dictate preliminary reports that are usually accurate, and need some editing by faculty. * Suggest additional studies during with faculty, analyze results and anticipate need for further studies or consultation. |
| **Practice-based Learning and Improvement**  Adapts practices based on literature review, case outcomes, peer and 360 reviews, and system demands; seeks and gives feedback to improve self and others. | The resident:   * Continues to use feedback from preliminary diagnostic errors to improve diagnostic accuracy. * Uses information accessed on past cases to more efficiently arrive at a diagnosis in subsequent cases. * Uses feedback and questions from clinicians to refine approach to reporting cases. * Accesses learning sources (textbooks, medical literature, online resources) to fill gaps in medical knowledge before coming to signout. |
| **Interpersonal and Communication Skills**  Effectively communicates in a variety of settings, including during conferences, while providing consultations, and teaching peers. | The resident will   * Interact in a collegial way with treating physicians, other learners who request information or attend signout. * Volunteer his/her opinion of cases to faculty, with explanations of rationale * Dictate reports that are designed to answer both the articulated and anticipated clinical questions. * Recognize cases that indicate the need to notify treating physicians, and suggest this need to faculty at signout. * Bring cases to consensus conference and relay pertinent information |
| **Professionalism**  Manages patient care duties and interacts with other providers with compassion and respect for diversity; recognizes and responds to need for help from colleagues. | The resident:   * Attends daily consensus conference and Friday GI Consensus conference, setting aside cases as directed * Assures successful transfer of cases to next rotating resident * Offers assistance to other members of the team as appropriate |
| **Systems-based Practice**  Improves patient outcomes and promotes efficiency by making decisions based on best evidence of outcomes, and by involvement in quality initiatives. | The resident:   * Is knowledgeable about and suggests the most efficient and effective ancillary studies in difficult cases. * Gives feedback to laboratory about quality and timeliness of slides and case delivery * Initiates intradepartmental consultations so as to improve case turnaround time. * Calls attention to practices that may increase the risk of error. |

The goal of the **Final GA Rotation** is for the resident to move from being

**Competent** (The competent learner grasps the relevant facts, can sort information by relevance, can bring his/her own judgment to each case, and solve problems. Guidelines are adapted to unexpected events. He/she feels accountable for outcomes because of increasing decision-making.)

To

**Proficient** ((Characterised by the progress of the learner from step-by-step analysis and task performance to a holistic perception of the entirety of the situation. Uses pattern recognition arising from experience to identify problems. Perceives deviations from what is expected.  Learns from the experience of others.   Sense of responsibility grows with increasing decision-making. )

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| **Final Rotation Goals** | **Final GA Rotation Objectives** |
| **Medical Knowledge**  Exercises judgment in application of evidence-based knowledge to patient and to patient population; assists junior residents and other learners in accessing sources of medical knowledge. | * The resident will acquire knowledge about rare lesions of the gastrointestinal tract, liver and pancreas. * The resident will independently bring new clinical and scientific evidence to the discussions at signout and apply it to challenging cases. * The resident will serve as a resource to other learners (junior residents, medical students, clinical fellows). |
| **Patient Care**  Recognizes clinical cases and circumstances that are rare or unique and selects appropriate additional studies; initiates consultant role in unusual cases; directs other providers and learners in challenging situations. | The resident will   * Recognize subtle deviations from normal or common lesions and seek out relevant information to explain the findings. * Recognize subtle discrepancies between endoscopic reports and histologic findings. * Be able to ask sophisticated questions of clinicians about cases with complex or confusing gross or microscopic findings. * Proactively seek expert intradepartmental consultation on cases for which this is required. * Give direction to other residents, technical staff, and pathology assistants regarding the handling of unusual cases. * Serve as a resource for other learners regarding interpretation and diagnosis. |
| **Practice-based Learning and Improvement**  Facilitates collaboration and teamwork to promote learning. | The resident:   * Work with other learners, such as fellows, other residents, and medical students, to share tasks related to gathering knowledge * Recognize gaps in others’ learning (fellow, residents, students, and faculty) and contribute to filling the gaps. * Recognize circumstances in which the current state of clinical and scientific evidence is lacking. |
| **Interpersonal and Communication Skills**  Demonstrates skill in dealing with conflicting opinions or perspectives; responds independently to questions from other providers, patients, and families; generates sophisticated reports that relay information about complex cases. | The resident will   * Manage conflicting opinions or perspectives in such a way that optimal patient care is protected. * Independently handle inquiries for clarification or additional information, and initiate tasks necessary to provide this. * Generate reports that convey diagnostic information about both simple and complex cases effectively, needing little or no editing by faculty. |
| **Professionalism**  Recognizes impairment in themselves and peers and takes steps to address this. Mentors others in use of inter-professional and multi-disciplinary collaboration; Is a role model to other learners regarding accountability to self and others. | The resident:   * Can be viewed as a role model in understanding and managing the strengths and weaknesses of him/herself and others. |
| **Systems-based Practice**  Identifies sources of error and inefficiency and initiates action to assess and fix them. | The resident:   * Identifies processes that lead to inefficiencies and potential errors, and suggests improvements. |

**Plan for Training**

During residency training in anatomic pathology, there are four 2-week rotations in surgical gastrointestinal pathology, distributed between the second part of the first year of training and the final year of training. Faculty rotate onto the service each week, so residents are likely to be mentored by 2 different faculty members during each rotation. The resident will divide responsibility for grossing large specimens with the pathology assistants; biopsies are grossed by histotechnologists. Slides are available to preview starting around noon of the day before they are signed out. Residents are expected to preview slides and dictate preliminary diagnoses according to the guidelines below.

During the first rotation, it is the responsibility of the faculty members assigned to the GI pathology service to guide the residents regarding patient care issues, including the clinical significance of each diagnosis, the types of cases that require rapid diagnosis and the need to communicate specific diagnoses or meanings of diagnoses to the clinical services. As the resident rotates on the GI service later in the residency, the resident will take more personal responsibility for these issues.

Resident education is accomplished primarily through one-on-one tutoring and mentoring by the assigned faculty and GI and surgical pathology fellows, using the daily case load as the topics for daily learning, and through conferences given by the faculty, online didactic resources maintained by the department and accessible through the department website, and literature references, including textbooks and journal articles.

There are no GI/liver clinicopathologic conferences that the resident is required to attend, but it is strongly recommended that the resident on the GA service attend the monthly liver pathology conferences, held on the second Thursday of every month at 7:30 AM in the UH faculty office library/conference room.

**Signout guidelines for residents and fellows on the GI services:**

1. Signout begins at 9:00 AM and will conclude no later than 1:00 PM. Any cases that are not signed out be 1:00 PM will be handled by the faculty member and fellow assigned to the service so that the resident may attend to grossing and previewing responsibilities. The resident should organize the cases so that those with the greatest educational value and those that the resident has grossed are likely to be done before 1:00 PM, leaving those with less educational value until last, in the event the signout runs after 1:00 pm. Rush biopsies will always be done first or when available, however.
2. Residents who are rotating on the GI service for the first time will be responsible for previewing 40 cases. These cases include all cases for which the resident has performed the gross evaluation. The remaining cases will be divided between the faculty member and the fellow (if there is a fellow assigned to the service), and should be claimed by them in the early afternoon so it is clear to the resident which cases are his/hers to preview.
3. When the resident on the GA rotation is returning for a second or subsequent rotation, he/she will preview those cases that are left after the fellow and faculty have each removed at least 3 three trays of slides to sign out independently; ideally the resident will have no more than 5-6 trays of biopsies. When there is no fellow on the service, the faculty member will remove at least 6 trays of slides to sign out independently. The fellow and faculty member should monitor the case load and remove more cases on particularly busy days, fewer on lighter days. In the event that the resident finds himself/herself with too many cases to preview so that he/she would violate ACGME duty hours, cases should be left to signout the next day so that he/she can leave at the appropriate time.
4. When slide delivery is delayed, slides that are received after 6 pm may be held (not previewed) for signout the next day, if there is insufficient time.
5. It is the responsibility of the faculty and fellow, when signing out cases without the resident present, to identify and save cases with high educational value and bring them to the next signout session to share with the resident.
6. After 6 pm, the specimens resulting from any gastrointestinal, pancreatic, or liver resection cases that are still ongoing in the operating rooms may be grossed the following day. It is important to communicate with the evening grossing PA to be sure the specimens are opened or good fixation.
7. The GI or Surg Path fellow will handle all rush cases and all calls in the afternoon in order to allow protected time for the resident to gross specimens as part of the resident/PA grossing team. If there is no fellow, the decision on who fields rush cases and calls will be determined by the resident and attending.
8. A list of specimens that are to be grossed by residents as much as possible:

Esophagus/EGJ cancers, because of the need to look for scant residual cancer

Gastric cancer, because it is rare

Whipple’s resections

Inflammatory bowel disease

Appendix with apparent tumor or cyst

Anything with which the PA is unfamiliar

The resident should ask for assistance from the faculty or fellow on any gross specimens with which the resident is unfamiliar.

**Supervision**

The following activities are to be conducted with **Direct Supervision** (the supervising physician is physically present with the resident):

* The first 3 gastrointestinal, liver, and pancreatic gross dissections (mandated by ACGME; direct supervision may be provided faculty or by 3rd or 4th year resident or fellow)
* Electronic verification of diagnoses, additional or amended diagnoses, and comments.
* Frozen sections (if called upon)
* Communications with other providers, during the first GA rotation.

The following activities may be conducted with **Indirect Supervision** (direct supervision immediately available either within the hospital of by telephonic or electronic communication):

* Gross dissections other than those described above
* Communications with other providers for those who have completed one GA rotation.

The following activities may be conducted with **Oversight** (the supervising physician is available to review with feedback after activity is completed):

* Dictation of preliminary diagnoses

Evaluation

* Electronic (MedHub) evaluation completed by faculty at the conclusion of each rotation
* 360 evaluation completed by fellows and technical staff semi-annually
* Resident Inservice Examination (annually)