

# Improving the Surgical Resident's ED Experience

by John Schuler, MD

Dr. Schuler is a general surgeon, and Director of Surgical Education, at Mount Auburn Hospital, in Cambridge, Massachusetts.

The teaching hospital emergency department (ED) should be an ideal setting in which general surgical residents can develop skills they will use throughout their careers. In the ED, trainees can learn independent evaluation and management of the kinds of patients they will be expected to treat in their practices. They also can learn how to conduct themselves as consultants.

However, ED staffs have their own mission: to triage, evaluate, treat, and move patients through the system. An ED's physical facilities and personnel are often overwhelmed with patients waiting to be seen, lying on gurneys in hallways, and awaiting imagings (especially CT scans). And now that diversion to other hospitals is no longer permitted (in Massachusetts), the only way to alleviate the crowding is to become more efficient. The pressure is intense to decrease waiting times and manage patients faster.

Unfortunately, training residents slows the flow of patients. Even at teaching hospitals, some Emergency Medicine (EM) physicians would prefer to work up the patients and call the admitting staff surgeon or resident and say "I have a patient with acute cholecystitis for you to admit; antibiotics are in." This path is much more efficient than waiting for a resident to be paged, come to the ED, examine the patient, and then discuss which tests to order with the EM physician. While the latter course encourages the resident to think about the patient's problem and how to begin solving it, it consumes precious time.

But surgical residents need opportunities to develop their ability for inductive logic and to improve their clinical sense through repeated exposure to undifferentiated, ill patients. With this experience, the surgical trainee sees a variety of clinical problems and patients, learns to think critically while under stress, practices his or her skills, learns from mistakes, and ultimately develops confidence in his or her decision-making and clinical judgment.

To maximize this phase of his or her professional development, a surgical resident must learn how to assume the role of consultant to the EM physician who requested the evaluation. This role requires his or her ability to create a differential diagnosis, formulate a cogent work up, and defend it to surgical and EM physicians. This builds essential communication skills with senior staff, peers, and other hospital personnel. This path of learning, however, may complicate the job of the EM physician; it takes time, patience, commitment, and a willingness to partner with the surgical resident while at the same time safeguard the patient (such commitment is no less required on the part of the attending surgeon).

## Opportunities for Improvement

EDs and the attending physicians and surgeons who staff them can take a number of steps to allow the resident to fulfill the consultant role more effectively, and to help expedite patient flow.

*Establish an emergency service rotation at the PGY1 or PGY2 level.* This would introduce the resident to the ED staff and acclimate him or her to the pace of the work. During this introductory rotation, the resident would learn how one feels when on the receiving end of consultations. The resident would also deal with the issue of pain management without sedating patients to the point where physical examination is compromised. He or she would learn how to deal with frightened families and with seriously ill patients. He or she would learn to work under stress and see the ABCs of trauma management put into practice. And, the resident would participate in caring for patients in shock and in preparing patients for urgent surgery under supervision.

*Designate a mid-level (PGY3) resident as the surgical consult.* These residents should have enough experience to work efficiently and to provide meaningful help to the EM physician. Most PGY3s can comfortably evaluate patients with abdominal pain and trauma and are familiar with the algorithms of management. Likewise, they will be familiar with the ED staff, making working together much easier. In some hospitals, PGY2 trainees fill this role, but often lack the experience to offer value-added input. In all hospitals, the availability of these residents is diminished due to work hours restrictions, someone is always absent from the hospital, post call.

*Improve communication.* Text messaging the name of the EM physician requesting the surgical consult and the question posed immediately gives the resident important information. If the resident is unable to come promptly to the ED, he or she can discuss the case with another resident who might be available or directly with the EM physician to begin instituting the work-up.

*Follow up.* After completing the consult, the trainee can review his or her findings and management plan with the EM attending to "close the loop." The resident concurrently reports to the attending surgeon and chief resident. If there is disagreement, the surgical resident involves these senior staff to resolve the differences with the EM attending.

We are fortunate that the EM physicians at Mount Auburn Hospital continue to support the resident role as surgical consultant, despite the inevitable inefficiencies that may occur. As do we, they realize, that this training is essential to developing competent general surgeons, skilled in their ability to care for emergency and critically ill patients. ■