

Association of Women Surgeons

Pocket Mentor



A Manual for Surgical Interns and Residents

Third Edition
2001

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Third Edition

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First and Second Editions

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The Association of Women Surgeons, founded in 1981, is an organization whose mission is to inspire, encourage, and enable women surgeons to realize their professional and personal goals. Because of the small number of women faculty in most Departments of Surgery, many women find it difficult to identify appropriate role models and advisors to facilitate their surgical education. This book provides a background of practical information which we believe will make your residency less confusing, and thereby more rewarding. We hope it will improve communication with your peers and attendings, and give you more confidence in yourself. Your membership in our organization is strongly encouraged.

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Preface

This book is based upon the experiences of a number of women surgeons and is intended to help you through your residency. The ideas expressed are the personal opinions of the authors, and the Association of Women Surgeons will not take responsibility for decisions made by readers based upon the material within. These ideas are intended to be helpful, but should be taken with a grain of salt. Residency programs vary across the country, and some of the situations described may not apply in your case. Legal counsel is advised early on if you have any questions about your circumstances, particularly if your job is in jeopardy.

This is our third edition. Future editions will be revised and expanded as our resident members indicate a need. We would appreciate your comments, suggestions and contributions. Please send them to:

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INTRODUCTION

Welcome to the world of surgery. You are about to embark upon the most exciting, challenging, stressful and yet rewarding years of your life. Surgery residency is a period of intense education that requires a depth of commitment found in few other endeavors. Technical skills and an immense body of knowledge must be mastered thoroughly in order to develop the judgment, decisiveness, and confidence required to be a competent surgeon. Women face unique challenges during surgical training. Hard work and common sense are essential. Your task will be simpler if you know not only how to avoid obstacles, but how to overcome the ones which will be placed in your way. Our society does not encourage women to think independently, yet you must be able to make decisions and live with their consequences if you are to succeed as a surgeon.

Women also bring with them some advantages that they should not be afraid to utilize. Many women have excellent *fine motor skills* that have been developed as children learning to sew, crochet, knit, play the piano, etc. Though some aspects of surgery may require brute force or sheer strength, those situations are rare compared to the constant importance of *gentle* handling of tissues, *careful* tying of knots, and *attention to detail* that are the hallmark of a skilled surgeon. Women are also *good listeners* and *communicators*, which can instill confidence and trust in patients. It takes much greater strength of character to be gentle and *nurturing* in the surgical environment. Patients need and deserve your *empathy* and *attentiveness*. They also need your knowledge, technical skills, efficiency, and just plain hard work.

This book is written by women who have succeeded and wish you success as well. We hope our suggestions will streamline the learning process for you, help you learn how to cope with difficult people (surgeons as well as patients), maintain your sanity, trust yourself and your own abilities, and learn to love surgery as much as we do. The hazing and intimidation maneuvers that characterize some residencies are part of the indoctrination process to make you strong and self-confident enough to be a good surgeon. Many times no one mentions what you are doing right, and your self-confidence plummets. There are better ways to teach responsibility and judgment, but learning to have a thick skin is

essential to survival in some programs.

- Realize that one can lead a team without being authoritarian or arbitrary, but some are better at it than others.
- Do not take every criticism as a personal attack, but as a challenge to do better.
- Establish an alliance with a faculty member you trust and respect and seek out that person's advice and suggestions on how to improve your performance.

If you find you hate what you are doing, find another specialty or subspecialty. Don't torture yourself, your colleagues, and your patients if you decide surgery is not for you. A good surgeon must learn to trust herself, her judgment, and her abilities. We hope this book will make life as a surgery resident easier for you, so that you can spend more time learning the art and craft of surgery and less time worrying about the hassles. We look forward to your joining us among the ranks of surgeons!

Despite nearly half of all medical students being female, less than a quarter of all surgical residents are women. We hope that number increases with each year.



CHAPTER 1

Learning to be a Surgeon

"The reward for work well done is the opportunity to do more."
--Jonas Salk, M.D.

There are three primary facets to becoming a good surgeon: knowledge, technical skills, and decision-making. The obvious professional activity that distinguishes surgeons from other physicians is the performing operations. Becoming a surgeon involves the development of technical facility through repetition. While good operative technique is critical to competence, the fundamental ability surgeons MUST possess is incisive clinical reasoning. It is this skill that allows her to not only make accurate diagnosis, but also conduct the operative procedure and manage the patient's clinical course. The care of the surgical patient is accomplished by a series of clinical decisions, some large, most small, often in the face of inadequate data. Developing the ability to make reasoned and prompt judgments under stress with overt confidence is essential to independent surgical practice.

KNOWLEDGE

One of the criteria universally used to evaluate surgical residents is their "fund of knowledge." This refers to whether or not you know the things you ought to know at that stage in your career. If you are simply carrying out a series of assigned tasks with no understanding as to why, you will never make an adequate surgeon. Some knowledge is gained daily simply from experience. Some hospitals have "patient pathways" for specific diagnosis that teach you general management strategies for that problem. You can also learn a lot by both watching and speaking with your attendings and more senior residents. Attend scheduled conferences, especially grand rounds and morbidity and mortality to hear the latest and greatest about a field as well as how to

handle complications when they arise. Nurses can be excellent sources of practical information, as can scrub technicians, x-ray techs, and other ancillary personnel.

However, you will never completely get the "big picture" without spending some time reading. Both textbooks and surgical journals must become part of your own personal library. Surgery is not a static profession - it is constantly changing and improving. New technologies and basic science research have transformed surgery from the barbaric to the sophisticated. One of the great joys of being a surgeon is that you never get bored. There is always something new to learn, so get into the habit right from the start of reading about your cases.

Every surgery resident should OWN and USE at least one standard surgical text and a good atlas (See Chapter 7 for suggested texts). Review every surgical diagnosis and procedure should be preoperatively in your text and atlas. Prepare for every elective surgical case, particularly the first time you encounter a problem or procedure. In the long run, reading which is motivated by actual patients' problems is most likely to expand your knowledge base. Most training hospitals have libraries with these books in case you are on call and don't have your copy with you. Consider keeping one in the trunk of your car in case the library is closed or are at a hospital that has few current texts. Besides having the general idea of the surgical technique, you should also know the indications for and possible risks and complications of the proposed procedure. Some procedures require specific preoperative orders (such as a bowel prep for colon surgery-see chapter on "Getting the Work Done"), that your chief or attending may forget to mention to you as they may assume you already know. When in doubt, ask questions. The major steps taken during any procedure should be familiar to you, at least in general terms. If it is an emergency, look it up if you can, but at the very least, get some experienced help.

Some hints for reading during residency:

1. Carry a pocket copy of one of the major surgical texts, or the Mont Reid Surgical Handbook with you at all times. You can't pass your Boards with one of these, but they will help you familiarize yourself with the basics so you understand what is happening to your patients, and alert you to related concerns.

2. Read completely through the pertinent chapters in your reference text which apply to the service on which you are serving. Set a specific goal of a certain number of pages each week, *and keep to it!*
3. Utilize the quiet times when you are on call to read rather than watch TV. They are also handy for putting you to sleep if you are wound up over something.
4. Pick one journal and read it each month, even if just to skim it. Read through the abstracts or the summaries, then if there is time you can read the articles in full. Mark for future reference those items that have the most applicability to you for future reference. You may want to start a reference file by saving only those articles by subject, keep file cards, or use a computer database. You will likely receive a few "throw away" journals in the mail for free. Tear out the better articles and keep them in your lab pocket for reading during down-time.
5. Try study cards or a computer abstracting service (see Chapter 7).
6. Make your own study cards.
7. Subscribe to Selected Readings in General Surgery, and make sure you read the overview each month (see Chapter 7).
8. Look upon your reading time as a treat, not as a chore.
9. Ask for suggestions on specific reading from your attendings (senior surgeon of record), particularly if you are doing something new which is not covered in your texts.



DECISION-MAKING

Seasoned judgment is the consequence of making decisions, observing the results, and learning from both the successes and the failures. Much more is learned from mistakes, particularly one's own, than from that which goes well. It is easy for the junior resident to focus on pragmatic immediate tasks to be accomplished for the patient, chief resident, or attending, rather than considering the problem the patient presents as an exercise in diagnosis and management. Only by actually making judgments and observing the consequences of judgments made will you develop the confidence to function independently. With each new patient, try to evaluate the problem, make a differential, and formulate a plan of action, even though others may have presented the case signed, sealed, and delivered. This can be difficult to do given time constraints.

Be complete in your work-ups: you will often find things others miss, such as identifying a colon cancer by rectal exam on a hernia patient. Many of your senior residents will seem to emphasize the speed with which you complete your work. But in the long run, you will learn more if you force yourself to think past the admission H&P. If an operation is indicated, decide which one, the ideal timing of the procedure, if any additional studies are needed preoperatively, and what are the alternatives to surgery. Look up lab results and follow trends in them from day to day. Review the radiographs of your patients with a radiologist so you learn to read films yourself. Go to the pathology lab and view the slides of specimens. Ask attendings about patients that have been discharged for information on outcomes if you don't see the patient yourself. If a patient dies for uncertain reasons, try to attend the autopsy or, at the very least, follow up on the findings of the autopsy.

When presenting a new case to your chief or attending, have a plan of action already in mind and don't be afraid to suggest it. Only by demonstrating your own problem-solving abilities will you be judged capable of being a surgeon. Carefully follow the course of your patient as directed by the attendings and chief residents and compare it to your own mental treatment of the patient. At the very least, whenever a new diagnosis comes up, review the appropriate section in your pocket textbook. You may be able to avoid having to ask for advice on orders and labs, and even impress skeptics.

TECHNICAL SKILLS

Dr. Milton T. Edgerton, a plastic surgeon admired for his fine technique has written an excellent text, The Art of Surgical Technique (see bibliography section), which beautifully describes the basics: how to suture, tie, cut, etc. If your professors do not have the time or patience to instruct you in the nuances of the art of surgery, this book is a must read. There are also some very basic tips outlined at the end of Abernathy's Surgical Secrets. Find out who in your program is known to be the best technician (this may or may not equate with the fastest or the best surgeon overall). Try to scrub on that surgeon's cases, or at least make it a point to observe their technique. Usually it is best to introduce yourself before the start of the case and ask permission if you do not already know the surgeon. If someone asks what you are doing there, be honest and say that you want to observe the case. There is no need to be defensive or flattering, just matter-of-fact. The best surgeons use no wasted motion. Try not to hesitate; decide what you are going to do, then do it. You will be better off at first with slow, deliberate movements (in case the attending wants to stop you midway) than if you attempt to hurry up. Fidgeting around and multiple trial movements before the real thing waste time and make for lousy technique. Speed will come with proficiency. Listen attentively and try to implement technical suggestions that may be mentioned during your cases. There is no substitute for practice. Or as Arthur Rubinstein answered a stranger in NY when asked how to get to Carnegie Hall, "Practice! Practice! Practice!" The same thing is for surgery.

Most interns will need to practice skills in knot-tying and instrument handling. Some programs run technical skill courses for junior residents. If not, review and practice handling suture as well as basic instruments such as dissecting scissors, hemostats, and forceps with your senior residents and on your own. Knot-tying boards are available from the major suture company representatives such as Ethicon or Davis & Geck. The OR Supervisor should be able to give you a name and phone number. If possible, get one even before you start your internship so that you can practice during senior year in medical school. (At least tell your students who are interested in becoming surgeons to get one!) Another option is to practice at home with uncooked chicken breasts. Ask the nurses and scrub techs to save unused suture for you. Consider buying a used or cheap needle holder and forceps to practice instrument handling. (Some ERs use disposable

instruments that will serve.) Use waiting time between cases or quiet times when on call to practice your skills.

Nothing discourages surgeons from passing down more of a case than bungling basic tasks such as tying knots. Learn to tie two-handed knots before one handed. It may not look as "slick," but some attendings are critical of junior residents using one-handed techniques. When practicing suturing, be sure to follow the curve of the needle. Grasp the tissues gently with your forceps. Learn to reset the needle in your needle driver without grabbing it in your fingers. Become proficient in releasing instruments with both hands. Practice does make perfect. Start slowly and deliberately. Speed comes with frequent repetition of precise movements, as they become more and more automatic and you do not have to think about each one.

Be a good retractor holder, and you will earn appreciation. You can learn a lot from watching more senior people operate, even observing a case you may not do yourself for two or three more years. Don't just stand and hold the retractors: watch the overall conduct of the case, listen and try to learn the names of the various clamps, scissors, forceps, and other instruments. Learn which instrument is used in which circumstance. Observe how the instruments are held, and how the tissues, needles, and sutures are manipulated. You will soon know which surgeons you want to imitate. The more you can learn about their techniques, the better you will be able to visualize and practice those moves yourself. Learn which type and size of suture is used and why. Try to stand as still as possible, and don't be moving your hands and/or the retractors all over the place. Never move the lights unless you are asked. Try to anticipate how you can best help. If you are not sure what to do, just keep doing exactly what you are doing, and don't move. Listen carefully when instructed. Don't be afraid to ask questions. Let them know that you are there to learn, not just putting in your time, and not trying to catch up on your sleep. If you cannot see the operative field, don't risk losing the surgeon's view just to satisfy your own curiosity. Ask to see the anatomy at an appropriate time, such as when things are going well, when waiting for x-rays, right after a stitch has been tied and cut and the surgeon is getting ready to put in another. Try to correlate the anatomy you are seeing with the pictures in the atlas you used. If it doesn't make sense, ask the surgeon to explain it to you. (Hernia anatomy is what you will see most of as an intern, and it is probably the most confusing to start out. Keep asking until you get it straight.) After each case, try to review the atlas again to reinforce what you have seen and done.

OPERATING ROOM STRATEGIES

Many women finish surgical programs with fewer operative cases than their male colleagues. This may reflect more selectivity regarding operative indications or a greater tendency of women to hand over cases to junior residents. It may also reflect bias on the part of superiors, or insecurity on the part of the resident. However, the surgical trainee must not denigrate her abilities and fitness to perform cases appropriate for her training level. You will not be offered cases unless your superiors feel you are ready to attempt them. Male residents are usually just as insecure about their ability to perform a procedure new to them; but they are far less likely to reveal any lack of self-confidence to their peers or attendings. For junior residents, your senior residents and attendings create your initial operative opportunities. Preparation and confidence in your abilities will enable you to take advantage of all cases that come your way. Find out which cases are usually handled to particular years in training, and with which attendings. Set your goals high, and don't be afraid to try a case that is usually offered to upper level residents. If it is offered, you are ready - be bold!

Here are some strategies to will help you obtain cases:

1. Read up thoroughly on assigned cases the night before. Even if you will only assist on a case, still try to read as much about it as possible.
2. Discuss the case with the attending at the scrub sink or in the lounge so that she or he knows you have read about and are prepared to do the case.
3. Arrive early and be in the room ready to go even before the patient is asleep. Show that you know how the patient should be positioned for the case. Be gloved and gowned first so that you can immediately step to the position of the operating surgeon (usually the right side of the patient) if invited.
4. Ask if you may start the case, or at least if you can make the incision. Find out the surgeon's preference on incisions: some like to go straight down to fascia with the first cut, others prefer just cutting the dermal layers with the knife, then cutting down to fascia with the electrocautery. It makes a big difference with some attendings. Sometimes just by starting the case, they will let you continue on through the rest.

5. Try to be an attentive, courteous assistant. Next time with the same attending, try "I really learned a lot watching you on that last case we did together. Mind if I try this one?" Even when not allowed to do the case, show your preparedness by being an excellent assistant. Do not sulk or stop assisting if you don't get to do the case. See if you can anticipate the next instrument, the next move, etc. A good assistant shows, by her actions, that she is ready to do the next one.
6. Develop cordial working relationships with other surgeons. If the attending knows you better and is relaxed around you, they are more likely to let you do things. Sometimes a sincere compliment and some charm are worth a try. (A recent sociological study found that pleasant, charming women are more convincing in their competence than those considered neutral.) Ask questions about techniques. Have the surgeon demonstrate a particular knot, or how to dissect in a particular situation. Encourage attendings and senior residents to show off their knowledge and skill.
7. Get the nurses and scrub techs to work with you. If they hand instruments to you to do little things like cutting or holding tissue, they may eventually hand you the needle driver or scalpel, and the attending may not take it away.
8. Try assuming that you are going to do a case. Be sure you are prepared, then while scrubbing, or better yet while gowning and gloving so that there are witnesses to the conversation, say "Dr. X, I am so pleased that I am going to be doing this gallbladder (or whatever) today. Resident Y (pick someone in your year who has already done a similar case with Dr. X) said that you were really an excellent teacher." If the attending says that you are not ready yet, then ask for assistance in identifying and learning the skills which will make you ready.
9. Learn the unique preferences of each attending and remember them. Keep a notebook with information about each surgeon's techniques and procedures. That way you will be prepared for the next time you do the case with that surgeon. Some surgeons believe their way is the ONLY way to do it, and failure to recall their techniques could prevent them from allowing you to do the case.
10. Exude confidence. Know that you are just as qualified as most other residents at your level. Chances are you are even better (but don't remind them of that). You would not have been selected for your residency if the staff did not feel you were qualified to be there, and capable of learning. Believe

- in yourself. Self-confidence breeds confidence from others.
11. Remind yourself and others why you are there. If you make it very clear that you are there to learn, it puts them on the spot to teach. And remember, it is "see one, do one, teach one"! Show your interest in each and every case by scrubbing as much as you can. Don't spend all your time on the ward or in the ICU (or sleeping post-call): you must learn to operate! Sometimes the most valuable thing you will learn is what not to do. Make time to scrub cases that are above your level. Gain a reputation for being interested in learning and highly motivated!!! If you love to operate - let it show! If you dread every single case-find another specialty.

If you are not being allowed to do cases that you expect you should be doing, talk to your chief resident. Some attendings are stingy. Some don't like women invading their territory. Or you may indeed need some additional work on certain skills. If you don't ask what the problem is, you will never know. If you are not the problem, ask your chief to intercede for you, reminding the attending of what year you are in training, what cases you are expected to be doing, and that you are there to learn to be a surgeon, not to be an assistant. (An occasional attending has even had to be threatened by the program director or chair with loss of residents if that attending doesn't start letting them do cases.) Also realize that different residencies and even different hospitals within the same program may have different policies about which cases are appropriate for residents at a given level of training. Sometimes having the senior resident along with you on the case helps.



ROUNDS

"Be prepared-you never get a second chance to make a first impression."

The style of rounds will vary with your program and the hospital at which you are rotating (assuming you are in a program with multiple hospitals). Work rounds tend to be devoted primarily to patient care, while attending rounds serve the dual purpose of teaching as well as keeping the staff informed of patients' progress. If you are in a private hospital, you may find you only make rounds with individual surgeons to whom you have been assigned. This can get tricky if several round at the same hour, but won't round together. Then you will have to choose. Generally you will be better off to round with whoever has the most difficult and interesting cases. Sometimes there will be a preferred political choice, so check with a senior resident on this.

Your behavior and performance on rounds is of utmost importance during internship since this will be your first and best chance to prove yourself. It will also be your most frequent exposure to staff, and the decision as to whether or not to assign cases to you can depend on this. Be sure to read the chapter on "Getting Your Work Done."

Here are some tips:

1. Be on time.
2. Pay attention. Idle chitchat and socializing is a great way to miss out on learning as well as important details of patient care that could really hurt someone.
3. Know the patients and be able to give a BRIEF description of their problem. This usually consists of the patient's age, current surgical diagnosis and procedure (planned or completed), date of the procedure, and current progress and treatment planned. Be ready to review vital signs and trends (i.e. spiking fevers, rising pulse rate, etc.), pertinent labs and imaging studies, and formulate a plan for dealing with any problems you have identified so that you can get them okayed or modified.
4. Make sure people can see and hear you. Move to the front if someone else has been presenting before you. Use note cards as needed, but, don't "read" everything - show you

know the patient. Speak up and speak clearly. Make declarative statements, bringing your voice down at the end of a sentence. Don't end your remarks, ideas, and treatment plans with a tag question such as "don't you agree?, ok?, you know?" These expose your uneasiness and need for reassurance. Hedging phrases like "sort of, kind of, could be" also diminish your impact, signaling insecurity. Use strong verbs like "I will.." rather than "I'll try.." or "I hope to.." or "I would like to..." (Better yet, read *Hardball for Women*, by Pat Heim, or *You Just Don't Understand*, by Deborah Tannen for insights into speech patterns and styles that are effective.)

5. Stay organized. Present patients in a logical, orderly fashion. Know what you are going to say before you say it. Give the patient summary, vital signs, physical examination, lab results, radiology results, assessment and plan in a consistent manner. Jumping all over the place makes you look unorganized and makes it difficult for those listening to understand what's really happening with a patient.
6. Don't be afraid to say "I don't know" or "I haven't done that yet." NEVER make up lab values or x-ray reports if you don't know them, even when you should. NEVER say you have done something if you have not. This is both unethical and dangerous and will get you fired. If you normally work hard, pay attention, and show interest, your superiors understand that some details will get lost in the shuffle and will not hold it against you. Lying is not the solution.
7. Keep a handbook in your coat pocket, such as the Mont Reid Surgical Handbook (see Bibliography), in case you need to look up some basic values as you are walking to the bedside of a more complicated case. (For example, you might want to double-check the correct weaning parameters on a patient that is about ready for extubation.)
8. Anticipate needs on working rounds to make them more efficient. For example, keep a few gloves and lubricant handy, or dressing supplies if you know a wound is going to need to be checked. Everyone appreciates a timesaver.
9. Keep a neat and clean appearance. If the attendings don't wear scrubs on rounds, you probably shouldn't either.
10. Have a good attitude. If good-natured bantering occurs, respond assertively, not defensively. Learn to laugh at yourself.

PRESENTATIONS

"If all my powers and possessions were to be taken from me with one exception, I would choose the power of speech, for by it I could recover all else."

-- Nathaniel Webster

Throughout your residency you will be required to present at various conferences, such as M&M (morbidity and mortality), or Grand Rounds. The manner in which you do this will play an important role in how you are perceived by your colleagues. Presentations should be viewed as an opportunity to learn and enhance your reputation, and require definite effort on your part beforehand. If you are not well prepared, you will lose ground fast.

For all presentations:

1. Make sure you are on time. If you are detained in the OR, or have an emergency, arrange for another resident to present the case.
2. Speak clearly, precisely, and loud enough to be heard by everyone present. If a microphone is available, use it. If you have a soft voice, stammer, or language difficulty make a conscious effort to improve this. Practice speaking in a similar room with a friend or two to critique your efforts. Nothing makes a worse impression than if you cannot be heard or understood. Avoid talking too fast or too high-pitched: they are dead giveaways that you are nervous.
3. Plan what you are going to say carefully. Speak from note cards with key words until you gain experience. Avoid memorizing a script as you are more likely to lose your place this way.
4. If you stumble, pause, smile, and then continue on. There is no need to profusely apologize, as this tends to just draw closer attention to the error.
5. Think in advance of what questions you may be asked. Either include the answers to these questions in your presentation, or be prepared with the answers at the end. If there is a visiting professor, try to ascertain their area of expertise ahead of time and be prepared for more exotic questions. Do not guess an answer to a question or make an excuse why you cannot answer. Simply reply that you do not know, but

that you will make an effort to find out, if that appears to be required. You could refer the question to someone present who most likely would know the answer. "I do not know, but Dr. X may."

6. Try to ascertain after the conference how well you did by asking your friends. If you make mistakes, try not to repeat them at the next presentation.

Most often you will be giving a case presentation of a patient you cared for. Case presentations can be fun as well as educational when you have done a good job. You will have a real sense of satisfaction!

Some specific rules apply to the way case presentations are given:

1. Be concise. Present only the data that is pertinent to the specific conference or rounds you are attending. More of the H&P details will be required at a case presentation conference than, for example, at a Morbidity/Mortality conference where the surgery performed and its complications are the main issue.
2. Prepare to answer any questions in regard to data you did, or did not present. You should know every aspect of the case you are presenting. Bring with you, or arrange for path reports and pertinent imaging studies to be available at the conference. If equipment to present slides or films is required, make certain it is available. Sort forms and choose the appropriate images ahead of time so that you are not flipping through dozens of films while everyone waits impatiently. Be certain you can interpret the slides and films yourself. Review them with a pathologist or radiologist if necessary.
3. Review a basic text regarding your case. If time permits, try to have done a literature search prior to the conference. Being able to cite references makes an excellent impression, but only in addition to the above. References alone will get you nowhere if you don't know the specifics of your own cases.

For more formal presentations -

1. When preparing a presentation on a topic, think of your audience first. Decide what the audience will want to know - it's more important than what you think they should hear.
2. The first thirty seconds of your presentation are CRUCIAL -

consider starting with an interesting fact or the relevance of your subject to the audience.

3. Next, preview the main point of your presentation, followed by the body of the presentation, and then a concise conclusion summing up the relevant points.
4. Use short sentences, expressing only one idea per sentence.
5. If presenting from slides, standardize the background and color formats of your slides. Studies show that blue backgrounds with white letters are the easiest on the eyes. Stick with three or fewer colors for word slides (blue background with yellow titles and white text is common) and use picture slides in place of text slides whenever possible. (If you always use the same background, you can mix slides from various presentations without a problem). Stick with horizontal slides, as vertical ones tend to run off many projection screens.
6. Arrange your slides carefully. Make sure they face the right direction. Number your slides in the corner such that you can read the number when the slides are in the slide carousel. This way, you know the slides are in the right order and facing the right direction.
7. Avoid reading your slides. The bullet points on slides should give the key words - you provide the explanation.
8. If using a laser pointer, balance your hand on the podium or with your other hand to minimize the appearance of tremors. Avoid caffeine before your presentation.
9. When you finish, stand ready for questions. Don't gather up your notes to leave or back away from the podium. Begin answering the question with eye contact to the questioner, then move to the rest of the room.
10. Remember, you will usually know more about your topic than anyone else in the room. Project confidence!



ABSITE: THE AMERICAN BOARD OF SURGERY IN-TRAINING EXAMINATION

Each year, usually in January, residents of all levels take a written examination known as the "In-Training Exam." Residents at all levels take the same exam, but you will be scored according to your year in training, and ranked on a percentile basis. Some programs will use these results for selecting candidates for a fellowship position. Find out the date of the exam, and try if you can to get a good night's sleep before the exam. (Specialty residents rotating on your service may not have to take the test, so arrange for them to take call the night before.) If you have been reading as suggested above, you should do fine. However, if you are in a program that doesn't allow much reading time, do make an effort for about 6-8 weeks before the exam to review a text. The examination is quite heavy in the basic sciences. Especially popular topics are interleukins, prostaglandins, and growth factors. There are always questions on the coagulation cascade, GI hormones, and a host of endocrine questions, so review those chapters just before the test.

Several texts now have study question workbooks that are certainly worth considering, since they help train your brain for taking this type of exam. SESAP (see Bibliography) is another good study question format. It allows self-scoring so that you can identify specific areas of deficiency. You may even recognize some of the questions on the In-Training Exam.

Studies have shown a direct correlation between in-service scores and successful completion of Surgery Boards. Studying consistently will make your life smoother and easier as Boards approach. Realize that your scores reflect on the quality of education you are receiving, and residency programs want you to score well so that they look good. Seek advice from your program director, or more senior residents. When your scores return, you will get feedback on which questions you missed. Ideally, you should review your weak areas immediately, then plan to focus extra attention on that area when studying for the following year's exam. If you seem to do poorly on this examination consistently despite reading on your own, consider taking the Basic Science Review Course put on by the Association of Program Directors each year. It's a bit costly to travel and stay in a hotel (no to mention the potential loss of vacation time to this) but may be worthwhile if you want to pursue a competitive fellowship or if you are concerned about passing your boards.

CALL

Taking call is an essential part of surgical training. Caring for critically ill patients over 24-36 hour periods gives you the chance to see how quickly patients can become ill and recover, how fast or slow they respond to interventions, and how to respond to emergencies without the entire team of attendings and residents immediately at your side. Often you will have your first opportunities to do more difficult cases on call, as there are fewer senior residents available to take patients to the operating room. Undeniably, call takes its toll on you physically and emotionally. It's harder to function on fewer hours of sleep, but it's part of the training. Learning to function when tired is an important skill and for the remainder of your career there will be occasional sleepless nights and 3 a.m. emergencies requiring your attention and concentration. Take the good with the bad and do it as pleasantly as possible.

Fortunately, the days of every other night call for months on end are giving way to mostly every third night call, with occasional increases and decreases in frequency. While accreditation bodies encourage every third night call, the world of surgery has not yet embraced this recommendation. Complaining to attendings and fellow residents about call is unlikely to make things better for you. In contrast, you may be perceived as a whiner no willing to do what is needed. Also realize that you are on the bottom of the totem pole as an intern and junior resident. Usually someone senior to you makes up the schedule, and they aren't always obligated to obtain your input first. Do what you are assigned without complaint or risk making things worse. (In one instance a resident complained profusely that she resident had 10 calls while another had 8. The next day the revised schedule came out with the complaining resident having only 8, but they were all the Saturday's and Sundays of the month.) If things become grossly abusive or you feel you are being taken advantage of because you are a woman, consider discussing what is happening with your mentor or a trusted more senior resident. If they acknowledge that there is problem, ask the person in charge of the call schedule for an explanation of the arrangement. If you still have a problem, your program director may be the next best person to approach. In some institutions resident unions may be an advocate for fair call schedules.

Additionally, don't complain when extra call comes your way because another resident requires a leave of absence. You and your fellow residents need to act like a team in this respect. You never know when you will require emergency leave and they will pick up the slack for you.

Call is a great time to try to catch up on reading, get ahead on paperwork for patients, and even spend a few peaceful moments in thought. Keep a good attitude about why you're there and take advantage of any opportunities you have to learn new skills and management strategies. The next morning, wash your face and try to look as fresh and alert as possible, no matter how little sleep you got the night before. Most people will know you were up all night, and there's no reason to milk others for sympathy by your appearance. You can do it!



CHAPTER 2

Getting Your Work Done

"Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives."

--From a motivational poster

"I long to accomplish a great and noble task, but it is my chief duty to accomplish humble tasks as though they were great and noble. The world is moved along, not only by the mighty shoves of its heroes, but also by the aggregate of the tiny pushes of each honest worker."

--Helen Keller

To survive your surgical residency, you must be organized and efficient. You will find that time is a precious commodity and must be managed expertly or you will be lost - a dangerous situation both for you and your patients. Your primary function as an intern is to be the gatherer of data, keeper of information, and doer of tasks. You will also be learning about surgical disease processes and doing some operations, but that is rarely perceived as a priority by your senior residents. The medical students will also be looking to you as a teacher, but unless you fulfill your primary job, that will have to wait (or better yet, teach and delegate tasks to make your life easier, if you can).

Here are hints from the survivors:

PAY ATTENTION.

Really listen to what is being said on rounds about the patients and their proposed plan of care. If you are juggling coffee and charts while chatting with the medical student you are not going to know what's in store for a given patient. Do not let yourself be distracted by patient requests during rounds. You may have to ignore or "shh" a patient at times. This may seem rude, but is sometimes necessary. Offer to notify the nurse, if appropriate, but your job is to learn surgery and do resident work. Pay careful attention to how each attending does things - never assume that Dr. X does it the way Dr. Y does (and never suggest that to one

attending that how the other does it is better). Realize that there are lots of ways to do things, and try to learn them all so you can decide what's best for you. Be alert, ask questions, and above all:

WRITE IT DOWN.

As soon as a plan is formulated, put it in writing. You will NOT remember everything that is supposed to happen every day to every patient. You cannot afford to try perfect recall-you must write everything down. Many programs have interns use clip boards, patient lists, scut books ("The Book of Clinical Opportunities" for some.) Whatever system you use, be consistent and always write it down. Keep all your lists and notes in ONE place. If you start keeping lots of scraps of paper, you will either not have the right one, or not be able to find it. At a minimum, you should always have with you the following lists:

- **Patients** - name, diagnosis, location, attending, ID number, pertinent meds, antibiotics, etc. Many residents find that a stack of 3X5 cards imprinted with each patient's hospital imprint card is a handy way to keep track. Others have service print out lists.
- **Labs** - which tests, which patients. If you must draw the blood yourself, set up a check off system so no one gets missed.
- **Radiology** - which tests, which patients. Who needs to be scheduled, when will the test be performed, what prep is needed, when will results be available.
- **Consults** - which service, which patients, which resident or attending to call.
- **Other studies** - EKG's, ECHO's, etc
- **Scut** - dressing changes, IV starts, CVP lines, NG tubes (unless your nursing service does them), drain tubes to be pulled, etc.
- **OR schedule** - who needs pre-op and post-op checks (and what cases you will go to).
- **Admissions** - scheduled and emergent. Don't forget to add them to your service list and check their labs, etc.,
- **Paperwork** - dictate discharge and transfer summaries, contact primary care physicians, prepare prescriptions, etc.

DO IT NOW.

Following rounds, begin the day's work immediately. Organize your day by looking at the list of things you noted on rounds and consolidating as many as possible. For example, sit down and make all your phone calls at once; if labs are done at 10 AM, check them at 10:15. Do not procrastinate, even on a light day. Do things that depend on others first (like calling consultations and scheduling x-rays). The early bird does catch the worm: tests scheduled first thing after rounds will usually be scheduled earlier than if you wait until afternoon. Both you and the scheduling service are also more likely to be accommodating before things get down to the wire. Next, begin the discharges. Getting people on their way allows rooms to be turned over, nurses to be freed up, and admissions to come in. You never know what disaster lurks in the ER or when a surprise admission from clinic may wreck your plans to do things later. If you know someone is going home the next morning, fill out the patient's discharge paperwork and prescriptions the night before (or on a slower night on call). Delegate if you can, but be sure to follow-up on your assistants.

"The surest way to be late is to have plenty of time."

--Leo Kennedy

START YOUR DAY EARLY.

Try to allow enough time to get to the hospital and evaluate your patients before rounds. This will be hard to do if you are sleep deprived, but if you can force yourself to do it, you will see the benefits every day. You will expose the unexpected tangles that may ruin your usual routines later, and organize around the contingencies that have occurred. The sooner you know about problems, the easier it is to solve them. Good planning makes execution that much easier. If your service has grown larger than usual, come in 30 minutes earlier. It is MUCH easier than trying to cram all the extra work into the same amount of time. It will also help you avoid feeling that you have "no control over what is going on." Do as much of the following morning's work (such as ordering tests, doing discharge planning, etc.) the night before. Your system will depend on your own program's setup, so ask for hints from those residents ahead of you. If the "scut" can possibly be completed before the start of the regular workday, you will have time for all the icing on the cake and will even have fun. Just before retiring, or immediately upon arising, review the previous day and plan the next. Then if the sky falls as soon as you enter the hospital, you will know how to rearrange things. If possible try to schedule in some OPEN time that can be used to

read, nap, or even exercise. Don't just let the work expand to fill the time allotted, because chances are, someone will find a way to add more work, and you won't be able to find a place to squeeze it in. Being organized will increase your productivity and satisfaction.

SET PRIORITIES.

Do the important things first, not just the urgent things. Scut must be completed, and sick patients tended to, but remember that you are there to learn to be a surgeon. Determine with whom you should spend "face to face" time during each rotation. This is usually the attending surgeon, and will usually occur in the OR. Your superiors will not know that you are working when they do not see you. All they know is that you are not there doing the most important work of all. Learn the idiosyncrasies and work habits of the various attendings so that you can maximize the quality of your interaction with that person. For instance, if one attending makes rounds early, be sure you have seen his or her patients first, and be available to round with that attending. These people are important to your evaluations and your future. While some may consider this "polishing the apple", doing the most you can to work well with your superiors will help you in the long run. Your efforts will be appreciated by those attendings, who are then more likely to give you better cases and share with you more of their own personal secrets to successful surgery.

MAKE WAITING TIMES PRODUCTIVE TIMES.

While waiting for a case to begin, write the post-op orders. Or make those phone calls. Or read the next section in your pocket manual. You may prefer to sit in the lounge and talk shop, but most lounge conversations are rarely educational unless you make a point to turn the conversation to the case at hand. (However, occasional social conversations may keep you from appearing stand-offish.) While scrubbing, ask the attending or senior resident about post-op management or any preferences re: orders, dressings, drains, tubes, etc.

START ADMIT EXAMS AND WORKUPS EVEN IF YOU DON'T THINK YOU HAVE TIME TO COMPLETE THEM.

You may think you need more time than turns out to be necessary and you are apt to never feel you have a single large enough

block of time. **JUST DO IT!** This can be especially important if you need a translator, or some family member who may not be there when you come back, prolonging the time required. Patients do not mind having their exam interrupted nearly as much as not seeing the doctor there at all. You may also discover tests that have not yet been ordered that will need to be expedited after you get the patient's history and medication list.

KNOW YOUR CASES.

Be sure you get your case assignments at least the day before so that you will have time to see the patient yourself, and to absolutely **MAKE** time to read about it.

KEEP REFERENCE LISTS.

Your life will be made easier if you keep lists of attendings phone numbers, the formula for a bowel prep, the format for H&P's, op notes, discharge summaries, everyone's beeper numbers, etc. in a convenient place. Keep track of surgeon preferences both in the operating room and in patient management to help keep these issues straight. Pocket computers and data banks are excellent for these tasks. Many prefer a notebook, or an address book with alphabetical tabs, or index cards.

KEEP A CASE LOG AND COPIES OF YOUR OP REPORTS.

You will need a complete list of ALL your cases, especially one's in which you are the primary surgeon or the first assistant. Most residencies require submitting this list at regular intervals. You will also need this list in order to apply to take your Surgery Boards upon completion of residency. You also need to record cases in which you acted as the "attending" by being the "teaching assistant" to a more junior resident. It is also important to keep track of procedures, including chest tubes inserted, central lines and Swan-Ganz catheters placed, anoscopies, sigmoidos, and other endoscopies, etc. You must also list non-operative trauma and ICU cases that you have managed. (For your own information and edification, also record any complications you may have had.) For each of these procedures record the patient's name, medical record number, date, attending surgeon, service (general surgery, plastics, etc.), the procedure, and what role in the procedure you played (primary surgeon, first-assistant, teaching resident, etc.) Some residencies will also require you to list the CPT code

assigned to that procedure. Some residents do this by imprinting an index card with the patient and case information, others use stickers in a logbook, and others use personal organizers. (If you use a computer system, be sure to have an updated back up at all times!!! Many a resident has lost their case log this way.)

KEEP COPIES OF ALL YOUR OWN OP REPORTS.

These can be a great resource when you do similar cases later, as you will probably include a lot of details that are often not mentioned in the texts and atlases. Also, realize that in certain parts of the country, and in certain hospitals, you must produce the actual op reports for documentation of your experience and training when you are applying for operative privileges. Some credentialing bodies will not accept a simple statement or report from your program director. It is infinitely easier to start your lists and tallies during your internship rather than having to chase around during your chief year hunting through OR logs for your cases. Ideally, this will be computerized by your program, but keep your own log to be sure you get credit for all you have done.

DELEGATE.

Let other people do their jobs. There may be a tendency to think that you need to solve all your patients' problems, such as arranging transportation and/or dealing with social problems. This can take huge amounts of time, and you cannot do it nearly as well as the social workers and other ancillary personnel who are trained to the task. Put your med students to work, but be sure to follow up on them. If something is not done because it was assigned to the medical student, it is your responsibility and NOT be an acceptable excuse. You need to instill a sense of responsibility in the students, but don't jeopardize your reputation or your patients' condition by relying totally on med students. When you assign a task, also set up a time to review it. When a student asks you a question (academic or practical) for which you do not know the answer, tell them where to find out. Specify when you expect them to let you and the team know the answer, and don't forget! Reward your students by teaching them those things you wish your surgery residents had taught you when you were a student yourself.

INFORM YOUR SUPERIORS.

If you must spend the day on the ward and not in the OR, make a point of informing your Chief Resident and attendings of tasks accomplished and any significant changes or abnormal results you may have identified. If something you think is very important comes up, inform your chief between cases, or go into the OR. Be careful that you are not interrupting at a critical point in a case. (Try asking the circulating nurse if it is a good time or not, or just wait quietly off to the side within the peripheral vision of the attending, who may speak to you when ready. Better yet, ask before the situation arises how your chief wants these type of things handled.) Many times your appearance in the OR will give you a chance to see something interesting, and it informs your attending that you are both interested in the case and are staying on top of things on the ward.

DOCUMENT YOUR ACTIONS.

In this litigious society, it didn't happen if it's not in the chart. Every time you have a significant interaction with a patient, especially if you are checking in a critically ill patient, briefly note it in the chart. Not only is this good for medico-legal reasons, it lets your attending and others know you are following closely.

COMMUNICATE WITH YOUR COLLEAGUES.

When signing out to the "on call" resident, give them enough information so that your patients will be well cared for and you will not have to start your next day with disasters. Prepare a legible list of your patients with pertinent highlights and potential problems. If someone needs to be double-checked later in the evening, say so. Insist that other residents be equally considerate when they sign off to you.

KEEP THE NURSES INFORMED AND INVOLVED.

In the days of managed care, the nursing staff is often down on manpower and stretched thin. By spending 5 minutes after rounds informing the nurses of the plan for the day, you can simplify both their lives and your own. Save them from having to page you 10 minutes after you leave the floor by asking if there is anything needed for their patients before leaving.

PATIENTS FIRST.

There will be times when you are needed in multiple places at the same time and you just can't do it all. A general rule for staying out of trouble is to "Keep the interest of the patient foremost in your mind." If a patient is critical and you can't make it to conference, have a nurse or someone else call your immediate superior (be it a more senior resident or an attending) and let them know where you are and why you can't be there. Few attendings will get upset if they see you were putting the interest of a sick patient first. (This does NOT apply to non-critical issues and things that should have been done previously, like discharge summaries).

BE NICE TO EVERYONE.

Of course, this is impossible and sometimes not even the best course. At the very least, control your temper. Residency and hospitals can be extremely frustrating, aggravating, and sometimes ludicrous. But as a general rule, you will get more accomplished and feel better about yourself if you stay upbeat. Learn the names of support staff, and you'll be amazed at how this can pay off when you need help. There will be days when you think you are too tired to even smile, but it does not pay to make people angry. Everyone can get you one way or another, so it is better to have all those people on your side, especially for those down days.

DON'T WHINE.

There is always more to do than is humanly possible on most surgical services, but complaining about it only makes things worse, and wastes energy and time that you need to get the job done. Stay organized, follow the suggestions above, and you can do it.



CHAPTER 3

Surgical Politics

"Becoming "one of the guys" is not necessarily an adequate, comfortable, or feasible way to win the game...Understanding the guys is what it takes to triumph in their world."

--Pat Heim, Ph.D. *Hardball for Women*
Plume Books, 1992

It is absolutely critical for you to realize from the very start of your internship that Departments of Surgery are just as political as any other organization or community that you have dealt with during your education thus far. You will be dealing with very strong egos who are accustomed to making life or death decisions based on incomplete information. This tends to carry over into decision-making in other aspects of surgeons' lives. First impressions DO count, so you will want to make yours a positive one. It is much easier to maintain and build upon a good first impression than it is to have to overcome a bad one. Female residents should expect equality and equanimity, not superior treatment and certainly not inferior treatment. By behaving in a fashion which expects no more and no less than male residents, training programs and the profession itself will evolve into a greater understanding and appreciation of this equality. Women certainly are different than men, but for nearly all aspects of the surgical residency-training program, this difference should be inconsequential.

LOOKING AND ACTING LIKE A SURGEON

APPEARANCE

Attendings, other residents, nurses, and patients as well, will be forming an opinion of you as a doctor and as a coworker. As a female, particularly if you are the one and only or one of an elite few, you will be in the spotlight and characterized by what others see. You may have many other qualities, but you must look and act like a professional while on the job. You may or may not have a flair for style, but you must be clean, neat, and dressed in a practical manner. Find out BEFORE starting internship just exactly what the usual attire is for your particular program. Some have specific dress codes. In others, everyone wears scrubs most of the time. Women's clothing tends to be more difficult for people to decide whether it is or is not within the norm. Avoid anything that can remotely be considered seductive. Specifically, avoid short skirts, low collar lines, and tight anything unless you also want to deal with sexual harassment issues. Boring yes, but you are here to become a surgeon, not find the love of your life or win the best-dressed award. Bright colored clothing is an individual matter, but men tend to wear black, brown, gray, and navy. Most patients enjoy a little livening up of the dreary hospital atmosphere, but you may want to establish your surgical reputation before breaking out the hot pinks and chartreuse.

You must learn to look professional and businesslike in your affect and attire if you expect to be taken seriously as a surgeon. Keep in mind practicality. You might be pulling an NG tube or helping move a patient in those clothes. If you are uncertain how your clothing is perceived by others, ask someone you trust to give an honest answer how they perceive your mode of dress. Do not be offended if someone compliments you on your appearance, just make sure your appearance is not the only thing noticed. Jewelry and makeup are a personal choice. Just be sure it is on securely, doesn't dangle outside your scrub hat, and doesn't take too much time to take on and off. Some ORs have strict rules on the jewelry issue, so check with the OR supervisor on this issue. Avoid keeping jewelry in your scrub pockets, as you may not think to remove the items when changing clothes. Keep your fingernails trimmed and clean. Some places even have rules about nail polish in the OR. You will find that short nails are easier to keep clean, and won't hurt patients when doing abdominal and rectal exams. Wear shoe covers in the OR or change shoes any time you step

outside the OR. Patients don't like to see blood-splattered shoes. Be yourself, but use some common sense.

ATTITUDE

Display an attitude of calm, confidence, efficiency, attentiveness, thoughtfulness, and respect for others (this includes nurses, students, technicians, and other residents as well as your patients and superiors). Keep in mind a TEAM mentality when working with others. You should display an eagerness for ALL your assignments, even the unpleasant ones. This does not mean that you should allow yourself to get shunted into all the dirty or menial duties, just don't complain about them. Look upon them as the items to dispense with as expeditiously as possible. Be open to LEARN from every situation you encounter, even if it may be learning what NOT to do. Surgeons tend to love their work, and will expect for you to show that same enthusiasm. (If they don't, they usually are not very good, either.) Make sure you verbalize this shared enthusiasm by initiating case management discussions, volunteering information regarding data collected or extra reading. Be willing to learn more than one way to do things. Demonstrate some common sense. Try to laugh and have fun, make friends with those you respect, and steer clear of those not worth your time.

BEHAVIOR

You will most likely be held to a higher standard of behavior than your male colleagues. Men are allowed to lose their temper, gossip, flirt, and behave like Casanova and still be tolerated. Women will often be labeled very derogatory names for the same behaviors. It is wise to keep your personal life to yourself. Make a list of adjectives that apply to the surgeons you admire most and least and their behaviors. Keep a list of the most admirable characteristics with your notebook or posted someplace you will see often, then try to emulate them.

A few starters: calm, energetic, professional, respectful, knowledgeable, well-read, decisive, thoughtful, orderly, well-organized, efficient, kind, courteous, enthusiastic, team player, etc. Do not imitate or tolerate negative or juvenile behaviors. Some descriptions you will want to avoid having applied to you: prima donna, lazy, irresponsible, untrustworthy, manipulative, work-dodger, back-biter, unprepared, doesn't read, lies, steals cases, technically inept, bitchy, patronizing, condescending, whiner, egotistical, smart-ass. You get the idea, and those labels can get you fired. A surgical residency can seem like a lifetime. The stress and

demands put upon you by your chosen profession are considerable.

It is easy to get lost in the haze of sleep deprivation, overwork, the desire to retaliate on your juniors when dumped upon by your seniors, and occasional favoritism, and frequent lack of recognition for your hard work. It may be hard to rise above the moment and look at the big picture, hard to see how you appear to others. Do your best not to emulate or tolerate juvenile behaviors. Remember the walls have ears! People who have no business evaluating you may watch how you act and behave and pass judgment. Even worse, they pass those judgments along to others, including your superiors.

DO NOT GOSSIP! Think before you speak or act. Damage control ahead of time can make the remainder of your residency more bearable. The world of surgery is amazingly small and the attending you operate with today may be friends with the head of that fellowship program you want in 2 years. Don't burn any bridges. Keeping your goals in mind can help you gain perspective and keep you on track.

CRITICISM

Do your very best to AVOID being defensive and hostile. Grow a thick skin, and when you are criticized, consider the criticism, its source, and motivation. Sometimes it may be valid and you simply need to do something different. Sometimes it is just to test you out. Sometimes it is just petty, coming from someone who doesn't think much of themselves, so they will try to enhance their own stature by trying to belittle you. In that case, stay calm and stand your ground. No response at all is needed in these situations. At most, simply say that you will "take that into consideration and do better next time." It is a lost cause making excuses whether you were the cause of the problem or not. Just take care of the issue, and prevent the problem from recurring if at all possible. It is difficult to believe when you are hit with an unexpected criticism, but it may be enormously beneficial to you to be informed of any way that you appear to have a weakness or shortcoming.

All surgeons make mistakes, and must learn from them. Do not take criticism as a personal attack. Better to be told to your face so that you can remedy the difficulty, than to have it spread behind your back. You will convert the doubters only by going about your business and doing your best work possible. Keep your criticisms of others to yourself, and avoid making enemies.

Dedicate each day to your goal of becoming a real surgeon, and learn from your mistakes. Don't dwell on them: identify how to avoid repeating the same error the next time and move on. Don't paralyze yourself with self-doubt, just put the past behind you. Forgive yourself and remember the lesson. You are preparing yourself for a lifetime of work. The five or six years will pass quickly. You will be faced with all kinds of situations when you are tired and stressed that will test your personal integrity, judgment, and stamina.

"You never know when you'll be in need of those you've despised."

-- Cormac McCarthy, *All the Pretty Horses*
Knopf 1992

LANGUAGE

Many residencies become linguistic schools of profanity. In times of stress and aggravation, you may find yourself using some words you never imagined you would speak. But you will hear them so many times, they might slip out almost automatically. If you don't get carried away, a few curses here and there won't really matter. However, profane language not very professional, and many of the older attendings will find it quite unbecoming and unladylike. You may think "So what?", but if it costs you cases, it really does matter. When in Rome, do as the Romans do, but in your program be careful how you speak. Profanity is one more way to dominate and exert control over others with demeaning and humiliating remarks. This may not be the type of behavior by which you wish to be characterized. Patients who hear you speak this way may also be alienated.

CHAIN OF COMMAND

Each residency program is a bit different from another, but all have some sort of hierarchy. Private hospital programs will differ considerably from university training, and single hospital programs will be easier to decipher than multi-institution programs. In general, each department will have a chair, division chiefs for the various surgical specialties, and a number of attendings whose role will vary considerably from one place to another. If possible, get a list of faculty and attendings from the secretary of the department chair or program director. The program director is most responsible for seeing that residents get educated according to the guidelines required by various organizations, such as the American Board of Surgery. Usually they are the ones who assign your rotations and see that you have training in each subspecialty as

required by the Board. Some also act as advisors, particularly if someone is having problems or decides that they want to pursue one of the subspecialties. Some are more helpful than others. Find out what kind of reputation your program director has, and try to get to know this person in a positive way. They are also often one of the primary writers of your residency evaluations and letters of recommendation. Ask this person to allow you to read your evaluations after each rotation in order to identify your strengths and weaknesses. These evaluations reflect how you are perceived in the program by the powers that be, whether you agree with them or not. If you do not understand a criticism in an evaluation, ask the evaluator or program director what are examples of exemplary behavior in your weak area.

The residents' hierarchy is largely determined by what year you are in training. There is usually a specific type of case or procedure associated with your year (i.e. - interns do hernias, fifth years do Whipple's). There are also specific tasks and rotations assigned by year. In some programs, everyone does the same rotations for the same length of time; in others, the rotations vary from person to person. In the programs with variation, you can usually get a pretty good idea of your progress if you are at or above your level in assignments. If you find you are falling behind the norm, talk to the program director to find out why. Most people have little insight into their shortcomings. Sometimes, though, it may be a case of gender bias and you need to take a pro-active role in overcoming it or you will fall farther and farther behind. Also pay attention to the hierarchy when caring for patients. If the intern informs the attending of problems but not the senior resident, problems with the team may ensue. No one likes to be caught off guard. Remember that trouble rolls down hill, and unnecessarily jumping the chain of command is a good way to make it roll harder and faster.

IN THE OPERATING ROOM

"Anyone can hold the helm when the sea is calm."

--Publilius Syrus

Generally, do just as you are told. If you see something that you can do to help and not be in the way, do so. If you notice a problem that no one else has identified, notify the appropriate person (usually the surgeon, but sometimes it may be more appropriate to tell the scrub nurse or anesthesia). If a case goes badly, pay very close attention. A crisis is not the time to assert your independence. If you get yelled at, remain calm and try to correct whatever you are doing wrong. Some surgeons lose their cool when problems occur, and you may be the most convenient target for their anger, even if you did not create the situation. Don't take it personally and fall apart. Don't get mad yourself and walk out. Don't shout back or try to defend yourself, even if the accusations are false. Take a deep breath, swallow hard if necessary, tell yourself to remain calm, and remember that your first obligation is to the patient. Usually it is best to keep silent and just listen until the surgeon calms down.

Realize that some attendings and senior residents will try to enhance their own sagging reputations and egos by attacking you, and they can be very cruel. Many men tend to see relationships in terms of hierarchies, i.e. who's "up" and who's "down," or who is winning and who is losing. (Read *Hardball for Women* for an excellent discussion of this topic.) If you start to look better than they, you may find yourself being sabotaged or criticized to put you back in your proper "place." They probably endured the same harassment in their training, and haven't figured out a more constructive behavior pattern. That doesn't mean you have to condone it, nor does it mean you have to repeat their actions when you are a chief. Sometimes such remarks are directed at you just to test you out to see how tough you are, and to see if you believe in yourself or not. BELIEVE!

"They can who believe they can."

NEGOTIATING HIERARCHIES AND POLITICS

Unfortunately, surgical residency evaluations are not always based on how hard you work, what you know, or how well your patients do. It often revolves on WHO you know and how well they like you. This does not mean that those other factors are not important, but realize that Departments of Surgery are staffed by human beings with all the same ego and insecurity problems that other people have, too. It is important for you to identify the patterns in your own program that are crucial to maneuvering the political battlefields. Learn the chain of command, learn whom you can trust, learn who is most and least respected and why, and make no assumptions. There are lots of petty jealousies and infighting that you can walk into unknowingly, so choose your alliances carefully. If you haven't already, consider reading a book on communications and negotiations (like Dale Carnegie's "How to Win Friends and Influence People").

The following are a few hints to help you through:

1. Learn the name and areas of interest of each of the attendings in your department. You may be able to get a list from the department secretary.
2. Ask the more senior residents to clue you in as you go through your rotations as to which surgeons are best at what, which ones to avoid, who has the best operative technique, and which ones are good teachers. Sometimes you will want to check out the other more senior residents on these criteria as well.
3. Once you are reasonably sure of the people in your program, try to identify someone as a mentor (see following chapter).
4. Do not go over anyone's head if problems develop - follow the "chain of command." If a co-resident is giving you grief, go to the Chief Resident. If he or she is the problem, go to an attending. If the attending is the source of your difficulty, go to the division head if there is one. If not, talk to your program director or the chair of the department. If the chair is the problem, you should probably check with the Women's Liaison Officer at your institution to decide where to turn. (See chapter 4.)

5. Keep your Chief Resident and the attendings informed of important changes in patients' conditions, or problems with the patient or family. If something seriously abnormal turns up on labs or x-rays, notify the appropriate person (usually your chief resident or the case attending) right away. Additional studies or treatment may be required, possibly immediately. This will improve the efficiency of patient care, shorten their hospital stay, and avoid delays arranging special studies. It will also keep you out of hot water by shifting that responsibility to a more senior member of the team. Formulate a plan yourself, then check it out before acting upon it. If you have "handled" a clinical problem yourself, be sure to inform your superiors. Not only do they need to know the problem existed, but you can confirm your actions, and maybe even get a little credit.
6. Call for help if a decision seems out of your league. While a certain amount of autonomy is expected, many clinical decisions rest on experience that you do not have as an intern.
7. Respect others. Treat ancillary staff, nurses, secretaries, and students well. They can be great allies or they can make your life miserable if you aggravate them. You may receive conflicting messages from some of them. As a woman in a position of authority, you may find that at first you are mistrusted or not taken seriously. They may go over your head, or simply ignore your orders and requests. To some you represent a threat to their sense of order or they may have had a bad experience with a female predecessor. Show respect for their input and suggestions by asking their opinions and listening to their answers. They can teach you lots of practical things, and make your life easier if they like you. If they have questions for you and you have time to teach, they will appreciate your efforts. You will also find that secretaries, nurses, and other personnel will go out of their way to assist you in ways that they will not for those who treat them poorly. Surgeons may think that they sit at the apex, but in realistically, they cannot do their work without the active, willing cooperation of others, including ward clerks, orderlies, nurses, scrub techs and housekeepers. You have to learn to treat everyone with respect. You are part of a team, so be prepared to cooperate and negotiate. Get the idea of collaboration.

8. Avoid yelling, screaming, or throwing fits. While it may work for some of the men, you will be labeled as hysterical b---- with permanent PMS. Male residents may get things accomplished by flirting, yelling and threatening, but these are no-win behaviors for the female residents in most cases. (One male chief's motto was "make an enemy a day.")
9. If you have trouble with a particular person, doctor or otherwise, first try to resolve the conflict by discussing it directly with that person. Often it is matter of simple miscommunication.
10. IF YOU GET INTO TROUBLE: Never try to cover up mistakes you make. Particularly when starting out you may find yourself in over your head before you even realize what is happening. In these situations do the following:
 - Get help.
 - DO NOT LIE!
 - Tell the truth, as you know it. State only facts. Do NOT offer excuses or try to blame someone else. Keep explanations under wrap unless specifically asked for them.
 - Be careful what you say of others - it will reflect just as much on you.
 - Accept responsibility when it lies with you. This is especially important when dealing with medical students and more junior residents. If you tell them to do something and problems ensue, accept the responsibility. Don't, however, let others dump it on you if you were really not involved.
 - If you don't understand what you should have done differently and why, ask. You may need to wait until later and any hot tempers have cooled to do so.

"You need to be willing to take the heat...You need to take responsibility for your actions...If you make a mistake, say, "I made a mistake"...But don't make excuses, don't try to cover it up, own up to it. If you admit to your mistake, it ends the conversation. If you try to cover it up, it extends it. It is respectable to say "I screwed up...I did it."

--Dawn Steel

MENTORS

The dictionary defines a mentor as "a wise and trusted counselor or teacher." Some are also referred to as a sponsor, which is defined as "One who assumes responsibility for a person or thing." The first criterion for a mentor is someone who is wise, which means not only knowing the facts, but also knows what is true, right, and lasting. They have experience, common sense, and good judgment. This usually means someone at the associate professor or full professor level. The relationship should be mutually beneficial, and evolve over time to where you become a valuable colleague to the mentor.

A mentor is absolutely essential for you to advance through the academic ranks, since that is really the only way you will learn the rules of the game. A mentor can serve many useful functions to make your life successful and progress easier. Advice on techniques, references, solving a tricky clinical situation, and advising you on when to do what is extremely important. The mentor should also help you to understand the hierarchy and "chain of command" in both your own program and the field of surgery. You must learn whom to trust, and who to avoid. Mentors can promote you by nominating you to speak at conferences, publish papers, become involved in lab research, or clinical trials. Mentors can give you thoughtful critiques on your clinical work and your writing. The mentor will alert you to useful meetings and conferences, both for their political as well as their educational aspects. They can assure that you receive challenging assignments that will showcase your talents. Association with and acceptance by a good mentor will in and of itself enhance your reputation. A good mentor will also help you to stay focused and avoid over-commitment of your time in activities that will not enhance your career aspirations. No one can do it all, and it is important to learn to say no to tasks that consume lots of time but are given little credit as being "important" to your career. A good mentor will also serve as a role model for you in terms of style, demeanor, dealings with patients and others, even by their family relationships. Simply having the mentor's friendship can be a protective measure if you find yourself in a hostile environment.

Though you may feel it is easier to communicate with the assistant professors, they are just getting started on the academic ladder themselves. Find someone who has a solid reputation within your

own institution (usually meaning tenured), has strong contacts within the national surgical societies, and is still actively involved in research. It will probably take six months to a year to identify someone and develop a working relationship. Don't feel that you are the only one who benefits from this association; there is a strong interdependence between good mentors and their protégés. If you are good, it enhances their posture among their own colleagues.

Some of the most lauded surgeons are department chairs who have promoted their own faculty so well that they have become department chairs in their own right. Be aware that you may surpass your mentor at some point and that jealousy and resentment can supplant the original friendship. Women often have a more difficult time finding a mentor, and you may need to build a constellation of mentors to help with different aspects of your career, sometimes even in different institutions or disciplines. Contacts and networking are key to success in the academic environment, and you must actively seek out a mentor yourself. Gender does not determine the quality of a mentor, although the qualities of a good mentor are often those ascribed to feminine characteristics. (For example, they know more about their workers' personal lives, and understand how relationships can affect productivity.) A good mentor will not feel threatened by ambitious young women.

"Yes, there are men who stop us. But there are also, and gratefully so, men who feel and act otherwise. There are men who feel invested in our success and who will help us if we let them."

--Dawn Steel

If you want to enter in private practice, find a mentor along those lines. Sometimes it is easier to ask someone with whom you have some rapport to help you find a job, set up practice, and choose between solo, group, or HMO practice, etc. Another option is to use the AWS Directory to find someone practicing in your area or the area to which you may wish to relocate, to help evaluate job opportunities. A large number of women in AWS are in private practice, and most are willing to offer advice to younger women coming up through the ranks. While the prospect of going solo may seem daunting, it is not nearly as difficult as it seems at first glance.

CHAPTER 4

Gender Issues

"If you can't be both liked and respected, make sure you're respected."

--Pat Heim, Ph.D. *Hardball for Women*

There are a number of issues that are very specific to women surgeons and their needs. The realities of being a female surgery resident can at times be a bit confusing or even overwhelming. You will find a way to overcome these difficulties, but the discussions here may clarify some of the specifics for you. It is difficult not to get preachy, so take the following for what it is worth: the hard, sometimes painful experiences of women who have learned the hard way.

Gender discrimination and sexual harassment are problems that most women physicians will have to deal with at some time during their careers. How these are dealt with is crucial; these issues are very important and can turn an unpleasant encounter into a disastrous one if not handled carefully. The following comments are not absolute rules but suggestions as to how to minimize the trauma dealing with these situations. Additional information can be obtained in a separate pamphlet on sexual harassment available from the AWS.

Just as it is important that you not be treated differently because of your gender, you should not use your gender to manipulate those around you. Women residents who are thought by their male peers to be using their gender to get good evaluations are almost universally criticized, sometimes to their face, but more often behind their back. Some attendings and senior residents will use their position to gain sexual favors with no intention of anything serious except to mark another notch on their scorecard. If you are interested in reciprocating, that's your own decision. (Recognize that the more professional contact you have with a person and the greater the difference in rank, the more the social relationship is fraught with danger.) If you are not interested, make this clear early on. If you continue to be approached, that is SEXUAL HARASSMENT. You may choose to just ignore it, or laugh it off. Often being very blunt in your refusal is sufficient. Don't send mixed messages - if you mean "no" say it and mirror it in

your actions. Don't continue playful teasing or joking about the subject. Guys may think your "no" is really a "maybe" and you just need a little wearing down. Sometimes a discussion of your personal life, particularly lack of social life, will be misconstrued as an invitation. If you feel you are being hassled by someone whose attentions you do not want, warn that person once, then report the offender.

GENDER DISCRIMINATION

Gender discrimination is defined as a situation where a superior uses your gender as the basis for a negative decision that affects your career. It may or may not be combined with sexual harassment. Examples of this would be if your department chair pays you less than a male physician for the same staff position or promotes a less qualified resident over you because you are a woman. Remember that you cannot be refused a position because you may be exposed to agents that would affect the health of any baby you might carry. This means that you cannot be refused privileges for any case that might require fluoroscopy or use of a teratogenic agent (though you should assess the risks, and take appropriate precautions).

Equally important is for you to understand what does not constitute gender discrimination. Since few affirmative action plans for women are still in existence, your employer or department chair is rarely under obligation to promote you over an equally qualified male solely to have a woman in the department. Likewise you cannot force a surgeon to take you on as a partner just because you are a woman. If he doesn't want a female partner that is his loss. Although you cannot be asked if you plan to be married or have children, if you volunteer that you are planning to take an extended leave (i.e. 18 months to 2 years) after each child, that can be used as a criteria for refusal of promotion or employment. (You have set forth conditions that would prevent you from fulfilling the duties of your job.)

SEXUAL HARASSMENT

Sexual harassment may be part of gender discrimination or can occur as an independent event. It is defined as any unwelcome sexually-oriented behavior, comments, demands, or physical contact made to or about you that interferes with your work, creates a hostile or offensive working environment, or made for the purpose of threatening your position or humiliating you. A blatant example is when an attending demands sexual favors or it will adversely affect your evaluations. Less obvious cases would be where you are in the OR lounge and several doctors start telling dirty jokes or stories with the express intention of making you uncomfortable, or programs where you are required to share the same on-call room with men, and you prefer not to.

It is equally important to understand what is not harassment. You have entered a predominantly male profession and cannot expect the establishment to bend over backwards to accommodate one or two women (though our numbers and strength are growing). Men will be men, and most will tell off-color stories from time to time. If they are not directed at you, try to ignore them, change the topic, or if it suits you, tell a few of your own. If you really are embarrassed or find such jokes disgusting and demeaning, tell them so and ask them to refrain. You can point out that it is inappropriate to tell such jokes in front of people who have too little power to complain (particularly if they are embarrassing medical students or ancillary female personnel), but try to do so without antagonizing the person and worsening the situation. Be very clear about this, and do not give any double messages while trying to be tactful.

Most men do not usually enjoy talking about sexual matters in front of women and will stop if you loudly complain in these circumstances. In some cases, an older man will call you "dear," or pat you on the shoulder. This may seem paternalistic and demeaning, but this was how he was raised to treat women, and he may perceive his actions as being polite and respectful to your femininity, rather than offensive. It is usually not too hard to tell the difference. And don't confuse courtesy with chauvinism: there is nothing that irritates a guy more than a woman who gets angry when he opens the door. In most cases this is not harassment. Sexual harassment also encompasses the use of sexist teaching materials, denied opportunities or poor evaluations because of

gender, and punitive measures based upon the refusal of sexual advances.

That being said, how should you deal with a presumed case of sexual harassment or gender discrimination? First, after the event has occurred, sit down, take a deep breath and try to look at the situation objectively. Record the facts of the incident in as much detail as you can recall. Review the problem with an objective outsider. Decide if the episode really was one of gender discrimination or if your pride has just been wounded (that is, it may be easier for you to blame your lack of promotion on gender bias rather than the fact that another resident actually did a better job.)

If you decide that this was a case of gender bias or sexual harassment, then you have several options:

1. Make an appointment with your department chair or program director to discuss the problem, even if the problem is not with him or her but with another resident or staff physician. One of the reasons for talking to the chair is to gain support, or at least neutralize his/her position if the problem is with a staff member. If the problem is with the chair, talk this over with the staff members who you feel are your mentors and let them help you. Be prepared to listen: it does no good to come in with a chip on your shoulder, and with a closed mind. There may be other perspectives that you have not really considered. If he or she suggests that the problem is inadequate work on your part, ask for specific examples and any suggestions on how to improve your performance.
2. You have the right to request documentation for any incidents that are being held against you and to respond to any complaints made against you. Do not accept a statement that "A complaint was made, but I won't tell you by whom, to protect their confidentiality." This type of secrecy does not apply if it affects your career. Above all, don't sound paranoid. Dr. X may indeed be opposing you because you are a woman, but you won't win your case by simply stating that "He's against me because I am a woman." Such blatant male chauvinists are usually a departmental embarrassment.
3. Be prepared to support yourself with documentation, if necessary, such as statements of witnesses of specific events,

or letters of recommendation from other coworkers, including other residents or nurses. (Prepare yourself to be let down here. Many men and women that you consider your friends are not willing to stick their neck out if they think it will be detrimental to their own careers.) Come to meetings with a copy of your CV and any additional material that you feel would bolster your case, such as evaluations from other physicians on staff.

4. After any meeting, make notes in a diary or daybook. Be assured that your chair will. If specific promises were made, document them here as well as any other comments made that you thought were significant. These notes may have legal import if you should have to go so far as arbitration or court.
5. If you get no satisfaction from your chair, check the bylaws, rules and regulations of your institution. Every teaching hospital and medical school should have a Women's Liaison Officer who is affiliated with the AAMC (Association of American Medical Colleges). That officer should be able to help you sort out your own program's policies and grievance procedures. Resident unions may also be supportive of your difficulties. Serious problems not dealt with effectively in your residency and interfering with your surgical education might deem reporting to the Residency Review Committee. In such cases the resident might consider obtaining a position in a different training program first. Reporting problems to this committee first may make it difficult to later find another position. At the same time, your complaint may prevent another woman from having to deal with the same problem in the future.
6. Legal action should be a last resort, but is a real consideration if you have serious, documented, legitimate complaints. If you pursue assistance outside your institution, it is time to get legal advice. Call your attorney if you have one, but be sure they are familiar with employment law, particularly as it relates to discrimination and harassment. If you do not know someone, contact the Equal Employment Opportunity Commission or the National Organization of Women. Both of these organizations have legal staff that will help with these problems. Quite often merely the threat of legal action will cause a problem to disappear, but don't cry "wolf." If you start a suit, be

prepared to see it through to the end if necessary.

7. Prepare for backlash. Your best defense against the rumors and innuendoes that can accompany such problems is to state your case out in the most objective way possible. This means not walking the halls muttering that Dr. X won't let me scrub on his cases because he thinks that women belong at home. That kind of action only hurts you and helps him. A better way to deal with it is to ask another physician why Dr. X doesn't ever have a woman helping him, or why Dr. Y has never graduated a woman resident. You will get your point across more effectively and avoid offending people. You must be prepared for the broader consequences of your actions. Fellowships, staff appointments, partnerships, and most jobs in our profession are made through the "old boy/girl network." If you antagonize too many politically powerful people with complaints or a lawsuit, you may have found yourself winning the battle and losing the war.



DEALING WITH PERSONAL RELATIONSHIPS

We are all human, and sex is one of the basic human desires. Additionally, surgical residency can be a time of great personal vulnerability. We've all been there. But the workplace is a hazardous environment to play the dating game. Your career and your education depend on the good will of your attendings and senior residents, most of them men. If you wish to be evaluated on the basis of your surgical skills and talents, you are best off keeping your social life to yourself, and keep it outside the hospital. People love to gossip, and speculation about your love life will not enhance your career. Unfortunately, the "double standard" is alive and well on the issue of playing around. Men can do it with little repercussion, but women can be viewed as anything from teases to sluts for the same actions.

The female resident is also vulnerable to the curiosity and scrutiny of her co-workers because she is just a different sort of woman. You just don't fit into their categories. A woman surgeon is still UNUSUAL in this day and age, though getting to be less so. Some people don't know how to deal with an assertive, aggressive female professional. And very unfortunately speculation and gossip can serve to further isolate you in a situation that is already impersonal, fast moving, and lonely. Your life outside the hospital is certainly personal, definitely private, but unfortunately also a subject of curiosity and speculation. Be careful not to mistake the interest of others and their friendliness for friendship. What are we driving at? Well, you need to keep your sex life (or lack thereof), attractions, and activities out of the hospital. This is especially true if you have chosen an alternative lifestyle.

Because your work hours prevent you from meeting eligible mates outside the hospital, the temptation to find affection and validation in the arms of your chief resident may well be overwhelming. Generally speaking, DON'T DO IT. Getting involved with anyone either above or below you in the chain of command can have serious repercussions. Relationships between unequal work partners rarely succeed. If it doesn't work out, you may feel hurt and you'll still have to see this person every day. Your work, and perhaps your career, may suffer.

Before you become involved think about why your superior is interested in you. Perhaps you seem attractive because of your

breathless adoration of this particular surgeon's technical skills. What will happen when you become the better surgeon? Or perhaps your eagerness to please and immediate response to orders seems attractive. How well will you be regarded when you are an established, confident surgeon who makes her own decisions, and who doesn't have time for hopping to the commands of others? Other possible scenarios could include:

1. You are under command and must do as you are told if you want to finish the program. (Sexual harassment at its simplest.)
2. You are there, and available. (Sexual laziness.)
3. The surgeon's present spouse is boring, or this person has never slept with a surgeon before, or perhaps sleeps with every woman available, or just wants a new experience to get the old juices flowing again. (Sexual adventuring.)

And why are you interested in them? Perhaps you know your evaluation is poor, so you decide to influence your chief by offering sexual favors (sexual opportunism). This strategy is doomed to failure. Even if you survive residency, your loss of self-respect may ruin your self-confidence. You will forever doubt your real abilities as a surgeon.

If you do decide to date another resident, or even an attending, keep your in-hospital dealings with each other strictly professional. You would not be the first (or last) woman resident to do so. Do be discreet, avoid rotations together, and keep your personal relationship out of hospital view. Realize that the AMA considers even consensual amorous relationships between those in a position of responsibility and their students or trainees to be unethical. It is possible that you and your chief resident (or other coworker) may be exceptions, that the two of you are such extraordinary individuals that concerns of unequal status and vulnerability and perceived inferiority and the power struggle, do not apply to you. Yes, and the sun may not come up tomorrow either.

You do not need to give up sex, love, caring, and relationships for the duration of your residency. Just look for someone outside the Department of Surgery. This may seem hopeless at first, but there are appealing partners who are not surgeons. Join a health club or a sports team. Meet people in other departments. Keep up on the activities that you enjoyed before you became a surgery resident, be it music, bee-keeping, or wind-surfing! And do keep

looking-you too need and deserve personal attention and affection. You are a wonderful person who is doing something marvelous and exciting with her life. There are many human beings out there who you will enjoy, and who will benefit from your company.

GETTING THROUGH A RESIDENCY IS JUST THAT, AND ANYTHING THAT DIVERTS ATTENTION FROM YOUR EMERGING SKILLS IS UNDESIRABLE.

Remember why you are at the hospital - to learn surgery. A surgical residency is one of the most grueling, stressful, and exacting endeavors that you can undertake. Your mind must be clear. You must be able to remember details about your patients and about didactic material. Emotional turmoil and a divided, distracted mind and heart can sabotage all your efforts. Certainly romantic involvement with other hospital employees, residents, or attendings can bring excitement, but they can also burden your mind and compromise your concentration. Your priorities must be clear. Consider very carefully any such involvement.

Also remember that you are not there to "enlighten, teach, or broaden perspectives." Remember the old saying, "Never try to teach a pig to sing. You waste your time and you annoy the pig." The objective is to get what you want from the hospital, the Chief of Surgery, and attending staff about learning the craft of surgery. Avoid having an attending's biases and judgments of your personal life limit your career. It is best to be perceived as "normal"...whatever that means. Change will come as others see you acting in an exemplary manner.

CHAPTER 5

Taking Care of Yourself

"We're accountable not only for our own lives but for the lives of many others whom we don't control. The subtle message to today's woman is: You'll do everything June Cleaver did and you'll be a top-notch professional. This can make you terminally tired, if not endlessly crabby."

--Pat Heim, Ph.D.

Surgery residency is one of the most physically demanding career choices you can make. Keep some basic principles in mind, and realize that you are human and will require some ongoing maintenance to survive.

BASICS OF SELF-PRESERVATION

First off, it helps to realize that you will not be alone in feeling tired and discouraged at times, though most of your colleagues will probably not admit it. Also realize that a good share of your exhaustion may be self-inflicted. Many women feel that they have to work harder, study harder, and spend more time being sympathetic with patients than their male counterparts. After all, you don't want to be a wimp, do you? And those rare quiet times during the day are ideal for reading and learning about surgery, even if you are going to be up all night, right? Wrong.

SLEEP is a top priority. First, realize that you are just as smart as the guys, or you would not have been accepted into the program. Second, realize that if you don't start taking care of yourself, you are going to wind up sick and out of commission, or at least chronically depressed. Third, if you are constantly sleep-deprived, you are going to be irritable and impatient and have a much harder time learning because you will not be able to concentrate. It doesn't take long before you will be labeled a witch rather than being considered tough. Certainly you must fulfill your work responsibilities, but don't add another huge burden on yourself by always trying to prove something.

Some of your time is being wasted with others in idle chitchat and you may feel obligated to be sociable when you have other things to do. It is not necessary to be rude, but cut off those time-consuming conversations as soon as possible. Try keeping a written log for a week, recording what you are doing every 15 minutes or so. (While this may seem time-consuming in itself, you will very quickly realize how much time you are wasting on no-benefit activities. When you have to write down that you just spent the last half hour over a cup of coffee while waiting to get a case started, rather than making those "urgent" phone calls, or dictating the last op report, you will start saving time including that week of keeping a log.) Go back and see if that time is being spent on your real priorities in life, or if you are allowing others to spend your time for you.

You don't know what your priorities in life are? Welcome to the club. Sit down and write out a list of your own personal and professional goals in life. Then try to list some specific steps you must take to accomplish each goal. You will be more productive and self-confident if you identify your goals. Then structure your time so that most of it is spent on your priorities, not someone else's. For example, if you finish a case and have nothing pending, don't feel obligated to hang out in the surgeon's lounge listening to the latest dirty joke, how the last ski trip went, or who is chasing after whom. Go take a nap! Or spend an hour in the library. The value of locker room "shop talk" is highly overrated in most instances. If you want some inside tips from the experts about a particularly difficult case, ask for them. Don't waste your time waiting for pearls and tidbits to drop spontaneously. (If you feel like your whole life is out of control, and want more complete descriptions of time management and learning to set priorities, read "Time Power" by Charles R. Hobbs, or "7 Habits of Highly Effective People", by Steven Covey.)

Second consideration, **FOOD**. Eating right during residency is admittedly difficult, but not impossible. Don't be jealous of the married folks whose spouses bring in a hot dinner, or at least pack food and treats for them. Bring your own. (You may need to hide it from the others, and DON'T feel obligated to feed every other hungry resident around. Some guys will eat everything in sight. Others will try to make you feel guilty for not sharing. Others will try to appeal to your maternal instincts. Ignore them. That food is for YOU. (You don't see too many married guys sharing theirs, do you?) Bring whatever you like, but always have on hand a stash of crackers, nuts, dried fruits, cheese spread, Instant Breakfast, even

candy bars and other nonperishables. Then you won't be forced to spend the price at the vending machines. (Even those are better than not eating at all.) Some residents have survived on Ensure or Sustacal from the kitchens on the ward. With the days of cost containment, though, taking these may now be considered stealing.

You will be more pleasant and work more efficiently if you have some fuel in your system. And coffee does NOT count. If you are lucky, you may have a microwave and refrigerator in your call room or residents' lounge. Take advantage of them: the frozen and microwave dinners these days are often more palatable than hospital cafeteria food, and usually less greasy. Try to drink plenty of water, and get plenty of bulk in your diet (fresh fruit, beans, whole grain breads, bran, etc. Metamucil even makes fiber cookies, and there are cereals with psyllium in them as well). Poor eating habits often lead to poor bowel habits, and call is bad enough without having to deal with hemorrhoids as well. The worst combination is no sleep, no food, and a cup of coffee on an empty stomach before you scrub in the morning. Even if that doesn't give you gastritis, it will make your hands shake enough to scare your attending. And a quick glass of OJ alone may give you a "sugar high" only to be followed by a hypoglycemic syncopal episode. (Remember the Somogyi effect?)

Use common sense when choosing your **CLOTHING**. You will want to look clean and professional at all times, but be sure you choose comfortable, non-restricting clothing. In general, you will find it to your advantage to wear clothing that is easy to get in and out of, that will wash easily. You are not going to have a lot of time to go back and forth to the cleaners, though some folks find that taking ALL their clothing to a laundry is worth the expense rather than using their valuable time off doing it themselves. Support pantyhose and/or knee high medium weight support stockings (such as TED hose or Jobst stockings) can do wonders for avoiding leg aches and varicose veins. Find flat, well-fitting shoes or sneakers, preferably that will allow some air circulation.

Since you may be wearing them long hours at a time, you may be prone to "athlete's foot" if you are wearing the same sneakers all the time. They are also hard to keep clean. Bloody shoes not only look disgusting to patients, they are actually a health hazard. Many surgeons find PLOGS by Medimex a good choice. They are an anti-static, rubber-like material, which can be machine-washed or gas sterilized if you are really a mess. They provide arch support,

ventilation, and are long lasting. They can be ordered on line at www.plogs.com or www.clogsonline.com for about \$65. Some programs may not allow you to wear them outside the OR. Once you ruin a brand new pair of shoes during an emergency, you will find this a good investment. Watch out for plantar fasciitis in clogs with higher heels, though.

One other hint for feet and legs: elevate them whenever you get a chance! Don't forget your back, either. Surgeons have more than the average number of back operations due to hours of long standing combined with poor posture. Learn to raise the OR table so that you don't lean over to work. If you are quite tall, make your assistants use lifts to stand on-don't sacrifice your back for their convenience.

Finally, **EXERCISE** and **FUN** make all the hard work tolerable. Any form of exercise will do, so long as you enjoy it. Couch potatoes are usually depressed. Even clinically depressed people improve with exercise - a 30-minute daily walk is as good as most antidepressants. Take the stairs whenever you have the chance. Do a few sit-ups, or find some minimal space exercises you can do in your call room. Make a list of 50 things to do for fun. If you are working too hard, you will probably have trouble coming up with that many. Think back to your childhood if you need to, but at least lighten up a bit! A sense of humor goes a long way toward surviving residency, in fact it is essential. Promise yourself the time to do at least one of those 50 things every single day. Then go for two. Short breaks are real energizers. Or learn to meditate or do guided imagery just to clear your head and get some perspective back in your life. (See suggestions under References.)

Most of all realize that **YOU** are important and unique, and you must take care of yourself as well as all those patients. Best of luck!!!

Also, a few of the more humorous hints:

Eat when you can, sleep when you can, and pee when you can.

A shower is worth three hours sleep.

If there's no time to sleep, eat!

Above all, conserve ATP.

Despite all these words of encouragement, there are those who start surgical residency only to discover that this is not what they

want to do for the rest of their life. It's important to ensure that you don't make a decision to quit residency on the basis of fatigue or in the throws of emotion. Many of us have considered quitting at one moment or the next. If you're ready to resign, start with a discussion with a surgeon you feel you can trust. Explain your reasoning and see if they have any helpful advice. Discuss your thoughts with family and friends who have seen you through medical school and at least the start of residency. They can often help you regain your perspective. If you still are ready to quit, ask your program director for a leave of absence. Clear your mind of fatigue and then begin writing down why you entered surgery, and why you think you should leave.

Think carefully about what life as a surgeon would be like outside of residency. If you want, contact the AWS and we can put you in contact with female surgeons who may be of assistance. Sometimes you have to suffer a bit for the rewards of the future. But if you don't see yourself happy as a surgeon and don't feel you will regret leaving, it's ok to make the decision that's right for you. Ideally, you will give your program director some time to identify a resident to take your place. Don't burn bridges behind you if you can avoid it. A significant number of residents quit surgery, only to ask to come back in a few weeks when their head clears.



LOCKER LIST

Listed below are some items you may wish to keep stocked in your locker. Keep a notepad there so that you can create a shopping list as you need to replace items consumed.

- Spare underwear
- Spare stockings
- Knee high TEDs or Jobst stockings
- Tampons, sanitary napkins, etc.
- T-shirt or undershirt to wear under scrubs if the OR gets cold, or your call room is cold at night
- Spare shoes and socks in case of unexpected messes, or just to let your others "breathe"; also gives your feet a change of pace, and your shoes will smell better and last longer.
- Toothbrush & toothpaste, mouthwash, floss, etc.
- Shampoo, conditioner, favorite shower soap
- Shower cap
- Baby oil or lotions for dry hands/skin (Hospital air tends to be very drying, and so will frequent scrubbing. You can avoid many skin rashes by keeping your skin adequately moisturized.
- Nail clippers/file/emery board, etc.
- Razor
- Portable tape player, favorite tapes
- Address book for family and friends
- Sleep bra
- Comb, brush, hair bands or ponytail holders, barrettes, etc.
- Food items that won't spoil, such as crackers, dried fruits, microwaveable popcorn, granola bars, canned tuna, Vienna sausages, deviled ham, ramen noodles, Cup-a-Soup, etc.

PHYSIOLOGY ISSUES

PERSONAL ILLNESS

This is a difficult issue, since you know that if you call in sick, it will mean more work for your friends and colleagues. Most coughs and colds can be dealt with without requiring days off. You don't want people thinking you are a "wimp" or sickly. Unfortunately, this attitude has resulted in residents coming in and plugging themselves into IVs to replace fluids from hangovers, diarrhea, vomiting, and all sorts of other afflictions. This is probably not a great idea, but it may save some hassles for the others, unless they get your contagion. If you continue dealing with patients while ill, wash your hands very frequently and consider wearing a mask to prevent dissemination. If you think you are going to pass out or throw up in the operating room, tell the surgeon you need to step away and then move away from the operating field. It's better to sit down than to fall face first into the sterile field.

"The doctor that tries to treat herself has a fool for a doctor and a fool for a patient."

Don't try to treat yourself. General surgeons are rarely experienced primary care docs. Ideally, you should find a primary care physician who can care for you objectively. Get to know that doctor so you can call on in an emergency and they will understand you and your situation. Your physician may also be the one to safely "take the blame" for you being away from clinical duties. This is also important in case some illness strikes that you really don't want the whole world to know about. The chauvinists will assume that any illness you have is really a pregnancy, so be prepared for some ridiculous remarks upon return from an absence from illness.

OCCUPATIONAL HAZARDS

Some programs have such a high prevalence of blood born pathogens in their emergency populations that exposure to these viruses is highly likely at some time during your residency. Prevention is the key and much of it is under your direct control. The time to start good habits is NOW. Learn the CDC "Universal Precautions" and follow them. NEVER touch body fluids unless wearing gloves, wear eye shields in the OR, and learn to operate precisely and handle sharps safely. Immediately wash your hands with soap after ANY inadvertent contact with wounds, body fluids,

or dressings. Double glove. Always be aware of any sharps on the field (consider saying "sharp" anytime you are passing one across the field so those nearby are aware). Any exposure to even potentially contaminated blood or body fluids needs to be reported and appropriate measures taken. If you don't report these injuries, you may not be eligible for medical care and compensation from your employer should you develop an infection.

If you are not already immunized against Hepatitis B, DO SO IMMEDIATELY. **Hepatitis B and C are much more prevalent and much more transmissible than AIDS.** Your employer is obligated by law to provide you with the immunization at their expense. (Be sure you get the recombinant vaccine, not a pooled vaccine.) Learn about AZT before an AIDS exposure so that you can make an educated decision about taking it if the issue arises. Keep your tetanus shots up to date. Tuberculosis is a real concern. Wear masks that filter very fine particles when exposed to these patients and change the mask when it gets wet. Have your ppd checked annually (many hospitals require it) and if positive, be treated appropriately.

MENSES

You will get little or no sympathy about problems related to your menstrual cycle. If you mention it or complain to men, you are asking for trouble. Men, for unknown reasons, prefer not to know that menstruation exists. (Men don't have periods and some think this is one reason women should not be surgeons). If you are in a bitchy mood, expect to be accused of "being on the rag". (Never mind the fact you haven't slept in the previous 36 hours.) Keep a stash of sanitary products in your locker. Stress and long hours may disrupt your usual menstrual cycle. If you are scrubbing a very long case, don't be afraid to excuse yourself for a "potty break". On long cases, most everyone takes a bladder break anyway. Just don't pick a critical moment to scrub out. If you have problems with bloating, cramping, PMS, irritability, etc., don't just try to "suffer through", because so will everyone else.

Hopefully, you have already found a solution, but if not, here are some suggestions:

- Ibuprofen - maximum 800 mg q8h. Most women do well with much lower doses. (This can be ulcerogenic, so take the lowest effective dose, and take with antacids if on an empty stomach.)
- Exercise

- Avoid fats and salty foods
- Evening Primrose Oil 1000mg 3x/day, every day of the month. (These contain a high concentration of essential fatty acids needed for production of certain prostaglandins (also good for breast cysts and tenderness).

BIRTH CONTROL

Married or single, an unplanned pregnancy during residency can create difficulties. The stresses of residency will often increase menstrual irregularities that compound the problem. Why state the obvious? Because.... Recent statistics indicate that HALF of all pregnancies in women surgical residents are unplanned. Birth control pills don't work if you don't take them, diaphragms don't work if you don't use them (nor do condoms), and abstinence doesn't work if you don't practice it! The best options include (no moralizing intended):

- Complete abstinence (clearly the safest and most effective)
- Norplant - gives continuous progesterone. Only 1% failure rate, but also can cause menstrual irregularities, headaches and weight gain, and involves a minor surgical procedure.
- An IUD (great with a single partner, but more problems with pelvic infections if you don't have a mutually monogamous relationship.)
- A diaphragm with spermicide or condom - higher failure rate and may limit spontaneity, but a good option for many
- Oral contraceptives if taken religiously. (One side benefit is that your periods will be predictable, and often with less flow.) During some busy surgical rotations, you may forget to take nearly half your BCPs if you are not careful. Keep extras in the call room just in case you leave your pack at home in the early morning rush.

PREGNANCY

As more women enter the field of surgery, the instance of a pregnant resident is increasing in frequency. Despite this, the vast majority of residencies have no mechanisms in place to deal with pregnancy, let alone deal with it in a non-judgmental, minimally obstructive manner. Regardless of whether the pregnancy was planned or whether pregnancy termination is a viable option, pregnancy is by and large considered an elective condition. People draw a distinction between the election of pregnancy during residency and other instances requiring time off, such as the onset of an illness, which is never desired and cannot be prevented. Consequently, the pregnant resident may be the recipient of unwelcome comments and possibly open hostility. Both faculty and resident peers can resent the additional burden that other residents must take on as the pregnant woman delivers and requires some maternity leave. AWS members have had successful pregnancies at all levels of training, but the majority feels that life is much less stressful if one waits until after residency if at all possible. The biggest problem is that both surgery and motherhood tend to be all-consuming at times. The anger and ambivalence that can arise are not conducive to doing a good job at either.

If a woman chooses to become pregnant during her residency, it is best that she does so in a supportive environment. Some women have found it helpful to discuss policies and schedules even before getting pregnant. Whenever possible, time the pregnancy during a year of lighter rotations so that the colleague call schedule will be less affected during the woman's absence. Internship is generally accepted to be the worst time to be pregnant, but beyond that the ideal timing will vary with the residency. Becoming pregnant just before the start of internship may be an even more dangerous time to become pregnant. If you are unable to begin residency due to your condition, your spot may not be held for you. Many residents have found that having a child while out of clinical rotations and in research years creates less stress for both the mom and her colleagues.

Let your resident coordinator, or department chair, know as soon as possible that you are pregnant. For many women, this is around 12 weeks, when the risk of miscarriage drops significantly. Planning and communication with the program director can go a long way to avoid many problems. Early warning allows the program director to make alternative plans for the residency, as needed. In addition, fellow residents can make plans for the

postpartum leave of the woman resident. Your chair, as well as the rest of the staff, may have never experienced or even considered the possibility of a pregnant resident, and may not know how to deal with you. Try to understand their predicament. It is wonderful that you are pregnant, but that is not why you were hired. You have just added one more concern to an already overburdened agenda. Be specific in communicating your needs to them. It is not necessary for you to apologize to them. Stand your ground that this is a done deal and the next step is to formulate a plan for working through your condition. . Approach your discussion in a cooperative and realistic manner, rather than being demanding. Do not convey a sense of entitlement or you are apt to undermine support from superiors as well as colleagues.

There are several ways in which a woman can lessen the resentment experienced during pregnancy and postpartum. If your condition allows it, plan to work a full schedule until you go into labor, as long as your obstetrician agrees. Many women surgical residents, completely healthy up to the point of delivery, have continued to work, taking call and scrubbing in on cases, until they began to labor. Program directors can often alter rotation schedules so that less strenuous rotations are taken at the end. Try to take catnaps, drink plenty of fluids, eat small and frequent meals, and get your feet elevated as often as practical. A few programs may allow time off prior to delivery, but you may find yourself bored, especially if you go postdates. It also prolongs the time your co-workers cover for you. In other women, the sheer physical stress and exhaustion may preclude you from competently caring for your patients at term.

See your OB regularly and follow the prescribed advice. If problems develop, don't jeopardize your own health and that of your child by trying to play Iron Woman. Notify the appropriate people of the problem, and adjust your schedule as needed. Exhaustion and poor eating habits can have serious adverse effects on a pregnant woman and her fetus, so your rotations should be planned accordingly. If you avoid using your condition to shirk work duties, you will most likely find that the other residents will help out to let you get off your feet from time to time. If a resident develops a complication of pregnancy then they have a true illness and the illness should be treated as any other illness. It is unwelcome, undesired, and unplanned, even if the pregnancy was planned.

You undoubtedly will have to put up with jokes and comments from those around you. People will comment on your weight gain, try to guess the gender of your unborn child, ask about cervical

change, and even touch your belly without asking permission. For the most part, it is just part of being pregnant and has nothing to do with you personally or as a surgeon. Try not to make a big deal out of the situation unless it's abusive - most people mean no harm.

Inform others as soon as you are comfortable as it allows you to be more up front about protecting your unborn from potentially harmful environments. Check with the Environmental Safety Department of the hospital to identify these potential risks, determine how relevant they are to her particular job responsibilities, and make reasonable accommodations to minimize them. Most hospitals have a policy about the types of infectious diseases or environmental hazards, such as radiation, to which a pregnant woman can be exposed. The American Board of Radiology allows pregnant residents and techs to work around X-rays and fluoroscopy with full shielding, until the seventh month of pregnancy. Talk with your chair and the radiation safety officer of your hospital and come to some compromise about your exposure during cases that require x-rays. It is hard enough to be scrubbed while pregnant without carrying around the extra weight of lead shielding, so you may have to give up doing Hickman catheters or intra-operative fluoro-cholangiograms. Studies to date demonstrate no apparent increased risk from exposure to the low-level anesthetic gases found in most ORs. (Higher levels are found at induction with mask anesthetics. Consider waiting outside the room at this time with some anesthetic gases.) Similarly, residents do NOT appear to have a higher risk of miscarriage. There is, however, a higher risk of pre-term labor (but not delivery) and pre-eclampsia. Talk to your personal doctor about potential exposures, and use your best judgment in each circumstance.

Check with your hospital's benefits office as to what part of your care is covered. You may find that your care is only covered if you deliver in your own hospital or if you use the staff doctors. Professional courtesy might be extended to you by your doctors to cover fees not paid by insurance, but don't count on it. Hospitals almost never waive unpaid bills if the resident does not work there. Learn the facts so that you don't find yourself with an unpleasant financial surprise.

Maternity clothes are now available in more professional looking styles. Maternity scrubs, as such, are not available but there are several scrub shirts on the market large enough and with high collars to accommodate. Do not expect the operating room or your department to pay for these any more than they would for other maternity clothes.

MATERNITY LEAVE

In January of 1993 the Federal government enacted legislation (The Family Leave Act) which provides for up to twelve weeks of unpaid leave to care for a new child (by birth or adoption). Previously, residents have been legally considered students by the national labor relations board (NLRB) and this not subject to this legislation. That changed with a NLRB ruling in 1999 that recognized residents as employees with the right to unionize. The impact of this change remains uncertain, but it may mean the Family Leave Act becomes applicable to residents. In the realm of surgery, no nationwide rules exist concerning the length of leave or even whether a residency position must be held open if you have a child. In some places, the overall hospital policy may dictate the policies. Most departments understand if an extended maternity leave is required, but be aware that the American Board of Surgery limits the amount of time that you can be away from your program for ANY REASON (and this includes maternity leave). It is not gender discrimination to require you to repeat a year if you have been out for several months while having a child. Currently the formal policy is that you can not be absent from your residency for more than 8 weeks in the last 24 months of your program, and this INCLUDES vacation time. Fortunately, program directors have some flexibility with this policy and many are more accommodating.

To the extent that the woman and her child are both healthy after the delivery, it is helpful to minimize the maternity leave as much as possible. Assuming an uncomplicated pregnancy and vaginal delivery and that mother and child are in good health, it is probably best to plan for six weeks of residency leave (with a minimum of four if the length of leave is a real problem). Cesarean section delivery will probably require a longer maternity leave so that the woman is able to return to full activity, unless a minimally strenuous rotation is available. The emotional liability which may accompany the exhaustion of new parenthood coupled with the pronounced hormonal swings that occur in the postpartum period make the first several weeks after delivery rather difficult. If the woman returns too soon, she not only is in poor physical shape for the demands of a surgical residency, but she is in a poor emotional state for these rigors.

A premature return to the residency program will be extremely difficult for everyone. You will may have to give up or adjust your

vacation time to account for this time off but don't short yourself. Both you and your new child need time to recover and get used to each other.

There is a mistaken opinion that staying home longer with the child will make the separation easier. This is untrue. If anything, the longer the maternity leave is, the harder it is for the woman to leave her child and return to her residency program. In addition, longer maternity leaves engender more resentment among fellow residents. During your first six weeks back at work, work full time if you are able. If you have planned your rotations with a pregnancy in mind, you may choose to be on a service that has a lighter call schedule. If you or your child are having medical difficulties, you are better off taking a longer leave than trying to manage both these issues and work concomitantly, even if that means having to repeat a year of training. You need to be totally committed to residency responsibilities when you are at the hospital, and not trying to juggle your own patients' needs with those of your child's or your own health problems. That is a hazardous situation for all concerned.

Working with your program director and your resident colleagues for the contingency of your maternity leave is helpful and demonstrates your cooperative spirit. Remember that a residency program should be a team effort. The residents who complete surgical training with you should be your friends for life. Treat them well and they should treat you well. If you approach them with mutual respect, this will be the case. There may still be snide comments made to you regarding the "vacation" you will be taking during maternity leave. Quite assuredly, this is no vacation. (Taking care of a newborn while recovering from the delivery is much like taking call every night while ill.) This is the time to call in any "markers" you have. Remind them that you have pitched in to help when they had excessive loads. If you took over the function of a coworker or the call of another resident for any protracted period of time during someone else's illness, be sure to refer to this. Also, demonstrate that you are willing to continue to work up to the time that you are unable to do so. This should help lessen any animosity that may arise.

PARENTHOOD

Quality childcare is crucial to your success in residency. It is never easy to leave your child at home, especially if the child care arrangements are with a relative stranger. Leaving a newborn child, especially a firstborn, is fraught with fear and anxiety. There is much guilt and concern associated with leaving a newborn child, and sometimes-older children, with child care providers, no matter how good they may be. Select the best childcare you can possibly find and afford, even if the cost of care is a financial strain. The better your child care arrangements and the better your peace of mind, the better you will perform as a resident away from your child. Consider all options seriously and carefully.

Interview each person more than once, and check all references very carefully. The more ground work put into this effort, the more comfortable you will feel with your choice, and the less apt you are to be looking for someone else shortly after hiring. You may also have to wrestle with finding emergent child-care if you do not have someone living in with you, or with feeling guilty about leaving your ill child with a sitter. Try to arrange back up plans in advance for times when your regular caregiver is unavailable due to illness or vacation, or your child is unable to attend day care due to illness. If other resident's in your program have children, consult them for recommended child care arrangements and see if you can develop a working agreement to have your caregivers "cross-cover" in case of emergencies.

It's hard not to feel guilty for not being there for every step of your child's development. Unfortunately, you might not be there for the very first step or word, or even that important soccer game. But know that you love your child just the same, and you will be there when you can. Children are adaptive and providing a loving caregiver for when you are away is evidence of your love. You don't have to give up all your personal and professional aspirations when you become a mother. Most women who are surgeons wouldn't be happy in the long run as a stay-at-home mother. And an unhappy mom at home is probably worse than a happy surgeon-mom who just can't be there for everything.

MAINTAINING YOUR MARRIAGE OR OTHER CLOSE RELATIONSHIPS

Surgical residency can be an extraordinarily time and energy consuming endeavor. Your spouse or significant others may become resentful of this and make you feel guilty for not paying them enough attention. You have very little control over your work schedule during residency, but there are a number of strategies and suggestions that can help. It is possible to be a good surgeon and have outside interests, but don't let your wish to accommodate everyone tear you apart. Recognize that what you are doing is important, that you have a right to pursue this career, and that you have emotional as well as intellectual needs. The support that loved ones can give during residency can make it easier, but you must not take it for granted. The one behavior a relationship will not tolerate is being ignored. Use those ideas below that suit you, and create others of your own.

1. **CALL.** You spend many hours on the phone arranging tests for your patients. Periodically, take a minute or two just to telephone your special someone and say hello, I miss you, I was just thinking of you, etc. Tell the latest joke, or talk about your latest greatest case (protecting patient confidentiality, of course). See how the other is doing, or ask your partner to help you with something, or set up your next activity together. You will be in trouble if you spend much time on personal calls, but it only takes a few seconds to let people know that they are special and important to you.
2. **LEAVE NOTES.** Some people will find (especially if their partner is also a resident) that they may not see each other for days, let alone sit down and talk together. Leave short notes of love and greeting, maybe even a poem or book you'd like to share. E-mail has made this infinitely easier (try www.bluemountain.com to send an electronic card). Communicate somehow, that is key.
3. **HIRE HELP.** If your mother was a perfect housekeeper, don't expect to do a repeat performance. For many women, housekeeping IS their career. They are good at it because they have the time to devote to it. But clean laundry, dustless furniture, and gourmet meals are not essential to a lasting relationship. Hire out as much of the work as you can

afford, especially if you dislike it. Why spend your free time at the Laundromat, or waiting on your washing machine when you could be out having fun? Many laundries will even pick up and deliver. There are housekeepers, lawn services, etc.

4. **SHARE TASKS.** If you cannot find or cannot afford someone to do the drudgework, make a list of tasks and split them up. The jobs that neither of you like to do should be alternated or done together. Even going to the grocery store can become fun if you shop together and find out what your food likes and dislikes are. Or if you are in a hurry, split up the list and have a race, and the winner helps the loser finish up. Be creative.
5. **READJUST YOUR PRIORITIES.** Quiet time together, with full attention to one another, is more important than making every concert in a series, or every game for which you just bought season tickets. If you have children, make sure you and your spouse go out at least once a month, every two weeks if possible, with no kids and no beepers. If you value this relationship, it deserves your time and attention. Your priorities are best defined by what you do, not what you say. If housekeeping is taking up more time than your spouse, what is the message? Utilize the Five T's: Trust, Time, Talk, Touch, Teasing. Laughter is a great way to relieve tension and relax together.
6. **PLAN TOGETHER.** This includes goal setting together, both short and long term. This is an ongoing process that will have to be modified and revised continuously. It may be that your career takes precedence during residency, but your partner gets preference on where your first job will be.
7. **SHARE MEALS TOGETHER.** Avoid eating on the run, especially when you are not on call. Mealtime is a great time to catch up on each other's lives. If you both enjoy cooking, stay home and cook and clean up together. If not, go out just the two of you. Hold hands, be romantic, sit right next to each other or straight across and look into each other's eyes. Think back to the early days of your relationship and try to recreate that excitement and sense of expectation.
8. **MEET AT THE HOSPITAL.** When you are on call and things are slow, arrange for your partner to bring in dinner from home or a fast food place. Or simply meet in the hospital cafeteria. The hospital is not off-limits, and even 15-20

minutes together is better than not seeing each other at all. You can even have your spouse bring the kids along so that they will remember who you are! Just be sure all parties understand that if you get called away, it's nothing personal.

9. **DON'T MESS AROUND.** There may be opportunities and temptations when you are on call that would have never occurred in other circumstances. But in the highly charged environment of trauma, emergencies, fatigue, and stress, some people find themselves seeking attention in the wrong places. Your own ego may need some bolstering, or you may just get to feel lonely in the competitive intensity of your work environment. Don't succumb. You already have enough complexity in your life.

SPIRITUAL ASPECTS AND PSYCHOLOGICAL ISSUES

Surgery presents great challenges and rewards, but you will also be faced with extremely distressing situations: death, pain, suffering, and deformity. It is important to spend some planned time each week dealing with the psychological stresses of your profession. You must learn that there is only so much you can do and not blame yourself if there is a bad outcome. Patients and families will look to you for emotional support, and you yourself may need some too. Seek the advice and wisdom of an experienced surgeon if you have a particularly distressing case that has you down. If you are a religious person, make the effort to get to church or synagogue. Go to the hospital chapel for a few moments of prayer and silent contemplation. If you are not into organized religion, at least take the time to examine your feelings when a favorite patient goes bad. Some people find that meditation is extremely useful for calming themselves and learning acceptance of what must be.

Find an emotional support system for yourself outside the residency if possible. While outsiders cannot understand all the details, they can be very comforting and helpful. Don't dwell on the disasters, but don't ignore your feelings either. Life goes on, and so must you. Concentrate on what you are doing for people,

not what you are doing to them. To maintain your equilibrium and balance, you must pay attention to mind, body *and* spirit.

Control of emotion is notoriously difficult for some surgeons. In women more so than men, their emotions sometimes pour forth in the form of tears. Those of us that cry when upset generally are angry and embarrassed that we do, and wish with all our might that we didn't. Others (usually non-criers and men) advise us "DON'T CRY," which would be the equivalent of saying don't laugh to someone who is ticklish and being tickled. Easy to say, hard to do. For criers, the only sound advice is to try not to let them SEE you cry. Take slow deep breaths, think of something other than what just happened and get thee to the nearest bathroom (or stairwell, or other hidden place). If you sense a cry coming on, say something about needing to get a drink of water and move away. If you are a frequent crier, consider keeping tissues and a compact of face powder in your lab coat for quick touch-ups. As much as possible, avoid thinking about criticisms until you're out of the hospital and can cry without notice. And most importantly, never use crying for manipulation.

There is a growing recognition that the mind has a tremendous impact on how well patients recover from an illness or surgery. Their expectations of rapid recovery can be just as strong as someone's certainty that they are never going to get well. You may notice that patients with confident surgeons seem to do better than patients of fretful worriers. (One study even showed that bowel sounds and appetite returned more rapidly if the patient was told to expect this!) You will learn to recognize when a patient has lost his or her will to live. Sometimes you can restore that, particularly if they have misunderstood their prognosis, sometimes not. But you cannot ignore this loss of will and expect them to survive. New investigations into the "mind-body" connection are becoming more scientific, but realize that traditional medicine (and particularly surgery) is not very open to these ideas. Prayer is not likely to replace penicillin, but it certainly won't hurt. You may even find that dealing with your patients as "whole people" not just as a diagnosis is more rewarding as well. The art of surgery blends technical skill, seasoned judgment, and honest compassion. Master all three and you will always have plenty of patients. (The References section offers some suggested readings to get you started if this interests you.)

FINANCIAL PLANNING

Although you may not think you are earning a large salary, you are now in the middle class. Therefore, you will be contacted by life insurance salespeople, financial planners, stock brokers, and become a target of a lot of "junk mail." But, you will also be eligible for some real opportunities of which you should be aware and able to evaluate intelligently.

Basics: You have a salary and expenses, so the first priority is a budget. This does not have to be a big deal. Develop an understanding of how much you are spending each month, how much you earn, and what should be left over for fun and investment at the end of a month. This is good training for when you have to do the same analysis in practice or budget as your department expenses in a staff position.

Salary: You should expect to be paid about \$30,000 for the first year of your residency and this should increase by a few thousand each year as you progress. Your salary is typically non-negotiable since hospitals and program heads meet to discuss keeping salaries uniform and you are not in a good bargaining position. You will probably find that your "big" salary doesn't go nearly as far as you expected, especially after all the various taxes are taken out. What really counts is take home pay, not the gross salary. You may also have noted that the more desirable the residency position, the lower the salary. Most of your benefit is in learning from the attending physicians who do take a real liability when permitting you to practice on their patients.

Benefits: This is where you will find the biggest difference in compensation between programs. Some programs provide subsidized housing close to the hospital, others leave you to find and finance your own housing. If housing is provided by the hospital, learn the rules early so that you can get the best arrangement for your personal situation. Some hospitals have "cafeteria plans" that allow you to choose from a variety of benefits, so you need to check carefully to see which ones are most appropriate for you. Other possible benefits may include meal service, laundry, workout facilities, etc. Day care may be an important consideration if you have children, and if it is not provided, check to see if there is some sort of hospital discount available. Also, look into Child Dependent Accounts that allow you

to put away money for childcare pre-tax. At the very outset you should identify all the available resources in your program so that you can be as economical as possible.

Insurance: Several types of insurance coverage will be provided for you as a resident. You may or may not be expected to pay a share of the costs. Insurance programs vary considerably, so DO take the time to read the fine print on these, and seek advice if you do not understand it.

- **Medical Insurance.** No more counting on professional courtesy in these days of cost containment. Make sure that your hospital has a comprehensive medical program for you, though you may have to pay a part of this coverage's costs. (If you are not familiar with current hospital charges, take ten minutes and visit your hospital's billing office and ask to see an itemized account on a recent case with which you are familiar. You will be astounded.) Health insurance is NOT optional!! One car accident could wipe you out for a long time. Don't take that chance. Dental and vision insurance may be more of an option than a necessity, depending on your health insurance. If major oral problems (such as abscesses requiring surgery) and eye injuries are covered under your health insurance, you may end up paying less for that annual eye exam and pair of glasses than you would by paying the insurance.
- **Malpractice.** The hospital will pay all the cost, but you should be familiar with the coverage limits and whether or not coverage continues after residency for cases you were involved with during residency. You do not want to find yourself named in a lawsuit two years after leaving your training, only to find out that the hospital's malpractice policy will not cover you if you are no longer an employee there. If you do not get satisfactory answers, talk with the insurance carrier yourself. They are usually very helpful, and can even give you pointers on how to avoid getting sued.
- **Life Insurance.** The hospital may provide some basic benefits, though you may be asked to pay some part. The basic policy offered by your program should be sufficient if you are single and have no dependents to worry about. If you do have a family that is counting on your income, you may wish to buy a larger policy. If the death benefit of a residency provided policy exceeds \$50,000 you may have to

pay income taxes on the "excess" premium costs. Tax laws are changing rapidly, and there is a possibility that all benefits may end up being taxed. There are two types of individual policies - whole life and term. Term is usually cheaper, has a fixed annual cost for a certain number of years (usually 10 years), but ends when you stop paying the premiums. Whole life policies are more expensive, but the payments are invested so the interest on your investment will begin to pay your annual premium at some point. Whole life policies can also be borrowed against (with penalties) if needed. But don't mistakenly use a whole life insurance policy as an "investment" - you can get higher yields in other ways. Cheapest rates for independent policies are available through various large associations, such as the AMA and ACS. (This is one good reason to join the ACS Candidate Group.) If you are in a military residency or the child of a military officer, check with USAA, a private company with inexpensive policies and good benefits. The younger and healthier you are, the cheaper life insurance will be. Consider getting it now.

- **Disability Insurance.** Disability insurance should be considered a necessity, not a luxury, especially considering your career choice. There are two types of disability, short-term and long-term. Your hospital will provide a limited, short-term benefit if you become disabled due to accident or sickness. Most of these policies have a fairly long waiting period before you see any money, and provide benefits for only 6-12 months. Consequently, you should obtain a long-term policy to begin when your hospital policy ends. This ensures you have enough to live on should your injury or illness be prolonged or permanent. Unfortunately, you will not be able to get a lot of coverage because the company will look at your current salary level, not your potential income. Other things to look for in disability insurance are: coverage for pregnancy complications and HIV infection, the person who determines your percent disability (your own doctor or one provided by the insurance company) and whether coverage is provided for inability to work as a surgeon or inability to work at all (called "Own Occupation" coverage). Be sure to increase this coverage when you enter practice and coordinate it with your pension program.
- **Automobile Liability Insurance.** If you own a car, you must buy basic coverage as provided by your state's laws. Get the lowest cost deal from the best company you can. And, get the highest personal liability limits you can. This protects you

in case of a lawsuit. Once the other side in a suit discovers you are a surgeon, they will go after you for as much as they can. Maximum coverage is usually not that much more expensive than the basic.

- **Renters/homeowners insurance.** A basic policy with maximum liability protection is the primary reason to buy this now, unless you own a home or some very expensive personal property that you cannot afford to replace. Sometimes you can get an "Umbrella" policy that increases your maximum liability coverage by obtaining your renters and automobile insurance from the same carrier.
- **Travel insurance, credit insurance, etc.** These are a waste of money. Some credit cards include this coverage "free" as part of your annual card fee. Law limits your liability for credit fraud. And the disability insurance recommended above should obviate the need for much of the rest of this.
- **Investments/Savings:** If you have any money left over after all expenses, you may want to investigate your hospital's Internal Revenue Code Section 403(b) Tax Sheltered Annuity and/or Mutual Fund Program. This is the single best savings and investment program while you are a resident because:
(a) It allows you to save BEFORE tax dollars increasing the amount of each dollar saved by the tax not paid on that dollar. (b) It allows your money to grow while in the program without any income tax on the earning until you withdraw the money (at a future date, usually at retirement). (c) A good program will allow you to borrow money up to 50% of your account balance at low interest rates and repayments are made to yourself. (d) It is an automatic payroll deduction so you don't have to think about the program once you have signed up. (e) This program is only available to you while you are an employee of the hospital. You will have several "rollover" options to avoid paying tax and continue to have your money grow tax-sheltered until retirement. This program is far superior to IRA's or any other savings or investment program available to you at this time, so take advantage of it if you can. Put the maximum you can into the program and still meet your other expenses. If you are married to someone who does not have such an option, spend their salary and invest yours. One woman resident was able to save enough to pay the entire down payment on a house by the time she had finished training. Now that's financial planning!

- **Income Tax Returns:** Now that you are earning money, you get to pay income taxes. Estimate that nearly 30% of your income will go to pay taxes. Most of this will come out of your paycheck before you get it. The amount you have withheld depends on what you put in the "Dependents" box when you are first hired (the lower the number the dependents listed, the more money taken out). If you put a lower number in (like zero), you are likely to get a refund a tax time. This is great if you aren't good at saving money for payment April 15. However, you are essentially providing Uncle Sam with an interest free loan and denying yourself the opportunity to invest that money yourself. If your only income is your salary, and you have nothing complex about your expenses, fill out your own tax return. The simplified forms are relatively easy, and you will gain some insight into this aspect of financial planning. You will learn some of the terminology that will help you later on when you are in practice and need to hire and deal with an accountant. The local IRS office will assist you in completing your return free of charge, and they are usually better than commercial tax services such as H&R Block. You can also do your taxes on the Internet, but be sure to use a secure server when providing any personal information. DO NOT wait until the last minute to do your taxes, especially if you expect the IRS to help. Do your return in February, as soon as you receive your W-2. If you are moonlighting, you may find it beneficial for tax purposes to create a self-employed business. For this you should contact an accountant or tax lawyer.
- **Wills and Estate Planning.** A simple will is always a good idea, but not a high priority. If you die without one, the state will distribute your assets according to law, not your desires. If you have a computer, there are even inexpensive programs that can help you prepare a basic will. Do not worry about estate planning until you have an estate to plan (at least \$700,000). When you do go into practice, however, you should find a good attorney early on who can advise you about contracts, type of practice entity, etc., and help you begin your estate plan with a will.

CHAPTER 6

Directing Your Future

"Success can be attained if you care more than others think is wise, risk more than others think is safe, dream more than others think is practical, and expect more than others think is possible."

--Anonymous

Now that you are a surgical resident you need to start thinking about the many possible options for your career after residency. Some decisions need to be made during your second or third year of residency. Others can wait until later.

RESEARCH EXPERIENCE

If you are considering a career in academic surgery, you will need to participate in research and produce publications in order to be successful. Consequently, spending one to two years out of the clinical realm and in a research laboratory is all but essential. This usually occurs after either the second or third year of residency and will stretch your training to a total of six to seven years depending on whether you take one or two years in the lab. Alternatively, the laboratory experience can follow a five-year residency, allowing one to carry over their research directly into their academic careers. Even if academics is just a consideration and not a final decision, you should consider spending time in a lab. Don't be concerned about your loss of technical skills while being away from the operating room. It's like riding a bike; you will pick these up easily within a few weeks of returning. Doing research teaches you how to critically evaluate an unknown, formulate a plan for investigation, learn proper data collection and analysis, and compose an original research publication. In addition, most research residents submit abstracts to meetings, learn to give a presentation to the scientific community, and meet some of the "names" in surgery at these conferences. A final positive of lab time is that the hours are a little better and the stress a little lower, so it can give a "burnt-out" resident a chance

to regroup and rekindle enthusiasm for surgery.

Selecting a good laboratory and a good mentor for your research is key to success, especially if you have never done research before. If you considering a fellowship in pediatric surgery, cardiovascular or some of the other more competitive fellowships, you should definitely consider research pertinent to these areas. First choose a topic of interest to you. If there are no research projects of interest to you or available in your program, scan the literature or check some textbooks to see who the big names in this field are. If you have no particular area of interest, look for a good mentor first and foremost. Being affiliated with one of the top people in your subject area is particularly important if you want to pursue academics; you will want this person to make introductions for you, write letters of recommendation, and, most importantly, steer you in the right direction. Who you know is crucial if you hope to gain name recognition yourself. Ask faculty or the chair to suggest someone they think you would work well with. Talk with fellow residents about their research experiences and ask them to suggest a lab. You need not always stay at your institution: arrangements can usually be made for research outside your program in order to be involved in specialized projects. However, be sure to clear this with your residency director before accepting a position.

One important consideration for lab time is who is paying for it. Some residencies provide full salary and benefits for their residents in research years, regardless of where the research is being done. Others fund this only if you stay at your home institution. Still others want you to do research time, but leave finding a salaried position up to you. Clearly, those that come with full support have the best chance of working with the lab of their choice (what surgeon would turn town a person doing research in their name at no cost?). All others will usually be placed in a paid position as part of someone else's research grant. You may simply be part of a larger project, or possibly be given a bit more independence to pursue your interests if you have a specific project and previous research experience.

A final option is to try to obtain your own funding through grant applications. Not only is writing a grant a tremendous learning experience, but obtaining a grant is quite prestigious. The American College of Surgeons gives out a number of these grants annually. They also publish a list annually of available research grants relevant to surgery. If doing more basic science, the NRSA

grants through the National Institute of Health are a good choice. Because most residents don't have much research experience, the ability to obtain these grants is highly dependent on the mentor and lab you have selected. Also be aware that the deadline for applying for these grants is often more than a year before the start date. Thus, the sooner you know what you want to do, the better.

If you have never done research before, consider taking a course on how to conduct research. The AAMC and the AAS sponsor courses on lab research each year that will be extremely helpful in getting you started. Your program or research lab will often pay the expenses for such a meeting. Be sure to ask about these. Also, the ASE sponsors a "teaching skills for faculty and residents" course. Ask your chair to send you.

Another important issue is how long you should spend in the lab. Most who have been there can verify that it's pretty difficult to conduct meaningful research in one year. It really takes two years to get projects up, running, and completed. If you are considering going for a Ph.D. while in research time, strongly consider three years. Residencies sometimes are willing to "jockey" positions of residents to allow one person to do a third year (especially if another resident wants to go straight through), but this requires careful planning. Speak with your program director EARLY about this. Because the length of time you spend in the lab is so brief, you will really have to be focused and organized to make it worthwhile.

Here are a few suggestions for maximizing your experience:

1. Choose a productive area where your research results will be important regardless of the outcome. If possible choose a project with multiple "arms" so that if one experiment doesn't work out, you have others to continue with. Putting all your eggs in one basket can lead to two years of research with no publication if you are not careful.
2. Emphasize quality rather than quantity. Academicians are more impressed by one good study than 5 case reports.
3. Seek advice and criticisms frequently. It's painful to find out you make a wrong turn in direction two months after you made it.
4. Keep careful notebooks. You never know if someone

years from now will question the outcome and you will be called upon to defend your findings.

5. Write it up and get it published! Research isn't of use to others if you don't spread the word. (Keep in mind the issue of authorship when selecting a lab. If the resident doing the research isn't going to be listed on the publication, steer clear!! While this is unethical and unlikely in surgical labs, many Ph.D. students have run into this problem. Ask before you come about authorship issues.)



FELLOWSHIPS

Once again, having research experience and a mentor willing to open doors and make phone calls on your behalf is key to matching in your ideal position. The sooner you make a decision on a fellowship, the more time you will have to identify a mentor, research the various programs, and begin the process of making yourself competitive.

Should I or shouldn't I?

For some, the inclination to sub-specialize may have been what brought you to surgery in the first place. Others find that they become interested in learning more about a specific area after doing a rotation on a subspecialty service. The decision of whether or not to pursue fellowship training is one that is closely tied to your vision of how you wish to practice surgery when you complete your training. While all are designed to train you as a sub-specialist who will provide complex surgical management of a specific health problem, some fellowships are also geared toward producing the next generation of surgical faculty and leaders. The majority of fellowships want you to be board-eligible for your primary surgical discipline before you start the additional training, meaning you don't begin them until after your five clinical years of general surgery are finished. However, plastic surgery has some "integrated" positions in which you do only three years of general surgery followed by three years of plastics. While most people go into a fellowship directly after completion of their primary surgical specialty, there are a few who decide to go back for extra training after being in practice.

An important consideration should also be your personal life. Are you willing to give up more time to for training? Are you willing to have someone else own your time for more years? How do you feel about dealing with the idiosyncrasies of faculty and being told how to do something that you feel you already know how to do? Being a fellow means putting some of your independence on hold while you gain additional expertise in an area. Talk openly with your spouse or significant other about your desire to get additional training as they may be putting career or child-rearing plans on hold until you finish. The financial considerations of continuing as a trainee should also be factored into the decision. Student loans can generally be deferred but other debt may be piling up. Despite

all of these sacrifices, if you really want it, go for it! Once the urge strikes, it is important to learn as much as you can about the discipline itself. There are several resources for the requirements of a particular fellowship. The first stop today should be the Internet. Find a website for the subspecialty. One place to start is the American College of Surgeons website- www.facs.org. It has links to a variety of surgical society websites that give information about subspecialty training. Ask to do a rotation in a specific area if you have not had the opportunity to do it previously. Talk with the current practitioners of the discipline to see if you see yourself as one of them. Explore both the private and academic options for the subspecialty. Try to get a sense of the availability of positions after completion of a fellowship. Others may say "there is always room for good surgeon," but you still want to be able to practice in a variety of settings in your subspecialty. Some disciplines, such as pediatric surgery, have even published workforce estimates. Transplant surgeons have limited the training spots available in their field because of limited organs and institutions where solid organ transplant can be performed.

The pursuit...

As soon as you know you want to pursue a certain type of fellowship, start working on the task. The application and interview process for some fellowships occurs as early as post-graduate year 3 for a position to start two years in the future. You can always withdraw an application or change your mind, but if you start the process too late, you may have to spend an extra year doing something while waiting to start your fellowship. (Vascular, pediatric, laparoscopic and cardiothoracic fellowships are currently the most competitive, so do not postpone doing your investigative legwork on programs and getting the required paperwork going!) Most programs use a "matching" process to offer positions to candidates, similar to that you used to enter general surgery. Because of the time delay between acceptance into a program and starting it, openings in good programs can occur because of the loss of an accepted candidate. Thus, if you make the decision late to pursue fellowship training, check around. You might find what you are looking for available when you least expect it.

Find a mentor early in the process to guide you through the unspoken rules. The choice of a mentor or mentors is critical to the successful pursuit of a fellowship. To succeed in getting into

some fellowships, it is not just who you are but also who you know. Just as when you applied for surgery the first time, your application may look the same as ten others who want the same position. Networking can mean the difference between a fellowship or not. The world of surgery gets constantly smaller with every step and the people who help you today may be your peers tomorrow. Do not be afraid to ask people within your department or those you meet at surgical meetings for advice and guidance. A mentor does not have to be in the same city. E-mail relationships abound!

The most competitive of fellowships generally want you to show a track record of interest in the discipline. Most often this is accomplished by taking extra time during residency to do research training and producing publications in the field. Taking this time will also help you to decide what type of fellowship within a discipline may be of interest to you. If you want to have a basic science lab as part of your academic practice, you may want to pursue a fellowship that will combine a basic science program with a clinical program. Here again, the additional time in the lab may discourage you from pursuing a fellowship, but you should take the time you need to get the training that will allow you to become the surgeon you want to be. It is not uncommon for the time span to last up to 10 years for completion of primary and subspecialty surgical training. Those of us who have done it will generally tell you it was worth it.

You need to know if the Accreditation Council oversees a fellowship for Graduate Medical Education (ACGME) or by a surgical society in order to find the specific training programs and their requirements. Fellowships under the jurisdiction of the ACGME will lead to special certification after passing an examination similar to the board certification process for primary surgical disciplines. Most society-accredited programs do not have a special board certification process. In general surgery, there has been a move away from creating additional certification so that hospitals will not limit the privileges of general surgeons. Thus, newer fellowships such as those in transplant surgery, surgical oncology and laparoscopy are overseen by the main society for each discipline.

As a general rule, make sure that the program you wish to apply for has some credentialing body. There are some lookalike programs out there (example - non-accredited pediatric surgery fellowships that upon completion to NOT entitle you to sit for specialty boards). Make sure the time invested in your fellowship

will get you the credentials you desire. Fellowships accredited by the ACGME, are listed in the Graduate Medical Education Directory (a.k.a. the "green book") for each subspecialty. Society websites are good resources for locating the society run programs. See the table below for more information. If surfing the internet isn't your cup of tea, then just call the main office of the society to get a list of approved programs. There are some fellowships that are currently in development in a variety of disciplines. These may be more loosely organized without a definitive organizing body. Be cautious about pursuing this type of fellowship. Again, make sure that you get the training and credentials you desire for the time and effort you invest. See the table below for types of fellowships available after the completion of general surgery.

Whatever your style and whatever you choose, good luck!



Credentials Associated with Subspecialty Fellowships

Subspecialty Fellowship	Certifying Body	Affiliated Society
Plastic & Reconstructive Surgery	ACGME	American Society of Plastic & Reconstructive Surgeons
Colon and Rectal Surgery	ACGME	American Society of Colon & Rectal Surgeons
Vascular Surgery	ACGME	Society for Vascular Surgery
Cardiothoracic Surgery	ACGME	Society of Thoracic Surgeons
Critical Care	ACGME	Society of Critical Care Medicine-Surgical Section
Pediatric Surgery	ACGME	American Pediatric Surgical Association
Organ Transplantation	Society	American Society of Transplant Surgeons
Surgical Oncology	Society	Society of Surgical Oncology
Breast Surgery	Society	American Society of Breast Surgeons
Laparoscopic Surgery	Society/ Independent	Society of American Gastrointestinal Endoscopic Surgeons
Burn Surgery	Society	American Burn Association
Trauma	Society	American Association for the Surgery of Trauma
Endocrine Surgery	Independent	American Association of Endocrine Surgeons
Hepatobiliary Surgery	Independent	American Hepato-biliary Association
Noncardiac Thoracic Surgery	Independent	Society of Thoracic Surgeons
Head and Neck Surgery	Independent	American Society of Head and Neck Surgery

BOARD CERTIFICATION

One of the purposes of spending five or more years in an accredited surgery residency is so that you will be eligible to take and pass the examinations necessary for board certification. Board certification usually requires that you pass a written (qualifying) and an oral (certifying) examination. The American Board of Surgery (Phone 215-568-4000 or www.absurgery.org) gives the examination annually with the qualifying exam in the fall and the certifying exam in the spring. There are two good reasons to pass these on your first attempt: 1) It is no fun to retake them. 2) You have to pay again each time. Registration for the qualifying examination must occur by July 14 and costs \$225. Its then another \$450 to take the actual exam. If you pass, the certifying is another \$675. You then must re-certify by written examination every 10 years.

As you prepare to take oral boards or interview for a position, remember that your examiners will score you on the basis of sensory input. What you say is only part of what they will perceive.

- **Smell:** Do not wear heavy perfume, consider breath mints (studies show that smells frequently are strong factors in creating impressions).
- **Touch:** Don't initiate a handshake unless you have a warm, dry, and firm grip to offer.
- **Sight:** Dress thoughtfully and in the way you want to be perceived. Consider a blue or gray suit, and avoid heavy makeup or flashy jewelry. Before your exam, practice sitting in front of a mirror to pick a professional, calm position; don't move out of it during your exam. Many examiners comment on nervous appearances (tapping fingers or toes, wringing hands, chewing your mouth or lip, crossing and bouncing your leg, playing with a tissue). If you feel the examiner is pushing you, don't shrink, lean forward!
- **Sound:** Don't make noises or pop gum. Before the exam, imagine yourself speaking in a calm and professional tone of voice and then do your best to do so. Avoid any and all sarcastic, facetious, or disrespectful remarks.

Don't forget to ask them questions like "anything else significant in the history, physical exam, lab, x-ray", or for any specific information you need. The examiner's job is to give you NO feedback, so don't look for any clues as to how you are doing.

The day of your exam, you will join a number of nervous people and have a briefing by someone from the Board. They will give you your 3 session exam schedule (your exam may begin immediately or several hours later) and remind you to fill out the change of address card (if applicable). For most of us, it is nerve wracking to become involved in the anxious talking pre and post exam. Consider avoiding this situation.

If you don't know the answer to a question, ask for a consult, call "a friend specialist on the phone" for emergency assistance, or say you don't know. They will go on to the other questions that you may know more about. Don't make things up. Give solid conservative treatment options, the kind you might use your first year in practice when you were being closely scrutinized. Respond in the amount of detail that you would use explaining your plan of action to an intern.

Consider studying Norton's "Surgical Decision Making" or develop your own algorithm treatment plans for cardiogenic shock, lung lesions, melanoma, hyperparathyroidism, neck mass, thyroid lesion, ischemic leg, gastric and duodenal ulcers, major fractures, bone tumors, ovarian and gyn tumors, head injury, pediatric abdominal pain and GI bleed, etc. You may also find it helpful to practice ahead of time with others also scheduled to take their orals. Ask your department to institute mock orals if they don't already have them. Your performance reflects on the quality of your program, so they should be receptive to this suggestion.

The questions are fair; the examiners just need to know that you can think well enough to be safe as a surgeon. Imagine that you are in the situation they give you, caring for that patient, so you can think more clearly. You have all the information you need to pass your oral examination: you've passed your written exam. Just show them you can work under pressure and care for patients (you do that every day).

PRACTICE OPTIONS

Your biggest decision during residency will be whether you plan to be in private fee-for-service practice, a salaried position, or academic practice. Talk to as many people as you can in these different areas, find out all the pros and cons of different types of practices. How health care reform will affect these options remains in flux.

Here is a brief outline of the basic points:

- **Private practice** (solo or group) gives you a lot of freedom, but requires you to be a business owner as well as market your skills and expertise. The practice management aspects can become very time consuming, and are annoying to some. Others view it as a challenge, and an opportunity to do things their own way. This option gives the greatest geographic freedom.
- **Academics** allow you to be on the forefront of new ideas, and the opportunity to teach. There will be less personal operating, but also less demand for direct patient care (some people see this as advantageous, others as a detriment). The primary downside is the "publish or perish" requirement. You need to establish yourself in the lab and obtain grant money. This career track tends to be more political, and may require much travel time. But you also teach residents. Others go into academics with research as their primary focus and clinical responsibilities as secondary.
- **Salaried employee** positions make you the direct employee of a hospital, HMO, or the military. These practice situations can be frustrating from the point of view of patient follow-up and lower earnings, but others welcome the improved lifestyle. Different plans have different arrangements, so check the details carefully before signing on. There may be restrictions on your freedom in making decisions. The income may seem wonderful to start, but may not be adequate to send your children to college, or fund other expensive goals you may have. It does allow a more definitive time schedule, which is attractive for those with families or other time intensive interests. The military option often allows great travel opportunities that you might never otherwise have until your retirement.

So How Do You Decide?

The first thing to do is ask yourself just exactly what kind of job you will want. Make a list of priorities for yourself, both personal and professional. Think hard and try to imagine just exactly how you would like to see yourself five or ten years from now. Discuss your thoughts with your family, because the perfect job for you may leave your significant others very unhappy. Many marriages break up shortly after residency because of unrealistic expectations of each other, such as "my husband will just have to go wherever I decide," or "I thought after her residency my wife would be able to spend a lot more time at home!" Here are some questions to ask yourself:

- Personal: Where do I want to live? What kind of leisure activities do I need to stay happy? Is there work for my spouse? How much free time do I need for family and recreation? What kind of weather do I like?
- Professional: What kind of cases do I want to do? Do I want lots of sub-specialists around? Do I want to make all my own decisions about finances, or will I be content to draw a salary and let someone else run the show? How much am I willing to go into debt? Do I want to do lots of endoscopy? Do I want to do my own critical care? Does this community keep up to date? Is the equipment I need there? If not, will they get it for me? Can I possibly go solo, or do I need a guiding hand and ready advice if I'm faced with a tough case?

Knowing what you are looking for is the first step. For the specifics of finding a position, there are a number of options:

1. **Find a recruiter.** Some will work for you to find just exactly the job you want. Others will check a list of open positions to see if it is something you may be interested in, and if you meet the criteria of the potential employer. (Usually the employer will pay the recruiter's fee.) Check the prominent journals for your field for classified ads. Increasingly, web sites list potential positions. Ask for references from previously placed physicians before signing any agreements. In many cases, your travel expenses will be paid. A good recruiter will also save you time by eliminating places that would be a "bad match" for your needs and wants.

2. **Pick a geographic area.** If you know where you would like to live, write the hospital administrator(s) of that community to inquire about job opportunities. If he or she refers you to another surgeon in town, keep in mind that person may not want more competition. They can answer your questions about the hospital and OR conditions, but you may get some different answers on community needs for surgeons by talking to someone in internal medicine or family practice. You will also get a pretty good idea of the quality of the surgeons there. (If you are a good technical surgeon, have a good bedside manner, and can get along with referring physicians, you can succeed almost anywhere if you are willing to work at it for a few years.) Beware of local politics. Sometimes talking to physicians in the next adjacent community will give you some wonderful insights into the medical community in which you are interested.
3. **Talk to the surgeons in your training hospitals.** Find one of your attending surgeons who has been in practice for several years and ask that person's advice on opportunities, local competition, academic vs. private practice, etc. Do not shy from asking financial questions, since you do not want to starve for the first five years of practice. If you have a good working relationship with that surgeon, they will usually be flattered to be sought out for their assistance. Many times they will be willing to have you come into their office to observe the mechanics of private practice, and let you talk to their office manager about how to set things up.
4. **Attend a seminar.** Several companies (e.g. Conomikes) provide one or two day seminars on setting up a practice which may be helpful in alleviating anxieties about the business aspects of practice. Many also give advice about negotiating your best contract options. Beware of "no compete" clauses in contracts if you decide to leave the first group you join and want to stay in the same area.

The more information you gather, the better perspective you will obtain on what situation is right for you. There are jobs available almost everywhere if you are willing to look. And as has been stated before, "There is always room for a good surgeon." Create your own opportunity if you wish. Women surgeons are becoming sought after commodities so don't sell yourself short.

CHAPTER 7

Tools For the Surgical Resident

COMPUTERS AND MEDICINE

Basic knowledge of computer technology in medicine is important for all surgical residents. From the operating room to the office, the surgeon is faced with constant advances in equipment, learning new technical skills and communicating with Internet savvy patients. For these reasons alone, every resident should become familiar and comfortable with the many ways technology is impacting medicine. Familiarity with computers and Internet access can also improve quality of life during a surgical residency by improving efficiency. Most people learn basic computer skills during medical school through literature searches, presentations and the use of e-mail. For those of you who do not feel comfortable with the basics a great place to start is at your medical school or hospital library. Most libraries provide access to computers with free Internet service, literature search shortcuts and access to very helpful staff.

The Internet in general is a very user-friendly place. Access to the Internet can be obtained a number of ways. Most hospitals now permit residents access through their main servers. At home you can access through your phone line, your cable TV line, or a DSL, which is a separate direct connection to the Internet. Availability and pricing of each of these services is dependent on where you live. If you don't mind the slightly slower access on a phone line, there are a number of free Internet Service Providers (ISP) available. *CNET.com*, a general computer technology site, occasionally reviews the different free services available and discusses the advantages and disadvantages of using a free ISP. The most recent top rated providers includes *www.1stup.com*, *www.netzero.com*, *www.freeinternet.com*, and *www.spinway.com*.

E-mail is a must. Most residency programs will set up an e-mail account for you. If not, it is simple to obtain a free account through any one of the search engine sites listed above (Yahoo, Lycos) or through sites such as *www.msn.com* which provides

Hotmail. In addition to e-mail, MSN and many other services offer free instant messenger service allowing you to have real time Internet conversations with people anywhere in the world. Both you and the people you wish to converse with simply need to obtain a user name and password for the system.

Online services can be a great time saver. One of the most frustrating aspects of residency life is never having normal business hours free to get to a store, bank or post office. Shopping online can be a great solution. Most mail-order catalogs are available online, plus there are a number of very good Internet-only shopping sites. Many of these allow you to e-mail gift certificates to your friends and relatives for online shopping - - great for that last minute gift. Grocery shopping online is relatively quick and simple and the cost for delivery is not outrageous. Most travel arrangements and purchases can be made online through the individual companies or through general travel sites. Banks and credit card companies often make personal account information available through their individual sites. The DMV of several states is also accessible via the Internet making online address changes and license renewals quick and easy.

Search Engines. For the computer shy person, a great way to begin is by utilizing a few of the more common search engines. Search engines are much like the library card catalog in that they allow you to peruse the contents of the net using a particular "search word." For example, *www.Google.com* is a very comprehensive index for text word searches that is updated on a daily basis. It works well for general text searches but is even better for locating web sites of institutions, businesses and organizations. *Yahoo.com*, *Metacrawler.com* and *Lycos.com* offer subtopics to explore and are better for searching broad topics, i.e., travel, entertainment, health, sports, business, and for specific yellow or white page searches.

Literature Searches. The National Library of Medicine (NLM) is the world's largest medical library. MEDLINE is the NLM database most physicians use. The NLM web site, *www.nlm.nih.gov*, has two different search engines for MEDLINE, PubMed and Internet Grateful Med. Most medical library computers have a shortcut icon for one or the other on the computer's desktop. Each is a little different in the way information is entered, limited and combined, but the tutorials and trial and error will help you become efficient very quickly. Keep in mind that you can search by text word, author or journal and the abstracts can be retrieved for review.

Reading the entire article is always best but a quick read through an abstract can be very useful just before conferences and lectures. MEDLINEplus is another NLM page more directed toward providing medical information to the general public. MEDLINE, a medical dictionary, a directory of doctors and hospitals, current clinical trials and drug information can all be accessed from MEDLINEplus.

Ovid.com is a separate site that provides online journals in full text. Most medical libraries subscribe to Ovid and keep a current list of the journals that participate. Ovid is the most convenient way of reviewing and copying articles and can be utilized from home by logging-on to the library's computer system. Ask your librarian for details.

Medical Information. There are numerous sites dedicated to providing medical information to physicians and the general public. Below are brief descriptions of some of the more helpful sites to get you started. Keep in mind that many sites make reference to surgery specific information, but often it is designed for general public or family practitioners so it is too simplified for the surgical resident.

WebMD.com offers quite a bit of consumer information. If you are willing to pay a fee, there are physician specific pages including Scientific America Medicine online, CME credits online, drug information including mechanism of action, and advice for office management. Access to reviews of recently published articles is available for free by subspecialty. For a limited time, they are offering a free year subscription to all residents. You will have access to Scientific America Surgery and full text access to the monthly journal Surgery. *MDConsult.com* is also available for a fee and is similar to WebMD, providing access to multiple online reference books, recent medical news, literature searches, etc. *Docguide.com* is similar but you can register for free. It also offers access to MEDLINE, notices about new drugs, an online medical dictionary and a special section on interesting cases. In your registration you can request updates from the site sent directly to your e-mail address.

Mdlinx.com is a free service that provides medical news and information updated throughout the day. In addition, you can specifically choose *surgerylinx.com* for news and information related to surgery. *Versalius.com* is a free site with an emphasis on providing case studies by subspecialty. The surgery cases

include illustrations and operating room photographs pertinent to the case. *Yahoo.com* has a complete Health section that provides a comprehensive directory of medical sites under Web Directory.

Achoo.com is one of the most comprehensive directories of Internet medical sites available. It is also very user friendly. The main gateway to the site is divided into Business and Finance, Organizations and Sources, Human Health and Disease Directory and Reference Sources. The site is also indexed by search, news, commerce and communities. In a matter of minutes you can locate online CT's, surgical atlases, patient support groups and even the latest projects in surgical robotics. If you can't find what you need here I recommend you wave a white flag in front of your favorite librarian!

Medical Association Web Sites. Most medical associations have web sites detailing the mission of the organization, contact and membership information and news about upcoming meetings. Some of the subspecialty associations also include information about fellowship programs.

Samples of sites are listed below:

- **Association of Women Surgeons** (our personal favorite)- *www.womensurgeons.org* - This site provides a full copy of the Pocket Mentor as well as conference information, membership, etc.
- **American College of Surgeons** - *www.facs.org* - This is a great resource. It offers direct access to MEDLINE, ACS news, highlights from the most recent Bulletin, a list of important surgery related web sites, a directory of government agencies and a list of all Board web sites. One of the best pages is the Education and Surgical Services Department. The Surgical Research Clearinghouse, a list of one and two year grants, is located here as well as a section on grant writing.
- **Association of Academic Surgery** - *www.aasurg.org* - This site is dedicated to research-based academic surgery. They strongly encourage resident participation.
- **Association for Surgical Education's** - *www.surgicaleducation.com* - This site is dedicated to improvements in teaching the art and science of surgery to medical students and residents.

- **Society of American Gastrointestinal Endoscopic Surgeons'** - www.sages.org - this site is for surgeons interested in minimally invasive surgery and endoscopy. They have a candidate member group for residents.
- **American Society of Colon and Rectal Surgeons-**
www.facrs.org
- **American Society of Breast Surgeons-**
www.breastsurgeons.org
- **American Society of Plastic & Reconstructive Surgery-**
www.plasticsurgery.org
- **Society of Surgical Oncology-** www.surgonc.org
- **Society of Thoracic Surgeons-** www.sts.org
- **American Society of Transplant Surgeons-** www.astso.org
- **American College of Obstetrics & Gynecology-**
www.acog.org
- **American Academy of Orthopedic Surgeons-**
www.aaos.org
- **American Association of Neurological Surgeons-**
www.neurosurgery.org

Handheld Computing. Hand held computers or Personal Digital Assistants (PDA) are a great alternative to standard index card organization. There are different types of PDAs available depending on your needs with prices ranging anywhere from \$150 to \$500. Palm Pilot is probably the most recognizable name but several others are available. Most residents find them to be a convenient way to keep phone numbers, addresses, a date book and patient information all in one place. Most have a memo pad function great for creating your own reference lists for facts and formulas you tend to forget.

There are several commercial medical software packages as well as free "shareware" to download off the Internet or "beam" from a friend. The patient data programs are excellent for ward organization and allow you to keep weeks worth of patient data with you at all times. Medical formula programs are great for quick calculations of a-A gradient, creatinine clearance, etc. and several drug handbook programs are available as well.

Carrying a hand held computer could be a bit of a hassle. Each

new series tends to be a little lighter and less bulky. Most will fit well in a lab coat pocket but should not be left behind when you go into the operating room. One option is to purchase a carrying case with a belt clip attachment. Also, all data should be synchronized with your PC on a daily basis and it is a good idea to keep extra batteries handy.

There are a few helpful web sites for the PDA consumer. *PDAMD.com* is a site dedicated to personal hand held computers for physicians. Reviews of the various products compare them based on memory, operating systems, software, size, battery life, speed and price. There is also a section explaining how the device can be helpful in medical settings. *CNET.com* covers computer technology in general with pages specific for hand held computers. This site also gives a very detailed breakdown of the different devices in table format including weight. Consumer reviews are available and are very informative. *Epocrates.com* has a free comprehensive drug list for the Palm Pilot that includes mechanism of action, pregnancy and lactation, pediatric dosing, etc. and has a function for auto up-date when you synchronize with your PC.

Listservs. This e-mail networking tool is an excellent way to obtain support, knowledge and ideas. Here's how it works. First you must subscribe to a list of interest. This is typically done by sending an e-mail to a specific subscription address. You then receive an e-mail confirmation that you are subscribed, which will serve to verify your subscription information and contain additional information about how to use the list. Whenever you have a question or are seeking an opinion or suggestions, you can "post it" to the Listserv. Your message will be sent to everyone who has subscribed. Subscribers can respond back to the entire list or to you, privately. In the same token, you will receive e-mails from subscribers, and be able to respond back.

The Association of Women Surgeons currently offers three listservs. You can visit their web site at www.womensurgeons.org for additional information, or send an e-mail to the addresses provided (*the subject line and message can be left blank*). Currently, there are three topics to choose from:

Balancing life - gives members the opportunity to discuss relationships or any family and life issues they may have. To subscribe,

send an e-mail to join-balancing-life@lists.womensurgeons.org.

Medical students/residents - Designed to assist medical students and residents, this list will help those of you who are the "up & coming" generation of surgeons. Practicing surgeons are also encouraged to join to provide advice and suggestions to those who are still in school or residency. To subscribe, send an e-mail to join-residents-students@lists.womensurgeons.org.

Breast - For any breast or general surgeons to keep in touch with others in the field. To subscribe, send an e-mail to join-breast@womensurgeons.org.

You can also join any of the AWS lists by going to <http://lists.womensurgeons.org/cgi-bin/lyris.pl> and completing the form to join.



RESIDENCY CALENDAR

Here is a list of things you can be doing as residency progresses to simplify your future.

Internship:

- Begin keeping case log. (Get a copy of the Operative Experience Form required by the American Board of Surgery from your department so that you know exactly which details to record.)
- Keep copies of your op reports. Don't forget to record and dictate procedures such as CVP lines, chest tubes, etc.
- Pick a mentor, or at least identify some potential ones.
- Scrub and do all the cases you can while still getting your ward work done.
- Begin looking for a topic of interest for research time. If you will go into research after your second year, apply now for grant funding.

Second Year:

- Write for fellowship information from several programs if there is a remote possibility of your seeking subspecialty training.
- Arranging a lab year if you plan to do one (or two). Apply for grants.
- Continue your case log.
- Scrub and do all the cases you can.

Third Year:

- Begin the fellowship application process in earnest. Identify which programs will be best for you, find people to write letters of reference, make sure you have met all the prerequisites.
- Finalize arrangements for a lab year.
- Continue your case log.
- Scrub and do all the cases you can.

Fourth Year:

- Decide more definitely about your career path. Send for info on places where you might be interested in practicing.
- Apply for fellowships.
- Continue your case log.
- Scrub and do all the cases you can.

Fifth Year:

- Start looking for a job in earnest. Consider signing on with a search firm, or doing Locum Tenens if you don't find the job you want.
- Get a permanent medical license in at least one state. (The license you practice under as a resident is conditional or temporary. You will need a permanent license to take your Boards after completing residency. The application process often takes 3-6 months.)
- Complete the official Operative Experience Form.
- Fill out the preliminary application for the ABS Exam. Deadline is May 1 most years. Check with your program director, since the forms usually arrive in late winter.
- Scrub and do all the cases you can. Before long, you will be on your own, possibly alone, so you might volunteer to staff the hernias and hemorrhoids so you won't start practice not having done one for four years!

Post Residency:

- Continue to keep a case log if you wish to become a fellow in the American College of Surgeons. You must be in practice for two years in the same place and situation, and they will want at least a 12-month case list (they specify the dates).

SURGICAL BIBLIOGRAPHY

The following list is not exhaustive by any means. We include those books our members most commonly felt were helpful during their residencies. The annotations will help you decide which will be most useful to you, depending on your program and interests. As a minimum, we recommend that you buy at least one major text, and one atlas. Many of the books are not only accessible through medical schoolbook stores, but also on-line, often at discount prices. Prices listed may have changed. Our favorites are indicated by **.

TEXTBOOKS: *These texts are generally considered the classical surgery textbooks. It is generally understood that you will study from one of the three. Check with your program to see if they work from a specific textbook, or have review sessions based on specific chapters from a text. Other textbooks are available and listed under supplementary resources below, and may be helpful for clinical decision making or reviewing disease processes.*

****Principles of Surgery**, 7th Edition. Seymour I. Schwartz, et al., 1998, McGraw Hill Text. This is the most widely used of all the major surgery textbooks. New chapters in the 7th edition include trauma, transplant, and surgical oncology. Ideally, you should read it cover to cover during your residency, preferably more than once. If you know the information in this book, you will do well on all your written exams. (One volume Version: \$125.00; Two volume Version: \$149.00)

Principles of Surgery: Companion Handbook \$34.00. Many residents find the handbook useful to keep at the hospital for ready reference, but don't rely on the pocket edition to pass exams.

Principles of Surgery: Pretest and Self-Assessment \$45.00. Useful practice for the In-Service Exams and Boards preparation.

Principles of Surgery: Pretest and Self-Assessment CD ROM \$235.00. Includes the text, 27 videos of surgeries including laparoscopic surgeries as well as pretest questions and reviews.

Textbook of Surgery: The Biological Basis of Modern Surgical Practice, 16th Edition. David Sabiston and H. Kim Lyerly, 2000, W.B. Saunders. Also an excellent textbook though somewhat less widely used and perhaps not quite as readable. Greater emphasis

on the basic sciences. (\$125.00)

Textbook of Surgery: Pocket Companion \$31.95

Textbook of Surgery: The Biological Basis of Modern Surgical Practice CD ROM \$185.00

Surgery: Scientific Principles & Practice, 3rd Edition. Lazar J. Greenfield, 2001, Lippincott, Williams & Wilkins Publishers. A newer entry into the textbook arena. Loaded with photos and diagrams. Fairly heavy emphasis on the basic science aspects, but written by some of the same academic surgeons who write Board questions. New features include a chapter on outcomes based surgery and a section on magnetic resonance angiography. (3rd edition, not yet priced. 2nd edition sold for \$115.00)

Study Guide for Surgery: Scientific Principles and Clinical Practice due out in 2001.

Surgery: Scientific Principles & Practice with disk for Windows or Macintosh is also available for \$45.00.

Surgery: Mastering Surgical Principles and Techniques CD ROM for Windows and Macintosh Greenfield and Nyhus. Includes the Greenfield textbook and review book as well Nyhas' mastery atlas (see below). \$249.

Current Surgical Therapy, 6th Edition. John Cameron, 1998, BC Decker. This is an excellent reference for the practicing surgeon and good preparation for the oral surgery boards. This has a stronger emphasis on clinical management and decision-making, and is updated every 2-3 years. It does not cover pediatric or transplantation surgery. (\$140.00)

Current Surgical Diagnosis and Treatment, 10th Edition. Lawrence Way, 2001, Appleton & Lange. This text is also more clinically oriented, emphasizing major diagnostic features and descriptions of surgical disease processes. It reviews procedures for evaluation and management in a concise, practical format. This book includes chapters on essentially all surgical subspecialties, particularly as they apply to the general surgeon. Good review text before In-Service and Board exams. (9th edition sold for \$54.95. New Edition due out 2001)

Care of the Surgical Patient: Perioperative Management and Techniques. Published by Scientific American Medicine. This is essentially a textbook subscription combination that provides continuing quarterly updates to its chapters. It is an excellent reference, provides many useful algorithms, comprehensive discussions explaining physiologic principles, and explanations of the diagnostic and therapeutic recommendations made. Very well written. This is a large two-volume loose-leaf format, though, so it

is much more useful as a home or library reference. Information available at 1-800-545-0554 or via mail at PO Box 647 Yorktown Heights, New York, 10598. (The basic manual is \$299 for the first year, renewal is \$149.00 per year)

Scientific American Care of the Surgical Patient. 2001. This textbook prepared in cooperation with the American College of Surgeons. Previously a loose-leaf text, this will now come as an annual bound edition (\$249) or as a CD ROM that is updated quarterly (\$395). Is extremely practical in its information but also gives thorough explanations of the rationale and physiology for its recommendations. Multiple authorship by some of the finest surgeons in each specialty. It is fairly expensive, but you may find you like it better than the other standard texts.

ATLASES

**Atlas of Surgical Operations, 7th Edition. Robert Zollinger, 1993, McGraw-Hill. This atlas is very popular with short, concise text, good illustrations, and can be scanned in a few minutes if you are short on time before a case. The latest edition includes 20 laparoscopic procedures. (\$175.00)

Atlas of General Surgery. David Sabiston Jr, 1993, WB Saunders. This newer entry to the market may supplant the previous "old standards." Covers nearly everything but thoracic procedures. (\$185.00)

Mastery of Surgery, 3rd Edition. Nyhus & Baker, 1996, Little, Brown & Co. An excellent two-volume atlas covering most all procedures you will encounter. See if it is available in your medical library. (\$325.00)

Maingot's Abdominal Operations Volumes I & II, 10th Edition. Michael Zinner, 1997. Appleton & Lange. This is probably THE classic multi-volume set of abdominal surgical technique. Besides multiple illustrations and detailed descriptions of technique, it also covers a fair amount of information on disease processes, diagnostic evaluation, indications for surgery and which technique to use and when. This should be in most hospital libraries, but you may want to purchase this in your more senior years of residency. (\$325.00)

Operative Strategy in General Surgery: An Expositive Atlas, 2nd Edition. Jameson L. Chassin, 1994, Springer-Verlag. One

program's approach to most types of general surgical cases, including tips on pitfalls to avoid, anatomic hints, pre- and postoperative management. (\$187.00)

Atlas of Laparoscopic Surgery. Garth Ballantyne, 2000, W.B.Saunders, Inc. If you need additional insight into laparoscopic techniques, this is a good supplement to your library. (\$115.00)

**Surgical Anatomy and Technique: A Pocket Manuel, 2nd edition. John Skandalakis et al., 2000, Springer-Verlag, Inc. This excellent pocket manual is especially good for interns to keep in your locker. It will give you the basic information you need to get through operations you are assigned at the last minute and haven't had a chance to read more thoroughly about. (\$39.00)

HANDBOOKS

**The Mont Reid Surgical Handbook, 4th Edition. Scott Berry et al., 1997, Mosby Yearbook, Inc. Written by residents at the University of Cincinnati and first published in 1987, many students and residents have found this to be an invaluable aid to patient care and improving the initial management of common surgical problems. The book is small enough to fit into your white coat or scrub pocket, written in an outline format with an extensive index. The basic principles behind many techniques, or the pertinent anatomy are even illustrated with simple black and white drawings. Highly recommended. (\$34.95)

**Handbook of Surgical Intensive Care: Practices of the Surgery Residents at the Duke University Medical Center, 5th Edition. Bryan M. Clary et al., 2000, Mosby Yearbook Inc. Assists in both pre- and post-op management of SICU patients. Another pocket guide written by surgery residents for their colleagues. (\$35.95)

Abernathy's Surgical Secrets, 4th Edition. Alden H. Harken, 2000, Mosby Yearbook Inc. A book of "pimp" questions that you may want to review prior to rounds on specific cases, particularly if the diagnosis is a new one for you. Also useful as a different way to review for Oral Surgery Boards. (\$39.00)

Surgical Recall and Advanced Surgical Recall. Lorne H. Blackbourne, 1997, Williams & Wilkins. Question and answer

format. Filled with questions that you will be asked in the operating room and on rounds. Surgical Recall covers basic information which may be more appropriate for medical students. Advanced Surgical Recall contains more in-depth information and some information on subspecialty surgery services, but does not include the basic information in Surgical Recall. (\$28.00/\$35.00)

SUPPLEMENTARY RESOURCES

**Selected Readings in Surgery. Also known as "The Parkland Papers." From University of Texas Southwestern Medical Center, a subscription to the Parkland Papers provides you with a packet of 45 to 60 articles from assorted specialty journals 11 times annually. The articles are accompanied by a summary of the current trends and thinking on a particular body system. The cycle takes about five years to complete. Reading the summary each month is an excellent way to study on a regular basis. File the articles for future reference as a Chief Resident, and when you start practice. Write to: Selected Readings in General Surgery, PO Box 36483, Dallas TX 75235-1483. Or call 214-648-2756 or call 1-800-631-0033. (\$217.00 annually)

**The Art of Surgical Technique, Milton T. Edgerton, 1988, Williams & Wilkins. This book beautifully describes the basics of knot-tying, suturing techniques, making incisions, etc. If no one seems to have the time to demonstrate good surgical technique to you this book is a must. (\$49.40)

**The Physiologic Basis of Surgery, 2nd edition. J. Patrick O'Leary, editor, 1996, Williams & Wilkins. This is everything you should have learned in the first two years of med school in one book. It has essential information for the ABSITE exam. A little reading here will go a long way. (\$115.00)

Surgical Decision Making, 4th Edition. Lawrence Norton et al., 2000, W.B. Saunders. A book of algorithms that can help you work your way through a variety of clinical situations. Very helpful in your more senior years or preparing for conferences. (\$89.00)

Cope's Early Diagnosis of the Acute Abdomen, 20th Edition. William Silen, 2000, Oxford University Press. The classic guide to physical diagnosis. A great concise and small book that will hone your history taking and physical examination skills. Changes have

been made from the classical writings to modernize the book including new discussion of CT findings and elimination of obsolete practices and diagnoses. Small enough for your pocket. (\$29.55)

The Effective Scutboy, 3rd Edition. Roberta Harrell, 1988, MacMillan. This is a practical guide on how to be a super intern or medical student. Handy to keep in your pocket. Out of print but still available from some on-line book sources. (\$19.95)

**Residents as Teachers: A Guide to Educational Practice.

Send \$12 to cover the book and shipping to Dr. Neal Whitman, Department of Family and Preventive Medicine, University of Utah School of Medicine, 50 N. Medical Drive, Salt Lake City, UT 84132 - 84 page book.

SUBSPECIALTY TEXTS

Critical Care, 3rd Edition. Civetta JM et al., 1997. Williams & Wilkins. If you will be doing lots of ICU work as a resident or in practice, this is the finest text available. If not, you may want to borrow a copy while doing your ICU rotations for reference. (\$199.00)

The ICU Book, 2nd Edition. Paul Marino, 1998, William & Wilkins. Paperback. A great resource for any resident doing a ICU rotation. Problem based approach to ICU with a good review of principles of basic science as well as calculations, treatments and dosing regiments that will come in handy. (\$59.95)

Trauma Handbook EE Moore, 2001, Appleton and Lange and Manual of Trauma Critical Care Procedures. EE Moore et al., 2001, Mosby Yearbook. Due out in 2001, these two books are written by the authors of the premier textbook on trauma, (Trauma), which is no longer in print. If your program has a high volume trauma service, they may be worth considering.

REVIEW MATERIALS: *Each of the major textbooks listed above has an accompanying review book. Included here are additional review materials that may be helpful for studying for In-Service or Board exams.*

****SESAP:** Surgical Education and Self-Assessment Program, No.

10, 2000. Published by the American College of Surgeons. Reduced pricing for residents (requires letter from program director), but even less if you join ACS as a candidate. This study guide is a question and answer format with lots of pictures and clinical situations. It is divided into four categories of questions, and includes a syllabus with discussion of the correct responses with brief explanations. Includes short bibliographies. Very useful for studying for the In-Service Exam, as well as Boards, particularly if you are tired of reading from a text. For more information, write SESAP, American College of Surgeons, 55 E. Erie St., Chicago, IL 60611 or online at www.facs.org. (\$200 for residents, \$150 for ACS candidates).

Rush University Review of Surgery, 3rd edition. Deziel et al., 2000, W.B. Saunders. Paperback. A good review of surgery in question and answer format. Great for bedside reading. \$47.95)

ABSITE Combat Manual, The Red Manual for the Surgery Boards, and Surgery 101: Basic Science Review, Volumes I&II, all by Hracht and Raffy Karamanoukian, 2000, Magalhaes Scientific Press. The Combat Manual gives bullet statements hitting testable topics while the other two are questions with answers. They are OK, but not the best study resources. (\$89.00, \$49.00, and \$39.00 per volume respectively)

**ABSITE Review Manual, reprinted annually. Richard E. Dean, 2000, Instructional Media Center at MSU. This review manual is published annually by the Michigan State University Department of Surgery specifically for review for the ABSITE exam. They essentially take the question topics for the exam and provide pertinent information about that topic. Great for last minute review. You can only obtain it from them at 517-353-9929 or www.msuvmall@msu.edu/imc. (\$49.95)

American Board of Surgeons Annual Written and Oral Board Review Courses as presented at Albert Einstein College of Medicine & Montefiore Medical Center. Audiotapes available through Conference Copy, Inc., Surgery Board Review, 8435 Route 739, Hawley PA 18428, phone (570) 775-0580, or online at www.confcopy.com. You can also buy specific tapes in your weak areas if you don't need the entire set. Pricey, but if you have little time to read and commute even fifteen minutes each way to work, it is a good way to study. Some people actually learn better by the auditory route. (The complete set for orals -28 tapes- is \$375, for the written -33 tapes- \$450)

MISCELLANEOUS REFERENCES

ORGANIZATION AND SETTING GOALS

Time Power, by Charles R. Hobbs, Harper & Row, 1987. One of many time management schemes available for increasing your productivity. This one is designed to work best with a daytime, Day-Runner, Franklin Planner, or similar daily planner calendar.

The Seven Habits of Highly Effective People: Restoring the Character Ethic, by Steven R. Covey. Simon & Schuster, 1989. This is a principle oriented book that demonstrates how to achieve balance in your life and profession by understanding yourself and your own motivations better. Provides a step-by-step outline for becoming a more effective person by improving communication and cooperation.

First Things First, by Stephen R. Covey, A. Roger Merrill, and Rebecca R. Merrill. Simon & Schuster, 1994. A very practical guide to setting priorities, finding balance in your life and time, and getting things done most efficiently.

UNDERSTANDING DIFFERENCES BETWEEN WOMEN AND MEN

**You Just Don't Understand: Women and Men in Conversation, by Deborah Tannen, Ph.D. William Morrow & Co., 1990. Observations by a socio-linguist on how men and women communicate and why they, so often, do not understand one another. Helps to clarify why men tend not to say they are sorry, and other critical insights. This can help a lot to decipher what men are really saying to you, and how you can better communicate with them to avoid misunderstandings.

**Hardball for Women, by Pat Heim, Ph.D. Plume Publ., 1993. Written primarily from a business point of view, this book is an excellent explanation of the stereotypical behaviors of men and women that create conflicts and misunderstandings. Heim's basic premise is that boys and girls learn the lessons of life from the games they play, and expect adulthood to follow the same rules. You will recognize a multitude of situations, and she offers very concrete strategies to succeed.

Men: A Translation for Women, by Joan Shapiro. New American Library-Dutton, 1992, or Avon 1993. One other woman's highly readable book on understanding the differences in communication styles between men and women.

DEALING WITH ATTITUDES

Forgive and Remember, by Charles Bosk. The University of Chicago Press, 1979. The psychology of residency and the hierarchy in surgery. Helps to understand some of the indoctrination process of residency.

The Gentle Art of Verbal Self-Defense, by Suzette Elgin. Reston Press, 1985. An excellent guide to defending yourself against verbal attacks without jeopardizing your own situation. Suggestions for redirecting and deflecting a verbal assault.

**They Can Kill You...But They Can't Eat You, by Dawn Steel. Pocket Books. 1993. A very entertaining look at one woman's battle to succeed in the film industry, this also provides a number of useful insights into how to succeed in a man's world.

How to Win Friends and Influence People, by Dale Carnegie, Pocket Books, Reissue 1994. This classic book on communicating uses vignettes from real life to illustrate effective leadership. It's easy and fast reading and well worth the time.

PREGNANCY AND RESIDENCY

May/June 1993 issue of the Journal of the American Medical Women's Association is devoted to maternity and medicine. Includes articles on the pregnant resident, colleagues attitudes, and the rights, rules and regulations regarding maternity leave. Single copies are available for \$5.00 by writing to AMWA, 801 North Fairfax St., Alexandria, VA 22314

"Medicine and Parenting." This is a booklet prepared by the AAMC. Covers timing of pregnancies in relation to residency, legal rights, leave policies, how to handle queries about childbearing plans during interviews, child care options, and more. Copies available through the Woman Liaison Officer at your medical school, or by sending \$11.00 to AAMC, 2450 N Street NW, Washington, DC 20037-0400.

"A Pregnant Surgical Resident? Oh My!" Emina Huang, MD, and Olga Jonasson, MD. JAMA 1991;265:2859-2860. Discusses how one residency program dealt with this issue in a purposeful and constructive manner. Very helpful with suggestions for maintaining good communications.

SEXUAL HARASSMENT AND GENDER DISCRIMINATION

Step Forward: Sexual Harassment in the Workplace. What You Need to Know! by Susan L. Webb, 1991. Mastermedia, Publ. This is a fairly concise book which explains the differences in harassment and discrimination, and how to deal with problems which arise.

Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures. Prepared by the AMA. Copies available by writing to 515 North State St., Chicago, Illinois 60610. This brochure is an **excellent** reference if you wish to help your program establish a specific policy on these issues, or even just to understand definitions and the hazards of amorous relationships between people of unequal status. (While most medical schools and universities do have such policies, it is still very common for residency programs not to have one.)

SPIRITUAL ASPECTS

Healing Words: The Power of Prayer and the Practice of Medicine, by Larry Dossey, M.D., 1993, Harper Collins. An internist reviews the scientific evidence that prayer complements, though does not replace, good medicine. Includes studies demonstrating that doctors and patients belief in a treatment increases its efficacy.

Beyond the Relaxation Response, by Herbert Benson, M.D., 1984, Times Books. Reviews various ways to meditate and the physiologic changes that occur with awake relaxation techniques.

Fire in the Soul: A New Psychology of Spiritual Optimism, by Joan Borysenko, Ph.D. Warner Books, 1993. Written by a psycho physiologist, several methods of prayer and meditation are explained which will appeal to a variety of people's styles and belief systems. She has several other books available also describing the "mind/body connection" and helped found The

Mind/Body Clinic at Harvard. Her original research dealt with investigations into the neurophysiology and immunology of somatic ailments such as migraine, irritable bowel syndrome, etc.

WOMEN IN SURGERY

Forged by the Knife: The Experience of Surgical Residency from the Perspective of a Woman of Color, by Patricia L. Dawson, Open Hand Pub., 1999.

The Woman in the Surgeon's Body, by Joan Cassell, Harvard University Press, 1998.

Walking Out on the Boys, by Frances K Conley, Farrar Straus & Giroux, 1999.

ACADEMIC CAREERS

"Why So Slow?: The Advancement of Women", by Virginia Valian, MIT Press, Reprint 1999

"Career development in academic medicine." W. Applegate. Am. J. Med 1990;88:263.

"The status of women at one academic medical center: Breaking through the glass ceiling." JAMA 1990;264:1817.

"Meeting the challenges of research and a family." WA Hsueh. JAMWA 1993;48:55.

JAMWA (Journal of the American Medical Women's Association) has many articles which you may find helpful. You can get a subscription to the magazine by joining AMWA. See glossary for address.

Annotated Bibliography of Women in Medicine 1983-1993. Beverly Walters, M.D., and Irene McNeill. Published by the Ontario Medical Association, this is an excellent base for easily finding articles related to women, medicine, and associated issues. Available by mail order through OMA, 525 University Ave, Suite 300, Toronto, Ontario M5G 2K7, Canada. Enclose a check for \$48.15, which includes postage and handling.

SURGICAL ORGANIZATIONS, SPECIALTY SOCIETIES, AND ASSOCIATIONS

There are a variety of organizations that oversee the world of surgery outside the operating room. Some are to ensure quality education, other set the standards for licensing, and others represent surgeons to governmental agencies. Below are descriptors of the major organizations likely to play a role in your world as a surgical trainee.

The **Residency Review Committee for Surgery (RRC)** inspects residencies on a regular (up to every five years) basis and either approves or disapproves them. Approval or disapproval is based on the quality of surgical education, documentation of adequate case volume for each surgical resident, passage rate of the Board examinations, the number and academic activity of the faculty, etc. This is the organization that sets the "rules" for completing surgical training, i.e.- length of training, rotations and even call frequency. If you ever wanted to know these requirements for all types of residencies, they are in the Green Book in the fine print sections. Your **program director** is the one responsible for ensuring your program and each surgical resident meet the requirements of the RRC. You must complete a surgical residency approved by the RRC in order to sit for your surgical boards.

The **American Board of Surgery (ABS)** is the accrediting organization for general surgery. Based in Philadelphia, this group administers the two board exams (Qualifying or written and Certifying or oral). It is by passing these two examinations that you become **board certified**. (If you have completed and approved residency but have not yet passed these examinations you are considered **board eligible**.) In your Chief Year, you need to contact them for an application for the Board exams (see Chapter 6 on board certification). The ABS also sells the ABSITE or in-service exam to surgical programs.

The **American College of Surgeons (ACS)** is the premier organization representing surgeons in the United States, based in Chicago. You can join as a resident (member of the Candidate Group) for \$25 per year. Do it! This will allow you to buy SESAP for a reduced price, admit you to the annual Clinical Congress held each October for free if you can attend, put you on their mailing

list, and receive the monthly Bulletin, which will open your eyes to some of the socioeconomic and political issues facing surgeons. A **Fellow** is a full member of the ACS. You must be Board certified, in practice for at least two years in the same location, and pass interviews by Fellows active in your state's chapter. You can usually tell who is a fellow of the ACS by the "F.A.C.S." after the M.D. in a surgeon's title. The main governing body of the ACS is the Board of Regents. There are 19 Regents, 18 elected plus the President of the ACS. A number of committees, as well as the Board of Governors advise the Regents. The board of Governors consists of 264 representatives from each area of the country, each of the major subspecialty organizations and a few international organizations. They are elected by the fellows and are the voice of the practicing surgeon to the ACS.

The **American Medical Women's Association** (AMWA) is the largest women's medical organization in the U.S. They have been active for many years in trying to improve the status of women's healthcare overall, as well as in the medical profession. Their journal (JAMWA) contains many articles of interest to women physicians. If you are interested in joining, write to 801 North Fairfax St., Suite 400, Alexandria VA 22314.

The **Association of American Medical Colleges** (AAMC) oversees medical teaching institutions. This organization generally has a Women's Liaison Officer (AAMC-WLO) assigned as the contact person between each of the teaching hospitals and medical schools and the AAMC. Usually this person has the most reliable information on your institution's policies about gender related issues, from sexual harassment to maternity leave. You should find out who this is and how helpful this person can be early on. Some of these people are great resources, and can be very helpful to you. The AAMC has been very active in promoting fair working environments for women in the medical teaching institutions.

Below are additional organizations that play a major role in "organized" surgery and are good contact points for additional information of particular interests. While extensive, this list is by no means inclusive of all the associations. For the most part, the capital letters in each title form the acronym for that association.

AAFPRS	American Academy of Facial Plastic and Reconstructive Surgery
AAO	American Academy of Ophthalmology

AAOS	American Academy of Orthopedic Surgery
AAOHNS	American Academy of Otolaryngology-Head & Neck Surgery, Inc.
AAP	American Academy of Pediatrics, Surgical Section
AAHS	American Association for Hand Surgery
AAST	American Association for the Surgery of Trauma
AATS	American Association for Thoracic Surgery
AAGUS	American Association of Genito-Urinary Surgeons
AANS	American Association of Neurological Surgeons
AAPS	American Association of Plastic Surgeons
ABA	American Burn Association
ACPS	American Cleft Palate Association
ACOG	American College of Obstetricians and Gynecologists
ACS	American College of Surgeons
AGOS	American Gynecological and Obstetrical Society
AHNS	American Head and Neck Society
ALA	American Laryngological Association
AMA	American Medical Association
AOS	American Ophthalmological Society
AOA	American Orthopedic Association
AOS	American Otological Society
APSA	American Pediatric Surgical Association
ASA	American Surgical Association
AUA	American Urological Association
ASAPS	American Society for Aesthetic Plastic Surgery
ASBS	American Society for Bariatric Surgery
ASSH	American Society for Surgery of the Hand
ASBD	American Society of Breast Disease
ASCO	American Society of Clinical Oncology
ASCRS	American Society of Colon and Rectal Surgeons
ASMS	American Society of Maxillofacial Surgeons
ASPS	American Society of Plastic Surgeons
ASTS	American Society of Transplant Surgeons
AAS	Association for Academic Surgery
ASE	Association for Surgical Education
AAMC	Association of American Medical Colleges
APDS	Association of Program Directors in Surgery
AVAS	Association of VA Surgeons
AWS	Association of Women Surgeons
CAOG	Central Association of Obstetricians & Gynecologists
CSA	Central Surgical Association
CNS	Congress of Neurological Surgeons
EAST	Eastern Association for the Surgery of Trauma
ISCS	International Society for Cardiovascular Surgery
MSA	Midwest Surgical Association

NMA	National Medical Association
NESS	New England Surgical Society
NPSA	North Pacific Surgical Association
PCSA	Pacific Coast Surgical Association
PNS	Peripheral Nerve Society
PVSS	Peripheral Vascular Surgery Society
PSRC	Plastic Surgery Research Council
RCPSC	Royal College of Physicians and Surgeons of Canada
SCVS	Society for Clinical Vascular Surgery
SPU	Society for Pediatric Urology
SVS	Society for Vascular Surgery
SSAT	Society for Surgery of the Alimentary Tract
SAGES	Society of American Gastrointestinal Endoscopic Surgeons
SCCM	Society of Critical Care Medicine
SGO	Society of Gynecologic Oncologists
SNS	Society of Neurological Surgeons
SSO	Society of Surgical Oncology
STS	Society of Thoracic Surgeons
SUO	Society of University Otolaryngologists
SUS	Society of University Surgeons
SUU	Society of University Urologists
SSC	Southeastern Surgical Congress
SNS	Southern Neurosurgical Society
SSA	Southern Surgical Association
STSA	Southern Thoracic Surgical Association
SSC	Southwestern Surgical Congress
SIS	Surgical Infection Society
TS	Triological Society
WSA	Western Surgical Association
WTSA	Western Thoracic Surgical Association



DICTIONARY FORMATS AND MNEMONICS

You have probably learned most of these in medical school. You will be able to make fewer omissions and dictate more quickly, however, if you keep a written list of formats handy. Be sure to follow the specific format your hospital uses if there is one.

HISTORY AND PHYSICAL

Chief Complaint

History of present Illness

Allergies

Current Medications

Past Medical History

Social History

Family History

Review of Systems

 General (good health, malaise, weight loss, etc.)

 Neurologic

 Respiratory

 Cardiac

 Gastrointestinal

 Genitourinary

 Musculoskeletal

Physical Examination

 General description

 HEENT

 Neck

 Chest

 Breasts

 Heart

 Abdomen

 Pelvic/Rectal

 Extremities/Back

 Neurologic

Admitting Diagnosis

Problem List

Plan of Therapy

Operative Report

Your name ("This is Dr. X dictating op report on...")

Patient's name and ID No.

Preoperative Diagnosis

Postoperative Diagnosis

Name of Procedure

Surgeon's name

Assistant's name(s)

Type of Anesthetic

Indications for surgery

Findings at surgery

Description of the procedure itself

Estimated blood loss

Drains used

Comment re: sponge and needle counts

Drains

Complications

Admitting Orders (a mnemonic)

Diagnosis

Activity

Diet (NPO, specific type of diet, IV orders, etc.)

Measurements (vital sign frequency, daily weights, etc.)

Objective (labs, imaging studies, EKG, other workup studies)

Medications (current medications as well as those needed for this admit)

Post-op Orders (a mnemonic)

Vital signs (include hemodynamic measurements, I&O, frequency, etc.)

Activity (bed rest, bed position, activity restrictions, etc.)

Nutrition (diet, IV fluids, TPN, etc.)

Drains (NG, Foley, J-Vacs, chest tubes, etc. and what you want done with them)

Drugs (Routine meds for this patient)

Antibiotics, **A**nalgesics

Labs, X-rays, etc.

Special (Respiratory care, dressings, etc.)

QUOTES

The following quotes may help pull you through from time to time. Some are humorous, some motivational. When you are feeling glum or discouraged, flip back to these pages to help get you back into a more positive frame of mind.



"Always put the patient first, despite what might be going on in your day or life...It's not just the knowledge you have as a physician but the bedside manner you develop and the way you treat patients that has a lasting effect on them."
--Stephanie Altobellis, MD, quoted in "Life in Medicine", Vol. 1, No. 5, 1993, p. 15.

The difference between a successful person and others is not a lack of strength, not a lack of knowledge, but rather is a lack of will.
--Vincent Lombardi

Working together means winning together.

Accept the challenges so that you may feel
the exhilaration of victory.

Success is a journey, not a destination.

The man on top of the mountain did not fall there.

Do not follow where the path may lead, go instead where
there is no path and leave a trail.

In the middle of every difficulty lies opportunity.

Goals are met when we coordinate our efforts with those of
others.

There are no secrets to success.
It is the result of preparation, hard work,
and learning from failure.

--Gen. Colin L. Powell

When you aim for perfection, you discover it's a moving target.

--George Fisher



Blessed is the person who is
too busy to worry in the daytime
and too sleepy to worry at night.

--Leroy Aikman

Talent is a flame. Genius is a fire.

--Bern Williams

Ability will never catch up with the
demand for it.

--Malcolm S. Forbes

A stumble may prevent a fall.

--English proverb

Some folks pay a compliment like they went down in
their pocket for it.

--Kim Hubbard

The man who removes a mountain begins by carrying away small
stones.

--Chinese proverb

The Four "A's" to success in surgery: accountability,
availability, affability and ability (and usually in
that order).

Be tough-minded but tenderhearted.



Laugh a lot - a good sense of humor
cures almost all of life's ills.

Strive for excellence-not perfection.

Your mind can only hold one thought at a time,
make it a positive and constructive one.

You can hurt me, but you can't stop the clock!

AWS POCKET MENTOR ORDER FORM

To request additional copies of the "Pocket Mentor", please complete the information below and mail this form to the Association of Women Surgeons. There is no charge for a copy of this publication.

Name: _____

Affiliation: _____

Address: _____

City, ST, Zip: _____

Phone: _____

Please send me _____ copies of the AWS "Pocket Mentor".

Thank you for your interest in the AWS Pocket Mentor, A Manual for Surgical Interns and Residents.

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