Message from the DIO
By Sugat Patel, MD, DIO

Please help me welcome our new group of trainees to Good Samaritan Regional Medical Center (GSRMC). Thirty-four interns and fellows joined our Graduate Medical Education (GME) and Samaritan family and will begin training in one of our nine programs. Thus, we return to the beginning of our annual GME academic life cycle. Summer marks a time of orientation for our new trainees and reflection for our programs. All new interns complete a week long indoctrination to SHS’s mission, values and vision. They meet with senior SHS leadership, GME administrative staff and the patient care team. During the first several months, each program aggressively mentors, supervises and supports these new physicians as they begin, arguably, the most time demanding and empowering phase of their training. They learn that patient care is a team sport where all members of the patient care team from the physicians and nurses to nutrition services and discharge planners are equal and vital members. Similarly, educating these new physicians is a team sport. Each member of the patient care team has an expertise vital to the education of our new physicians.

During this busy time, programs are self-evaluating all components of training. Each program has a standing Program Evaluation Committee (PEC) which meets to refine the educational curriculum. They are required to submit a report, the Annual Program Evaluation (APE), to the Graduate Medical Education Committee (GMEC) which is tasked to oversee each of our programs and ensure compliance to institutional and accreditation standards. The APEs are then summarized in an Annual Institution Report which is presented to GSRMC Board in the Fall. Through this recurrent cycle of self-evaluation, each of our programs evolves to offer better training in the ever-changing learning environment.

In this edition of the GME newsletter, we again continue our education and understanding of the CMS STAR rating and discussion on fatigue management. The assessment of trainees is critical to their development and we share how we evaluate their performance. Transparency in the operations of GME has been my goal since I look this position in 2016. This newsletter is meant not only to highlight our activities but also provide insight into how we function.

*Please note that throughout this newsletter the term “resident” may refer to both specialty residents and subspecialty fellows.*
Welcome new Residents and Fellows
Scavenger hunt fun...

GME decided to do something new this year during orientation. We sent our new residents off on a scavenger hunt. Broken into four teams, they went around the campus to answer a few questions by way of a photo-contest. Extra points were given to photos that included staff involvement and creativity. The winning teams’ photos are below. For a list of all the new interns, residents and fellows, please see page 4.

Thank you to all the staff who participated in this event!

**Winning Team Members:** Claire Unruh, DO; Stefani Altmann, DO; Adam Knutson, DO; Margaret Kim, DO; DeeAnna Hess, DO; Benjamin Yousey, DO; Christopher Dai, DO

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**Find Samaritan’s Mission and Vision Statement**

**Find your DIO ...**

**Locate the medicine resident lounge**

**Without speaking—take a photo of a poster that promotes a current Samaritan patient satisfaction initiative**

**Locate Medical Nutrition Therapy Office and answer a set of questions (given on the form)**

**Locate the surgery resident lounge**

**Locate a fire extinguisher in the Emergency Department**

**Locate the resident sleep rooms**

Photos continue on page 3...
Find where each program director resides and take a picture with them or their designee (8 in total)

Tracy Hume, DO, Associate Program Director, Internal Medicine

Bharat Gopal, MD, Family Medicine Core Faculty Member

Francis Celis, DO, Program Director, Cardiology Fellowship

Jacqueline Krumrey, MD, Program Director Orthopedic Surgery

Michael DeLollis, MD, Psychiatry Faculty Member

Hannah Fine, DO, Program Director, NMM+1

Tim Blumer, DO, Program Director Child and Adolescent Psychiatry Fellowship

Jennifer Serfin, MD, Associate Program Director, General Surgery
## Welcome new Residents and Fellows

### Internal Medicine Residents:
- Michael Chen, DO
- Lauren Dallas, DO
- Daniel Henery, DO
- Amandeep Kaur, MD
- Philippe Knapp, DO
- Adam Knutson, DO
- Tyler Schulz, DO
- Benjamin Yousey, DO
- Zachary Zanfes, DO

### Internal Medicine Traditional Interns:
- Stefanie Altmann, DO
- William Hund, DO

### Cardiology Fellows
- Sonia Hasbun, DO
- William Stoutt, DO

### General Surgery Residents:
- Christopher Dai, DO
- Kathleen Stutz, DO

### Family Medicine Residents:
- Ngoc-Tram Huynh, DO
- Amna Khan, MD
- Margaret Kim, DO
- Sapna Krishnan, MD
- Stefan Leo-Nyquist, DO
- Natalie Peck, DO
- Abdulrahman Rahim, DO
- Claire Unruh, DO
- Brittany Whitaker, DO

### Orthopedic Surgery Residents:
- Taylor Brown, DO
- Teigen Goodiel, DO
- Jared Sanderford, DO

### Psychiatry Residents:
- Yassmin Atefi, DO
- DeeAnna Hess, DO
- Ashley Hoeck, DO
- Connie Shen, MD

### Child and Adolescent Psychiatry Fellows
- Shannon Meador, DO
- Courtney Rosenthal, DO

### Neuromusculoskeletal Manucept Medicine (NMM) Residents:
- Joshua Skufca, DO

### Pharmacy Residents
- Amber Meier, Pharm.D.
- Chandni Patel, Pharm.D.

### Psychology Resident
- Terra Bennett-Reeves, Psy.D.

### Psychology Interns
- Kate Khoukaz
- Laurie Rullan
- Courtney Hurd
- Michelle Fong

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*Back Row: Left to Right: Jared Sanderford, Teigen Goodiel, Amandeep Kaur, Adam Knutson, Connie Shen, Michael Chen, Christopher Dai, Philippe Knapp, Daniel Henery, Stefan Leo-Nyquist, Benjamin Yousey, Abdulrahman Rahim, William Hund, Zachary Zanfes*

*Front Row: Left to Right: Tyler Schulz, Taylor Brown, Yassmin Atefi, Stefanie Altman, Kathleen Stutz, Sapna Krishnan, Ngoc-Tram Huynh, Margaret Kim, Amna Khan, Ashley Hoeck, Brittany Whitaker, DeeAnna Hess, Claire Unruh, Natalie Peck, Lauren Dallas*
Wellness Corner

Fatigue Part 2

In our Spring issue we discussed what fatigue is, the physical, mental and social consequences it has and how to recognize signs of fatigue. This issue will focus on the link between medical error and fatigue and identifying strategies for managing fatigue.

The information in this section is referenced from the LIFE curriculum developed by Duke University.

Fatigue and lack of sleep can impair a physician’s attention, judgement and reaction time, in turn, impairment in these areas can compromise patient safety and lead to medical errors. Without proper sleep your cognitive function begins to deteriorate.

- Baseline cognitive performance may be decreased by 25% after one night of no sleep and by 40% after a 2nd night of no sleep.

All medical specialties are prone to experiencing fatigue. Multiple studies have been conducted regarding fatigue and medical errors. The following are some examples:

- 20 % more errors and 14 % more time to perform simulated laparoscopic procedures
- ECG interpretation impaired
- Increase in time required to place an arterial catheter and to intubate
- Decreased reduction in comprehensiveness of physical assessment and documentation
- In-service training exam scores correlated with pre-test sleep amounts
- Needle-stick accidents that increase the risk of infection by blood-borne pathogens increase by 50% during night shifts, compared with day duty.

Fatigue cannot be eliminated, but it can be managed efficiently.

- When noticing excessive sleepiness in a worker—treat it as a performance issue and this should require an evaluation
- Workers may have conditions that have sleepiness as a symptom: Medical conditions such as hypothyroidism; Psychological disorder such as depression; side effect of a medication such as a beta blocker; primary sleep disorder
- Reduce exposure to Night Float systems—these systems are associated with greater risks for patient safety.
- Pay attention to night shift structure—no one formula for scheduling appears to work better than any other. Up to 95% of workers are unable to adjust, regardless of the division in hours.
- Prophylactic naps may help. Allowing for one-hour naps demonstrated enhanced awake activity; experienced less stress and felt workload was less burdensome. Napping during on call hours is helpful, but timing of naps can be critical
- Worst Nap Time: Evenings between 8pm and 10pm—but any nap is better than no nap
- If caffeine is used on-call remember it takes approximately 30 minutes for effects to take place; effects only last three or four hours and too much caffeine can develop into a caffeine tolerance; and it may interfere with subsequent sleep opportunities

For a list of wellness resources see page 13 or contact Megan Kinane at mkinane@samhealth.org

“Even moderate levels of fatigue produce higher levels of impairment than proscribed blood levels of alcohol intoxication.”
- Dawson, D and Reid K.
Alumni Spotlight

Vania Manipod, DO

Residency Program: Psychiatry
Completed Residency: 2012
Current Practice: Ventura, CA
Hometown: Rancho Cucamonga, CA

Where has life taken you after residency?
During residency, I hoped to find a way to incorporate my childhood dream to become a journalist into my future career as a psychiatrist. I started blogging about my life during residency as a creative outlet and also a way to connect with others, which evolved to become a social media platform with a goal to break the stigma of mental health. After my vulnerable post about my experience with burnout during my 1st job after residency was posted on KevinMD.com, it eventually led to multiple invitations for speaking engagements nationwide and media opportunities. After my experience with burnout, I became self-employed and currently work in private practice in southern California. I remain involved with my medical school as assistant clinical professor at Western University of Health Sciences and have expanded my advocacy efforts as a newly appointed council member of the American Psychiatric Association's Council on Communications.

What is your great takeaway from residency?
Take advantage of residency as an opportunity to learn as much as possible before you are out on your own, but don’t forget to have fun and get to know your co-residents—they not only might be some of the best friends you’ll ever make, but can also become like family to support you through ups and downs of training.

Best words of advice/wisdom from residency faculty members?
That a good leader doesn’t take the special parking space up front and to not let criticism deviate from doing what one is passionate about (when questioned about if it was appropriate and professional to blog during residency)—words from Mike May, MD, previous Psychiatry Program Director.

The importance of setting boundaries—Cindy Aron, LCSW

Biggest surprise when hitting the “real world”?
During residency I envisioned that graduating and finally being out in the real world meant freedom and instant happiness, but it was actually a big shock when I started to grieve being a resident and a student.

You don’t hear about the struggles dealing with adjustment after graduating, so I want anyone else who has felt the same to know that it is normal and okay if it takes a while to adjust to life after residency.

What do you miss most about the Corvallis area?
The clean air, how green it is, and the friendly people. But I especially miss my friends from residency and all the wonderful Attendings and staff I connected with during my time there.

If you were to start all over again would you choose your same career/specialty?
Yes, definitely! There is an art to psychiatry and the beauty of the specialty is in the therapeutic connections we develop with our patients. I look forward to contributing as much as I can to this growing field.

You may follow Dr. Manipod’s blog at http://freudandfashion.com/
To read articles published by Dr. Manipod on KevinMD.com please visit: https://www.kevinmd.com/blog/post-author/vania-manipod

ADVICE FOR MEDICAL STUDENTS/RESIDENTS:
Be nice to staff and the medical team.
You’ll be so busy caring for others, but don’t forget to care about your own wellbeing.
Quality and Patient Safety
CMS Star Ratings and the patient experience
By Barb Croney, VP, Research and Education

The Centers for Medicare & Medicaid Service (CMS) started the Star Rating program in 2007 as a way to provide consumers with quality information about nursing homes and Medicare Advantage Plans. These measures included a wide range of indicators including, clinical quality, customer satisfaction, regulatory compliance and other experience indicators (Zavadil, 2015). Public reporting through Hospital Compare began in 2002 to "promote reporting on hospital quality of care" but was not easy for consumers to understand. In 2005, 10 Core Measures were the first clinical quality indicators to be required for public reporting. By 2008 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results were added to public reporting (CMS.gov, 2018). Intending to provide simply presented information to consumers, CMS implemented the five-star rating system for hospitals through the Hospital Compare website in 2014 (Bresnick, 2014). Today, seven (7) groups of measures make up the overall star rating for hospitals. Four of the groups make up 88% of the total scoring. Each group includes multiple indicators and each indicator in the groups are weighted differently in the total percent score.

<table>
<thead>
<tr>
<th>Group</th>
<th>Group Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>22%</td>
</tr>
<tr>
<td>Readmission</td>
<td>22%</td>
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<tr>
<td>Safety of Care</td>
<td>22%</td>
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<tr>
<td>Patient Experience</td>
<td>22%</td>
</tr>
<tr>
<td>Efficient Use of Imaging</td>
<td>4%</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>4%</td>
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<tr>
<td>Effectiveness of Care</td>
<td>4%</td>
</tr>
</tbody>
</table>

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS is a survey of our patients that measures the patient experience and is required for a hospital or health system to receive payment from CMS. The survey is for adult inpatients, excluding psychiatric patients. An outside vendor, Press Ganey, conducts these surveys for Samaritan Health Services.

Our Patient Experience Score is based on the answers to the following questions:
How often did nurses communicate well with patients?
How often did doctors communicate well with patients?
How often did patients receive help quickly from hospital staff?
How often was patients' pain well controlled?
How often did staff explain about medicines before giving them to patients?
How often were the patients' rooms and bathrooms kept clean?
How often was the area around patients' rooms kept quiet at night?
Were patients given information about what to do during their recovery at home? *
How well did patients understand the type of care they would need after leaving the hospital?
How do patients rate the hospital?*
Would patients recommend the hospital to friends and family?*

The HCAHPS scoring is Never – Sometimes – Usually – Always for all measures except those indicated with an asterisk which are either Yes/No or a 10-point scale.
The only answer that gives us Star credit in the Never – Sometimes – Usually – Always questions is ALWAYS.

In the spring of 2018, Paulina Kaiser, PhD, MPH, Olivia Pipitone, MPH and Liam Finlay, MS in coordination with Theresa Herrera, MBA and Glen Cunningham, RN, MBA embarked on a “deep dive” analysis of the data held in the CMS data pool for each SHS hospital with the goal to use the data to drive decisions on where each hospital should focus its improvement efforts. This analysis showed that all 5 hospitals could make significant gains to improve their Star Rating through improving the Patient Experience. For Good Sam, the questions “How often was the area around patients’ rooms kept quiet at night?” scored a 1 star and “How often were the patients’ rooms and bathrooms kept clean?” a 2 star.

As a result, the Clean and Quiet campaign was launched on July 12, 2018 at Good Sam. This work includes raising awareness, expanding quiet hours and the addition of the Customer Experience Response Team (CERT) to the housekeeping staff. In support of creating a quiet environment and to improve the tools available to our patient’s rest time, a multidisciplinary working group that included 2 hospitalists, part of the Quiet Committee workgroup, tested and selected new ear plugs, ear buds and headphones. Staff are asked to encourage patients to use these tools anytime they want to rest. Physicians, includes trauma surgery, general surgery residents, hospitalists, and IM residents have also begun talking about the patient’s experience as part of their normal rounding conversation. Nearly all nursing floors had implemented quiet times but found it difficult to enforce and policies were not consistently supported or understood by other staff and visitors. By standardizing times, larger signs that are set out at the beginning of quiet time and put away at the end. This greater awareness will provide for better support and will help to inform both staff and visitors.

We strive to engage everyone to be an active participant in support of a more restful and healing environment. During quiet time, we ask everyone to lower their voices and limit activity (as much as safe and feasible). In a review of literature conducted by Dr. Sugat Patel, he found evidence of a reduction in delirium when quiet time interventions are implemented. Additionally, beneficial effects have been shown in anxiety and sedation frequency as well as improved satisfaction (Patel, 2018).

It is everyone’s responsibility to work together to provide the best experience for patients and families. When asked during the HCAHPS survey after discharge, our patients should feel confident that they can answer the survey questions with ALWAYS.

**CERT Contact Info**

**Customer Experience Response Team**

Call 541-602-0592 to dispatch the CERT Team when:
- You need an immediate response to insure excellent customer service
- A customer requests a spill clean-up, trash or linen removal, sanitizing, disinfection of restrooms or any other cleaning need

We need to ensure that our patients feel their rooms are ALWAYS clean

CERT hours of operation are 4 p.m. to 12:30 a.m. daily

For more information, contact aperlich@samhealth.org

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**Updates from the Research Development Office:**

**Committees you should know about**

By Olivia Pipiton, MPH & Paulina Kaiser, PhD, MPH

Paulina Kaiser (epidemiologist) and Olivia Pipitone (biostatistician) from the Research Development Office (RDO) are always available to help you plan, conduct, summarize, and share your research and/or quality improvement projects. But, if you are looking for additional support with scholarly activity or looking to get more involved with scholarly activity at Samaritan, there are some amazing committees that you should know about!

**The Scientific Review Committee (SRC)** was created in 2017 to review the scientific merit of investigator-initiated research projects at Samaritan, but has grown beyond its original scope to become a think tank for supporting all types of scholarly projects at all stages of development. This committee is a powerhouse of people with passion and experience in research and quality improvement, including the RDO, GME, physicians (inpatient and outpatient), pharmacy, psychology, clinical research, and residents. The SRC meets monthly to share research-related updates and discuss scientific and logistical issues with specific projects. If you are in the early stages of a project and would like an experienced group to brainstorm with, please join an upcoming SRC meeting!

**The Scholarly Activity Committee (SAC)** is subcommittee of the GME Committee and is tasked with supporting all residency programs in the growth of their scholarly activity curricula, resources, and experiences. The SAC’s overarching goal is to promote and develop Samaritan’s environment of inquiry and scholarship. Please email shsresearch@samhealth.org if you are interested in participating (the committee meets quarterly for an hour over lunch).

**The Resident Quality Council (RQC)** is a resident-led committee with representation from each residency program, the RDO, risk management, GSRM-C’s quality department, and GME. This group is focused on making meaningful change at Samaritan, especially where residents are involved. They have completed some very successful projects, such as the development of a resident tool for unusual occurrence reporting. They are also in the process of implementing a FREE group workout class for residents, in response to results of the resident wellness surveys. If you are interested in quality improvement, or have ideas for meaningful change within GME or Samaritan, please help us by joining the RQC!

If you are interested in getting help from any of these groups, or in participating as a member, please reach out to the RDO at shsresearch@samhealth.org.
Resident Spotlight
Eric Matthew Vinceslio, DO

Residency Program: Family Medicine  
PGY: 3  
Hometown: New York, NY  
Undergrad: Columbia University  
Medical School: Western University of Health Science—COMP NW

Dr. Vinceslio was nominated by GME leadership due to the dedication he exhibits among training, community, research and patient care.

Dr. Vinceslio has completed several research projects around the use of a novel ultrasound probe and its application in an extended fast exam under body armor in combat setting (see page 12 for abstract), as well as, interpretation in the field and helicopters using night vision. This technology and procedure has been used in Afghanistan and continues to be implemented in select military rescue units.

What did you do prior to medical school?
Prior to medical school, I served in the US Air Force as a Firefighter/Paramedic. This allowed me to serve overseas where I spent a total of seven years in six different countries. My service was during a time when military resources were stretched thin across multiple foreign operations. Witnessing the gaps in healthcare access in both those local communities, as well as, in our own military, motivated me to apply to medical school the with intention of returning one day.

Favorite Interest/Hobby?
I enjoy working out, cooking and exploring the PNW with my wife, daughter and our dog.

Do you have any advice for current and/or future medical students?
The person who said, “the days are long, but the years are short,” was likely referring to residency. Although, the inherent stress of this journey can cause you to count down the days until graduation, the reality is that you have a very limited number of years to prepare yourself before you are off to practice without the safety net that residency provides. Take advantage of every learning opportunity presented, but don’t lose yourself in the process. Remember to practice self-care, love those accompanying you on this ride, and most importantly, never lose sight of the fact that you have been given the honor of providing care to those in their most vulnerable states.

What is your most memorable moment or proudest moment during residency?
There are many but an aspect that stands out the most is being allowed the privilege of providing prenatal care to a patient, delivering her baby, and then becoming the newborn’s doctor. The ability to provide that continuity of care highlights one of the many things I love about my specialty.

What is on your wish list for the next 10 years?
After residency I will be returning to the military, although this time with the US Navy, where I will have eight years to serve before retirement. During this time I would love to secure a position at a post in Europe and/or Japan. Additionally, I look forward to pursuing additional training such as undersea medical courses and hyperbaric medicine. After falling in love with the PNW over the last six years, my wife and I are strongly considering returning to Oregon after our military service is complete.

Family Life
The Vinceslio home continues to host a competition we call “who’s the busiest”. My wife, Lucy, also works for Samaritan and will soon celebrate her 5th working anniversary. She spends her free time playing soccer, attending weekly trivia nights and making our home “the place where all the kids love to hang out”. Our daughter, Kate, was selected for an internship which allowed her to work on an engineering research project at Oregon State University. In the Fall, she will be starting her Junior year of high school, building robots, and tending to her burgeoning pet-sitting business. As for our dog, Ruby, the world continues to revolve around her and we wouldn’t have it any other way.

Please send all resident nominations to Megan Kinane at mkinane@samhealth.org
Please include the following:
Subject Line: Resident Nomination  
Email Body: Include the reason for nomination
Did You Know?

Resident and Fellow assessment and evaluation: Part One

By Megan Kinane, MHA

Residency and fellowship is a rigorous journey that entails clinical rotations throughout multiple specialties, mandatory research, long hours and lifelong learning. To mentor and shape young physicians into becoming an independent physician that provides top quality patient care and professionalism requires strict evaluation and mentoring to know when a resident and fellow are competent to work independently.

This article will showcase the evaluation process that all residents undergo when they are a part of a residency or fellowship program. Patients, peers, co-workers, administrative staff, attendings all play an integral role in the evaluation and development of our residents and fellows, so I hope that this article provides you with more insight on what takes place behind the scenes of GME.

Residency and fellowship programs are a competency-based education system, meaning that progression is not based on time, but mastery of a certain skill and knowledge set (Holmboe, Edgar & Hamstra, 2017). While each program still has an overall time requirement that must be met, completion of residency and fellowship is based off of a learner being fully competent in six areas. These six competencies (ACGME, 2017) are:

1. **Patient care and Procedural Skills**: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

2. **Medical Knowledge**: Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

3. **Practice-Based Learning and Improvement**: Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

4. **Interpersonal and Communication Skills**: Residents must demonstrate interpersonal and communication skills that result in effective exchange of information and collaboration with patients, their families, and health professionals.

5. **Professionalism**: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles.

6. **System-Based Practice**: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Over the course of their education they will have undergone many different forms of evaluations. While each program has a unique set of evaluation tools specific to their specialty, there are components of a residents evaluation that are required by ACGME. At minimum, each program must have these evaluations:

1. **End of rotation evaluations**: After each assignment a resident will be evaluated by an attending (physician providing the oversight and ultimately responsible for the resident). The end of rotation evaluations have component of each of the competency field, but will be specific to the type of rotation that resident was on.

2. **360 Evaluations**: These evaluations are highly important and involve every single person within the hospital and clinic. These evaluations reach out to other clinical team members to get a sense of a residents interpersonal and professional competencies. 360 are evaluations that go out to peers, patients, nurses, PAs, discharge planners, administrative personnel and any other team member that a program would like to include in the residents evaluation.

3. **Self-Evaluations**: Each resident should have an opportunity to self-reflect on their competencies and evaluate themselves.

4. **Procedural/Operative Skills Evaluation**: Residents are evaluated on procedure and/or operative skills specific to their specialty.

5. **Semiannual Evaluation** of resident performance with feedback: Each program is required to meet with the resident on a semiannual basis to review their progress and evaluation—this is known as Milestones. This process will be defined in detail in our next issue of GME Quarterly.

6. **Summative Evaluation**: This is the final stage of the residents education. The summative evaluation must document the residents performance during the final period of education and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

This is just a glimpse into a larger evaluation process that happens within GME. You may be wondering how one makes sense of all these evaluations, and how does it all tie together to create coherency? In the next issue of GME Quarterly, the role of the Clinical Competency Committees (CCC) in the evaluation process will be discussed.

Resources: ACGME Common Program Requirements (2017)
Simulation Lab

General Surgery Residents attend Hernia Lab at New SHS Sim Lab

By Megan Kinane, MHA

On May 12, 2018, the General Surgery Residency Program collaborated with Cook Medical to put on a Hernia Workshop, a first for our newly acquired simulation lab in Corvallis. "This is the first of its kind here in the mid valley," shares General Surgery Program Director, Toshio Nagamoto, MD. "We normally send our residents out for a weekend course for something like this."

The workshop was an all day event led by two surgeons, Rob Yates, MD from University of Washington, and Samaritan's own, Dr. Nagamoto. The workshop consisted of a morning didactic session on hernia repairs, followed by a hands-on session using freshly embalmed cadavers. The workshop allowed residents to practice skills on component separation techniques to repair complicated abdominal wall hernias in a safe environment. "Getting hands-on experience with personalized direction from an expert on anatomy we rarely get an opportunity to work with is one of the most helpful ways to learn," shares General Surgery resident Andrew Sweeny, DO. Dr. Sweeny is in his final (fifth) year of residency with our general surgery program.

The general surgery program is currently working on organizing another workshop this fall which will cover advanced laparoscopic skills. As the sim lab is still in its beginning phase of development, the hope is that the sim lab will soon acquire their own laparoscopic simulators where the residents can continue to practice their acquired operative skills in their own time and also allow the program to track their progress. "We would love to see an Advanced Trauma Operative Management (ATOM) course, which would be focused on the 4th and 5th years leading the junior residents through advanced operative cases," shares General Surgery Resident, April Jensen, DO. Dr. Jensen is in her final year of residency alongside Sweeny. It is clear that having a sim lab in this community is invaluable to all residents educational experience.

GME will continue to update you on sim lab development and how the space is being utilized.

If you have any questions about our Sim Lab, or if you would like to schedule an event, please contact Chrissy Anderson at 541-768-4906
**Featured Abstract**

Applying a Novel Ultrasound Finger Probe and FAST Examination to Identify Structures of the Abdomen and Thorax of Cadavers Wearing Personal Armor

Eric Vinceslio, OMS III; Noble Matthew, OMS III, Brion Benninger, MD Medical Anatomy Center, Western University of Health Sciences College of Osteopathic Medicine of the Pacific-Northwest, Lebanon, Oregon

**Introduction:** Protective armor dates back to 1400 BCE and has been implemented to protect the wearer from various injuries. As weapons have advanced through the centuries, so too have the protective garments developed to minimize their affect. Progress has similarly been made within the fields of medicine, and currently using ultrasound (US) stands at center stage. US has a wide spectrum of uses in the area of trauma screening. One such use is the focused assessment for sonography for trauma (FAST) examination. This examination implements technology to identify free fluid in the spaces of perihepatic, perisplenic, pericardium, and pelvic regions.

**Objective:** To investigate if US can identify FAST examination structures on cadavers wearing protective armor. Methods: Literature research was conducted regarding US use with cadavers wearing protective armor. Standard issue military flak jacket was placed on 10 cadavers and 3 healthy men. Conventional and finger US probes were used to identify spaces in the abdomen and thorax using the FAST examination.

**Results:** Literature research revealed no known articles regarding US use during FAST examination with protective armor on cadavers and in situ. Conventional US probe was unsuccessful in identifying structures. US finger probe was successful in identifying spaces in the abdomen and thorax with cadavers and in situ and with armor. The ability to perform the FAST examination on patients wearing protective armor could potentially improve triage and delivery of health care in and around the battlefield. Currently protective armor is removed to assess the injuries placing the patient at increased risk during evaluation and transport. This study revealed a valuable tool allowing safe assessment of spaces involved in life-threatening injuries. Conclusion: This study revealed that a novel US finger probe could be successfully applied to identify FAST examination anatomy spaces in the abdomen and thorax while wearing protective armor.

GME Directory and Resources

Wellness Resources

Resources to assist those experiencing burnout, depression and substance abuse:

◊ Vital Work Life (For Residents/Physicians)
◊ Calapooia Employee Assistance Program—From the SHS Insider, search “Calapooia Employee Assistance”, click on the first option and you will be taken to a PDF brochure. Please contact Megan Kinane or your HR office if you are having trouble finding this information.
◊ Health Professionals’ Services Program (HPSP) & Reliant Behavioral Health (offered through the State)

If you are battling fatigue—remember that SHS has multiple RESIDENT ONLY sleep rooms available:

◊ GSRMC first floor: 2 surgery sleep rooms
◊ Ancillary Building second floor: 6 sleep rooms

Counseling Services (family, marital, relationship):

◊ Vital Work Life (for Residents/Physicians)
◊ Calapooia Employee Assistance Program

Financial Counseling (budget and credit counseling, debt management plan, housing counseling (pre-purchase, mortgage and rent delinquency counseling) and credit report review):

◊ Vital Work Life
◊ Money Management International
◊ Principal Financial Group

Policies and Procedures

Resident and Faculty access: New Innovations Portal
All others: SHS Insider: Policies and Procedures: Departments: Graduate Medical Education