

The Residents Report

October 2005

Systems of Care, Sign-outs, and a New Professionalism

Jonathan Carter, MD

If you asked the average inpatient at UCSF to point to *their doctor*, more than likely you would get a puzzled look. Who would be singled out? The intern or the attending? The intensivist or the surgeon? It may seem as if the infectious disease fellow is the one really calling the shots. And what about the cross-cover guy, who seems to swoop in only when there's a problem?

But the patients would only know half the story. They have no idea how many times their care is handed off each day, behind the scenes. So, if you were to ask an intern the same question, he or she would tell you that the answer depends on the time of day, day of the week, whether the team is "capped" (it already has the maximum allowable number of patients), whether the intern was on-call or post-call, and so forth. And that is only for the primary team! When you count consultants, who themselves are organized into teams of cross-covering physicians, the situation really gets confusing. A patient hospitalized by medicine team B with specialty care provided by general surgery, nephrology, and infectious disease may be the subject of a transfer of care *every hour*. And we haven't even considered the care provided by others: nurses, nurse practitioners, therapists, care coordinators, dietitians, social workers. They also work in teams, transferring care from shift to shift.

With so many hand-offs, the hospital must have a highly efficient way of tracking the patient's progress and transferring information between providers, right? Wrong.

Our information system has evolved little over the past 80 years. We still depend on the paper-based chart. And as we know from experience, trying to reconstruct a patient's course-of-illness by reading the paper chart is often an exercise in futility. Even when the notes are legible, they are typically written by the most junior person BEFORE a plan for the day has been developed, or conversely, the note may first appear in the chart several days AFTER the information it contains is needed. Thus, the paper chart is often misleading and, therefore, a potential cause of error.

The problem is that the current hospital chart was designed to facilitate filing information, not

retrieving and summarizing information. The chart was designed by chart *builders*, not chart *users*. Lawrence Weed identified this problem in the 1960s: our source-based chart (i.e., information is organized by where it came from: laboratory, radiology, microbiology, blood bank) fails miserably. Weed championed the problem-based medical record, in which all information is organized around the patient's problem list. Unfortunately, Weed's ideas were never fully incorporated into practice. We still organize the charts by source. And too often physicians wind up primarily servicing the needs of the chart; the chart is unable to service the needs of the physician.

The problem is so bad that residents everywhere have created their own ad-hoc information systems to track the progress of their patients. These systems range from simple index cards, to Excel® spreadsheets, to PDA-based trackers, to FileMaker Pro® databases. On some services, these parallel informal systems have achieved a high degree of standardization and acceptance: interns make entries into the paper chart to satisfy the hospital, lawyers, and JCAHO, and in FileMaker Pro® for their team's own information and decision-making.

Such ad-hoc systems have a major problem: they don't interface with the real medical record. The information they contain cannot be shared, nor can data from the hospital information system be imported. As shadow charts, they remain limited. When I was an intern, my biggest gripe was that at the end of every workday I had to remain in the hospital an extra 45 minutes to "update the list". And every time I rotated to a new service, I had to learn a new system.

Times are changing. This fall, UCSF rolled-out UCare, a new hospital information system which replaces STOR, the bedside vital sign flowsheet, and much of the paper chart. By December, the system will be activated on most acute care floors at UCSF. Eventually, providers will use UCare for all inpatient clinical data, and the paper chart will be eliminated entirely.

But here is the best part for the house staff. UCSF residents and software engineers have teamed up to develop a patient-tracking and sign-out tool that will be an integral part of UCare. It will

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The Dean's Office, School of Medicine

GME LICENSE FAIR

For resident physicians, to facilitate the steps required by the California Medical Board for licensure, Graduate Medical Education is hosting a licensing fair. Bring your completed California Medical Board Application for Licensure available online: <http://www.medbd.ca.gov/Applicant.htm>

When: Wednesday, October 12, 2005
Where: Millberry Union, City Lights Room
Time: 12:30-8:00PM *Pre-Scheduled Fingerprints 12:30-4:00PM
*4:00-8:00PM ALL SERVICES
Cost: Notary Public Services - \$10 per signature
Fingerprinting - \$18 for Live Scan process
Photographs - \$7 for 1 photo (2 ¼" x 3")
(Cash and Checks only accepted!)

- *A photographer will be available to take a digital license photo, ready within minutes.
- *Bring a completed L1 Application form, and attach the photo for notarization.
- *The request form for USMLE transcripts from the Federation of State Medical Board can also be notarized.
- *Live Scan fingerprint services and forms will be available to process your fingerprints.
- *Fingerprints from 12:30-4:00PM will be pre-schedule. Sign up sheets will be available at the GME office on October 6th and 7th from 8:00AM-5:00PM.
- *Fingerprints from 4:00-8:00PM will be on a first-come-first-serve basis. Numbers will be handed out the day of the fair beginning at 3:45PM.
- *A Representative from the California Medical Board will be present to answer questions and certify diplomas.
- *Bring an original Medical School Diploma and 8x11 copy for the Med Board representative to certify.

Call the Dean's Office Graduate Medical Education
at 476-4562 for more details.

The Dean's Office, School of
Medicine GME License Fair
Blumberg Loan

Need a Loan to Pay For the Medical License Fee? Blumberg Loan



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The Blumberg Loan is an interest free loan in which current School of Medicine Housestaff and Clinical Fellows are eligible to take part in. Qualified applicants may request up to twelve hundred dollars (\$1,200) through this short-term loan program.

Repayment must be made on a monthly basis with a baseline amount of one hundred dollars (\$100). To facilitate in the repayment process, a payroll deduction option is available to applicants receiving salary from the UC Payroll System in addition to the traditional monthly billing.

Participants of this loan program may opt for a repayment period for a maximum duration of up to twelve months. Additionally, qualified applicants may re-apply for the Blumberg Loan once their current loan balance has been cleared.

Please call the Graduate Medical Education Office at (415) 476-4562 or go to <http://www.medschool.ucsf.edu/gme/residents/financial/> for additional information and details.

Creating a New Community

Lisa Cisneros, Senior Public Information Representative

Community Center, Housing Complex Nearly Complete at UCSF Mission Bay

Campus life at UCSF Mission Bay will take a dramatic turn for the better when the long-awaited community center and much-needed housing complex opens this fall.

Construction of the highly anticipated Mission Bay Community Center — featuring a state-of-the-art fitness center and pub café — and the housing complex is nearly complete. The campus community center is expected to open to the public on October 1.

Within the next six months, those working and studying at Mission Bay also will see the opening of new dining and retail outlets, and conference service at Mission Bay. As a preview, Campus Life Services offers this brief update of upcoming services.

Housing

Located at the Gene Friend Way Plaza, the Hearst Tower Mission Bay Housing at UCSF is a complex of 431 apartments with a mix of studio, one-, two-, three-, and four-bedroom units.

Housing is open to UCSF students, postdoctoral fellows and faculty members.

The projected occupancy date is early August 2005. For more information, call Housing Services at 415/476-2311.

Fitness & Recreation

The Bakar Fitness & Recreation Center will offer three floors of fitness, health, and recreation for individuals and families. The boldly colored building designed by award-winning architect Ricardo Legorreta, features a light-filled atrium, dramatic tower, an indoor teaching and outdoor lap pools as well as various cardiovascular and weight machines and free weights.

For the first time, UCSF will offer drop-in child care for those using the fitness center or visiting the building.

The projected opening date is October 1.

Membership to the Bakar Fitness & Recreation Center is open to UCSF students and employees and Mission Bay neighbors. For information about memberships, [email](#) or visit the [website](#).

Shopping & Dining

Mission Bay Community Center Pub Café Plans are in development to open a pub café on the first floor of the Mission Bay Community Center. The café will offer breakfast, lunch and dinner service. Menu items will be determined by customer feedback. By providing beer and wine service — the license will be held by the food service operator — the pub café has the potential of becoming a central point for social gatherings.

Mission Bay Housing Shopping & Dining Three to six retail specialty eateries will be located on the plaza side of the Mission Bay housing complex.

Restaurants will vary in size and provide dine in and take out and catering services. In addition, UCSF has plans to provide on-campus ATMs, dry cleaners, and a convenience store.

These retail businesses will be added in phases beginning in late 2005 through March 2006. For more information about shopping and dining at UCSF Mission Bay, send an [email](#).

Conference Services

The UCSF Conference Center at Mission Bay, located within the community center, will provide a high-quality alternative to downtown facilities for special events hosted by UCSF, its affiliates, and appropriate public customers.

The plan is to have the center managed by a reputable conference center operator. When chosen, the candidate will not only operate the conference center, but also provide banquet facilities, and food service at the pub and Cafe 24, the eatery located inside Genentech Hall. The projected opening date for conference services is late October 2005. For more information, contact [UCSF Conference Center Services](#).

Child Care

Currently, the Marin Day Schools' Spear Street center supports a small number of UCSF families, through a negotiated agreement with UCSF Child Care Service. In the near future, UCSF will expand service to 75 more children when the new Mission Bay Child Care Center opens.

The projected opening for a child care center at UCSF Mission Bay is February 2006.

UCSF's goal is to increase overall UCSF child care by 300 percent by 2006 through expansion of existing centers and the development of new ones at major UCSF sites.

As always, families can take advantage of UCSF Child Care Resource and Referral Service, which help more than 400 UCSF families annually find a variety of childcare programs throughout the Bay Area. For more information about resources or referrals, call 415/476-2692.



Mission Bay campus. Photo by Mark DeFeo.

Creating a New Community



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Surgical Infection Prevention (SIP)

Andrew Auerbach, MD

Patient safety and quality are the primary goal for UCSF Medical Center. One measure of our ability to provide safe quality care is in Surgical Infection Prevention (SIP).

UCSF has undertaken a major initiative to reduce surgical site infections. This initiative is based on robust evidence, as well as guidelines from a variety of national organizations including the CDC, American College of Surgeons, American Academy of Orthopaedic Surgeons, Society of Thoracic Surgeons, Surgical Infection Society, American Society of Anesthesiologists, and the American Society of Colon and Rectal Surgeons. Locally, the initiative has been endorsed by the UCSF Infection Control Committee, the UCSF Quality Improvement Executive Committee, the UCSF Patient Safety Committee, as well as the Operating Room Committee.

The goals of the UCSF SIP initiative, and key aspects of the practices are outlined below.

- 1) 90% of UCSF patients have prophylactic antibiotics administered 60 minutes or less before surgery.
 - a. Antibiotics will be administered by anesthesia staff in the OR using IV push or rapid IV drip (most antibiotics, including cefazolin (Ancef®, Kefzol®), can be administered in this fashion).
 - b. Vancomycin is often used in clean surgical procedures in those patients with a history of life-threatening reaction to beta-lactam antibiotics. All beta-lactam allergies should be clarified to confirm the need for vancomycin. In those instances in which vancomycin is required, intravenous administration must take place over an extended period (one hour for a 1.0 gm dose) to decrease the rate of infusion-related side effects. Consequently, additional coordination between surgical and anesthesia team will be required in those patients requiring vancomycin.
 - c. No antibiotics are to be administered 'On Call to OR' or hung in preanesthesia area (with the possible exception of vancomycin).
 - d. Confirmation that antibiotics have been administered or the time they will be administered will take place at the 'time out.'
- 2) 100% of patients requiring hair removal at the surgical site will have clippers used.
 - a. Clippers are now available in all UCSF OR's at Parnassus, Mount Zion, and the ASC.
- 3) 100% of patients will have the appropriate antibiotic used for prophylaxis.
 - a. Laminated guidelines for antibiotic choices are available in all OR's.
- 4) 90% of patients will have prophylactic antibiotics discontinued within 24 hours of wound closure.
 - a. Clean and clean-contaminated wounds do not require antibiotics beyond 24 hours following wound closure.
 - b. **Please note the wound closure time on the AOS**, or adult postoperative patient safety orderset, in order to facilitate correct timing of the final dose of antibiotics.
 - c. If infection or contamination is noted during the operative procedure, do not check 'prophylaxis' in the AOS – document the site of infection appropriately.
 - d. Surgical drains are not an indication for prolonging antibiotics, unless they drain an infected space.

The new Adult Post-op Patient Safety Orderset also addresses cardiac risk reduction (peri-operative beta blocker use), prevention of VTE, and hyperglycemic management for surgical patients.

A full outline of the evidence used to support the practices included in the UCSF SIP initiative can be found at the webpage for the National Surgical Care Improvement Project (SCIP)

(<http://www.medqic.org/dcs/ContentServer?cid=1089815967030&pagename=Medqic%2FListingPages%2FMainListingTemplate&level3=Web+Links&c=MQParents>)

With focused efforts, we can improve our ability to implement the best practices and provide the best care for our surgical patients.

If you have questions regarding the UCSF SIP initiative, please email Dr. Andrew Auerbach (ada@medicine.ucsf.edu), Dr. Joseph Guglielmo (guglielmoj@pharmacy.ucsf.edu), or Dr. Jeff Katz (katzj@anesthesia.ucsf.edu).

Surgical Infection Prevention (SIP)



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Medical Center News

News From the VAMC

Patricia Cornett, MD, VAMC Education Office

The summer of 2005 has seen several changes at the VA. Most notable, there has been a change in nursing leadership; Gloria Martinez from a Southern California VA has replaced the retiring Margaret Alderman. Ms. Martinez has taken a very active role in redefining nursing responsibilities at the VA. Expectations of the RNs caring for patients include competent patient assessment, timely implementation of treatments and medications as well as procedural support in the form of IV starts, blood draws, performing EKGs and Foley catheter insertions both in building 203 and 208. These added technical skills of RNs will be able to bring the point of care to the patient, rather than having the patient move to receive a specific treatment or assessment. In the future, the plan will be to provide LVNs with similar training.

There has also been a change in the national resident supervision policy. Although most of the changes will affect attendings and their documentation of resident supervision, it is important for trainees to recognize that all resident activities must be supervised by an attending. Each patient encounter and its corresponding documentation, must have the supervising attending's name in the documenting note. Most of the computerized note titles will have imbedded text where the trainee must fill in the supervising attending of record.



An aerial view of San Francisco Veterans Affairs Medical Center

Lastly, the VA San Francisco had 2 Inspector General audits from the national office this summer. One audit team looked at resident time and attendance to ensure that the VA was receiving its fair share of resident hours; the other audit team looked at resident supervision by attendings. We are proud to report that both audits went very well with only a few, trivial findings. One item that was uncovered in the first audit was the tendency, at least for one program, to mandate that residents preferentially take leave from the VA rotations. This goes against VA policy and can not be allowed; the GME office will now be monitoring the distribution of leave amongst the participating hospitals for individual programs.

News From the Library

New Library Staff:

Josephine Tan, Education and Information Consultant for Clinical Sciences

Josephine Tan is the new Education and Information Consultant for Clinical Sciences at the UCSF Library and Center for Knowledge Management. Josephine's primary duties include working closely with students and faculty in the School of Medicine to help them efficiently retrieve and manage information to support their education, teaching, and clinical decision making. Josephine is available to teach classes on clinical information resources and to provide one-on-one consultations to assist with your library research.

Josephine earned her Masters of Library and Information Science from San Jose State



Josephine Tan

University and her Bachelor of Science in Biology with a Minor in Literature from UC San Diego. She comes to UCSF with work experience at Genentech as a business information specialist and at the University of Hawaii at Manoa John A. Burns School of Medicine as an acquisitions coordinator, where she maintained the Native Hawaiian Health Database for the Native Hawaiian Center of Excellence.

You can contact Josephine at 476-2534 or josephine.tan@library.ucsf.edu.

News From the VAMC
News From the Library



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allow physicians to store the same data now contained in ad hoc FileMaker Pro® databases, while incorporating good-practice principles of physician sign-out. The data from the sign-out file can then be used to generate a Rounds Report. In the Rounds Report, vital signs, intake/output, and recent labs are imported automatically. Pre-rounding should become a thing of the past.

Why should we be concerned with transfers of patient care and automating data-gathering tasks? The answer is patient safety and quality of care. Every major study on the subject has found that medical errors stem not so much from lack of information, but rather, information not being available to the provider at the time the medical decision was made. As pointed out by Richard Cook, medical errors are associated with gaps in the continuity of care, where information is lost. A major gap is the

transfer of responsibility (sign-outs). Another is morning rounds, where bedside information is frequently missing. While these gaps will always remain a risk, UCare should minimize their risk to patient safety.

The impact of UCare, the sign-out tool, and the Rounds Report will have to be measured, but the promise is great. Instead of spending an hour searching for missing bedside vital signs, medical students and interns will have an extra hour to read or evaluate patients. Who knows? By automating many of the service-oriented tasks residents perform today, UCare may foster a *new professionalism* among house-staff – where the focus is on education, and performance is measured by medical knowledge (and other core competencies). After all, isn't that why we came to UCSF in the first place?

The UCare Physician Patient-Tracking and Sign-Out Screen

The screenshot shows the UCare interface for patient SALK, JONAS. Key sections include:

- Patient Info:** MRN: 20090693, Gender: M, DOB: 09/28/1925, Age: 79 Years, Visit: 100960.
- Resident MD Signout:** Admission Diagnosis / Course: 79 yo man s/p right hemicolectomy for giant villous adenoma. 3/21 CP: EKG lat TWIs. trop 1.4. Rx BBlocker, ASA, heparin gtt. Shafton GASCO following. Temp to 38.5. 3/20 HCT 43->38. low grade fevers. 3/19 R hemi. uncomplicated OR course.
- Vital Signs:**

Assessment	Value
Temperature (C)	37
Heart Rate	70
Respirations	21
Systolic BP	138
Diastolic BP	72
O2 Saturation (%)	98
O2 Delivery Device	
Set-FIO2%	
Restraints	
TEDs	Off
SCDs	On
ICS	
- Problem List:** ileus: on clears, awaiting bowel function; postop MI: treated medically, Shafton following, on heparin/ASA. no plavix for now; fevers: cultures NGTD, plan to CT A/P on POD7 if persist, agg pulm toilet.
- Medications:** ASA 325 qd, metoprolol 5 iv q4h, heparin gtt, lisinopril 10 qd, dilauidid PCA, benadryl prn, tylenol prn, zofran prn, kefzol x24h c/c 3/20.
- Anticipated Problems/ToDo List:** TONIGHT: check CXR, r/o PNA. if infiltrate, start cefipime; check troponin at 10pm. call cards with result; TOMORROW: consult ID for fevers.
- Allergies:** PCN -> rash, latex.

Systems of Care, Sign-outs, and a New Professionalism cont'd



The Rounds Report

Patient	Medications	Admission Diagnosis / Course	Problem List	Anticipated Problems / To Do List
Team, Medicine A1 Attending: PATTI SR: SMITH RI: JONES 12L SMITH, Joan 29 44575655 49 F 05/18/1955 AdmDate: 06/08/2004 HD #3 Code Status: Full Code Allergies: Iodine, Penicillin	Tylenol elixir albuterol nebs q4h prn atracurium nebs q4h prn MI Tylenol prn protonix 40 po bid synthroid 150mcg po qd lisinopril 10mg po qd kefzol x24h postop (completed)	DRDay: 06/08/2004 POD #2 49 F Morbid Obesity BMI 46, Pre-op w/u shows gallstones, scheduled for Lap Gastric Bypass, Lap Chole H/O Hypothyroidism, DJD, GERD, HTN, Asthma, WV/prolapse, Morbid Obesity 6/9 - UGI (-) leak, but no passage of contrast past gastric pouch, started sips of H2O 6/8 - Lap Chole, Gastric Bypass	1) RYGB: tolerating liquids, undergoing dietary training. OTW on pathway. 2) asthma: on alb/atra q4h prn. No desats since OR.	1) Foley d/c. Void check. 1) D/C in am?
6/10 06:00 T 38.2/37.8 6/10 06:00 P 85 (72-92) 6/10 06:00 SBP 172 (140-172) 6/10 06:00 DBP 74 (68-80) 6/10 06:00 RR 14 (14-21) 6/10 08:00 SpO2 99 (90-99) 6/10 08:00 deliv 2L NC Wt 123.3 (120.2)	Report from 0600 7/30 - 0827 3/31 In 1850 GI 470 IV 1270 Other 110 Drine 1736 Smells 50 Stool 2 Other 50	(9.37)-->[8.79] / [11.3] / [134][100] [18] [126.2]->[33.91] cs: 102->97->91->93	[]=6/10 07:01 / []=6/10 11:05 [1.2][21] / [1.1]->[1.01] ABG: 7.44/33/135/22 - 6/10 10:15	[]=6/10 07:01 / []=6/10 11:05 [1.2][21] / [1.1]->[1.01] AST: [33]->[36] ALT: [0.9] AlkP: [0.9] Alb: (3.7)

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Chief Resident Spotlight:

Eva Hurst, MD, UCSF Department of Dermatology

It's hard for me to imagine that anyone actually wants to read very much about the "life and times" of Eva Hurst, but we'll give this a shot and I'll try to be somewhat interesting.

I proudly hail from Flippin (yes, you read it right, Flippin), Arkansas. It's a town with a population of about 1,300 nestled in the beautiful Ozark Mountains in North Central Arkansas. In Flippin, reside possibly the nicest and most supportive parents on earth...mine! From Flippin High School's graduating class of 44, I made my way to Hendrix College, a small liberal arts college located about 40 miles north of Little Rock (yep, that's still in Arkansas). ☺ I earned my Bachelor of Arts in Chemistry, with emphasis in organic chemistry—but don't ask me to draw anything more than a benzene ring these days!

I migrated a little north for medical school to Washington University in St. Louis. While I didn't know what specialty I wanted to pursue, I was sure it wasn't dermatology despite my father (who had a very early melanoma diagnosed and treated at age 37) who was adamant that dermatology was for me. Well...as much as we all hate to admit it, maybe it's true that dad knows best because by the end of my third year I started to think dermatology sounded pretty cool. And after a fourth year rotation and a research elective with my most influential mentor, Dr. Lynn

Cornelius at Wash U, I was hooked. Dermatology attracted me because of the fast-paced clinics (it kept me on my toes), the ability to treat all ages, form lasting bonds with patients, and the opportunity to do many procedures.

All I can say is that I'm a lucky girl to have the good fortune to have matched at UCSF Dermatology. And now, after two years of unbelievable learning and fun, I find myself the Chief Resident. Now here's where the luck really plays in.... I have 15 of the most amazing, intelligent, and hard-working colleagues that a Chief Resident could possibly imagine. My fellow residents make my job, which involves a mixture of scheduling, clinic administration, and teaching, a great one to have. I think any students or residents who have had the chance to rotate through dermatology would agree we're a happy group of doctors.

What else should I say without being too boring? I'm interested in the art of effective medical communication (I wrote and taught a course to first-years during my last year of medical school) and am happy to get to polish those skills as Chief Resident. I'm collaborating with urology on research involving male genital malignancies. I'll be hanging around another year at UCSF as I lucked out yet again and was offered a fellowship in Mohs Surgery/Procedural Dermatology.

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Hurricane Katrina Update

Amy Anderson, Graduate Medical Education

Hurricane Katrina tore through Florida, Mississippi, Alabama, and Louisiana at the end of August. In her wake, the 250-mile wide storm, roughly the size of Great Britain, left billions of dollars of damage, hundreds of thousands of people without homes, and approximately 1,200 dead. In the aftermath, there has been a huge outpouring of generosity from all over the United States. The Red Cross has received more than \$1 billion in donations and thousands of people have put their own lives on hold to go to storm-stricken areas to offer assistance. The UCSF community, like the rest of the country, has done everything it can to assist in relief and relocation efforts.

More than 4,000 doctors from New Orleans alone have been displaced from their clinics and hospitals. Tulane University and Louisiana State University have both decided to continue the education of their respective medical students, residents, and fellows at their institutions. Much of

this will occur temporarily at various academic campuses throughout Texas and Louisiana until Tulane and LSU students and housestaff are able to return home. However, some residents, in conjunction with their home departments, have asked to be either permanently or temporarily relocated. UCSF has happily accepted one permanent transfer from Tulane and will have several other residents from both Tulane and LSU doing three-month rotations in departments throughout the medical school until their home institutions have been rebuilt. UCSF has opened its doors to postdoctoral fellows, basic science graduate students, and faculty from the New Orleans region.

Further efforts include UCSF medical students working with Dean Kessler's office to raise money by selling Mardi Gras beads throughout the month of September and more than 120 medical and nursing staff from UCSF volunteering to go to the Gulf Coast region to assist with the relief effort.

The recovery process in New Orleans and other areas damaged most by Hurricane Katrina will take a tremendous amount of time, effort, and money. The Red Cross is continuing to accept donations at <http://www.redcross.org>. Please continue to support the relief effort and keep these people in your thoughts.

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Hurricane Katrina Update



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Chief Resident Spotlight

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Because I have an interest in policy and administration, I serve as the Resident Representative on the American Academy of Dermatology Board of Directors. I call my mom every day and my two 83-year-old grandmothers every Saturday. I have unnatural fears of automatic flush toilets, tall electrical poles, and flying. And last, but not least, I might be Madonna's number 1 fan! Just ask any of my residents. ☺

If you still have enough free time on your hands to be reading, I have one last thought...I feel extremely privileged to have had this amazing opportunity to train in Dermatology at UCSF. I think that my background gives me a unique perspective in that I firmly believe you can go anywhere and do anything and achieve any success you so desire if you truly believe in yourself and are willing to work hard.

Halloween Masquerade Ball

Saturday, October 29, 2005

8:00pm – 12:30am
DANCE the night away to San Francisco's own club DJ-Jay Bee
Dress to Scare Costume Contest and
"ScaryOke" Singing Contest

Mission Bay Community Center
1675 Owens Street
San Francisco, CA

Admission:
Students- Free (limit 2 tickets per student)
Staff/ Faculty - \$5
At the Door- \$15

Admission includes: Entertainment, Hors d'oeuvres, 2 Complimentary Drink Tickets, Mission Bay Community Center Guided Tour Tickets are available through Millberry Union Central Desk & Student Activity Center- 500 Parnassus Avenue or online: For information call 476-2675

CampusLifeServices

Surgical Infection Prevention (SIP)

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Additional suggested readings:

Bratzler DW, Houck, PM for the Surgical Infection Prevention Guidelines Writers Workgroup. Antimicrobial prophylaxis for surgery: An advisory statement from the National Surgical Infection Prevention Project. *Clinical Infectious Diseases*. 2004;38 (15 June):1706-15.

Classen DC, Evans RS, Pestotnik SL, Horn SD, Menlove RL, Burke JP. The timing of prophylactic administration of antibiotics and the risk of surgical-wound infection. *New England Journal of Medicine*. 1992 Jan 30;326(5):281-6.

Esposito S. Is single-dose antibiotic prophylaxis sufficient for any surgical procedure?. *Journal of Chemotherapy*. 1999 Dec;11(6):556-64.

Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR. Guideline for Prevention of Surgical Site Infection, 1999 Centers for Disease Control and Prevention (CDC) Hospital Infection Control Practices Advisory Committee. *American Journal of Infection Control*. 1999 Apr;27(2):97-132; quiz 133-4; discussion 96.

Scher KS. Studies on the duration of antibiotic administration for surgical prophylaxis. *American Surgeon*. 1997 Jan;63(1):59-62.

Chief Resident Spotlight cont'd
Surgical Infection Prevention
(SIP) cont'd
Halloween Maquerade Ball
Many Thanks!



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Many Thanks!

The Dean's Office of Graduate Medical Education would like to thank the following for their time and effort with this issue:

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