1. INTRODUCTION

The state of General Surgery training in the Philippines developed from the invaluable and progressive efforts of our predecessors, who had the vision of producing an excellent and world-class society of practicing surgeons. The formation of an accrediting body, therefore, was intended to assure the delivery of the highest quality of surgical care by implementing a structured residency program and standardized curriculum. By doing so, the competence of those undergoing training in General Surgery in the different training institutions nationwide is ensured.

The joint PCS Surgical Specialties Accreditation Committee was formed in 1976 with Dr. Alfredo T. Ramirez as Chair. This included all the chairs of the surgical specialty boards or presidents of the surgical specialty societies. There were 8 hospitals that received full accreditation while 26 had partial accreditation by the year 1977. By 1995, the surgical curriculum for General Surgery was converted into competency-based educational curriculum. It was during this time that objectives, competencies, content, rotations, teaching-learning activities, and resources were defined by the committee. The standardized evaluation system for residents was introduced with rating scales utilized to assess clinical competence, psychomotor skills and attitudes. These were the parameters PCS used to determine the accreditation status of the training institutions.

The Accreditation Committee worked cooperatively with the Committee on Surgical Training (CST), the Philippine Association of Training Officers in Surgery (PATOS) and the Philippine Board of Surgery (PBS).

Through the Board Resolution 99-005, the moratorium for the residency training programs applying for accreditation was lifted in 1999. The implementation of the Surgical Curriculum and Standardized Evaluation began. It was also at this time that the Philippine Society of General Surgeons was established. PCS, then gradually handed over its task of accrediting General Surgery Training programs to PSGS, until May 4, 2002 when full devolution was made at the signing of the Memorandum of Agreement.

After a series of workshops and presentation at a public forum, it has been agreed that there will be a standard 5 years training in General Surgery. All training institutions desirous of receiving full accreditation shall comply with the index operations, which are mandatory. Looking forward, additional curricula shall be included at a later time, i.e. Minimally Invasive Surgery, Surgical Oncology, and Critical Care.

The PSGS Accreditation Committee is composed of 12 members, all fellows of the PSGS, 3 of whom are nominated by the Philippine Board of Surgery.
2. PROCEDURES FOR APPLICATION

Any hospital applying for Accreditation of its General Surgery Residency Training Program must follow these procedures:

2.1 The hospital/institution, through the Department Chairman and with approval of the Director or Chief of Hospital, must submit an application form (PSGS Form 2004-1, Appendix 1) and a letter of application addressed to the President of the Philippine Society of General Surgeons, expressing the following:

2.1.1. Mission-Vision of the department and institution(s).
2.1.2. Reason/s why the department and institution is applying for the accreditation.
2.1.3. Commitment to comply with the rules on accreditation set by the Society.

2.2. The institution will be provided with an Information Sheet (PSGS Form 2004-2, Appendix 2) and an Annual Report form (PSGS Form 2004-3, Appendix 3).

2.3. The institution will return the accomplished Information sheet and Annual Report (covering the 2 years prior to application) together with the application fee.

2.4. The Information Sheet and the Annual Reports will be evaluated by the Accreditation Committee to determine if the requirements for accreditation are fulfilled.

2.4.1. Institutions that will meet the minimum requirements will be visited by the Committee on Accreditation which will evaluate the program and submit its recommendation to the Board.
2.4.2. Institutions that do not show evidence of meeting the minimum requirements for accreditation will be notified by the PSGS Board of Directors.

2.5. The Board of Directors will decide on the recommendations of the Committee on Accreditation and will notify the applicant of its decision.

2.6. The same set of requirements for accreditation in general surgery will be followed in the evaluation of new programs. However, residents of newly approved programs are to start their formal residency levels 1 year lower than their current levels, i.e., upon accreditation, a 5th year resident will start as a 4th year resident; similarly, a 4th year resident will start as a 3rd year resident, a 3rd year resident as a 2nd year, and a 2nd year as a 1st year resident. The 1st year resident will remain as a 1st year.
3. MINIMUM REQUIREMENTS FOR ACCREDITATION IN GENERAL SURGERY

3.1. HOSPITAL REQUIREMENTS

3.1.1. It must be a tertiary* hospital with a minimum of 150 beds, excluding bassinets.

3.1.2. Major clinical departments must be present and accredited (Medicine, OB-GYN, Pediatrics and Anesthesiology) **.

3.1.3. Outpatient Facilities

3.1.4. Laboratory Services:

3.1.4.1. Facilities for hematologic, serologic, biochemical, and microbiological examinations.

3.1.4.2. Facilities for blood storage.

3.1.4.3. Histopathology:

3.1.4.3.1. Submission of all specimens to a pathologist for evaluation (gross and/or microscopic). Lesions reasonably non-neoplastic need not be subjected to microscopic examinations.

3.1.4.3.2. Facilities for frozen section must be present in the hospital or within the community. In case of the latter, results must be available within approximately one (1) hour.

3.1.4.3.3. Facilities for FNAB must be present.

3.1.5. The following diagnostic facilities must be present in the hospital:

3.1.5.1. Radiologic facilities

3.1.5.1.1. Plain X-Rays: chest, abdomen, KUB
3.1.5.1.2. Contrast X-Rays: Upper GI, Barium Enema, IVP
3.1.5.1.3. Facilities for Intraoperative cholangiography

* per DOH Classification
** For new applicants, the other departments not yet accredited must show proof of intent to seek accreditation.
3.1.5.2. Ultrasonography
3.1.5.3. Proctosigmoidoscopy

3.1.6. The following must be available in the community:

3.1.6.1. CT Scan
3.1.6.2. Facilities for upper and lower GI endoscopy.

3.1.7. Medical Library

3.1.7.1. Textbooks
   - Principles of Surgery
   - Atlas of Operative Techniques
   - Anatomy or Surgical Anatomy
   - Physiology
   - Pathology
   - Surgical Oncology
   - Trauma, Critical Care and Minimally Invasive Surgery

3.1.7.2. Surgical Journals
   - PJSS
   - Foreign Surgical Journals and/or Information Technology facilities with subscribed internet access.

3.1.8. Emergency Room, Operating Room, Recovery Room & Critical Care Facilities

3.1.9. Functioning Hospital Tumor Board is encouraged.

3.1.10. Quality Assurance Board or Committee.

3.1.11. A skills training laboratory for residents is encouraged.

3.2. TRAINING PROGRAM REQUIREMENTS

3.2.1. Training Staff

3.2.1.1. The CHAIRPERSON: must be a Fellow of the Philippine Society of General Surgeons (PSGS) and/or Philippine College of Surgeons. At any given time, he/she can be the chairperson in only one (1) accredited training program.
3.2.1.2 Training Officer: must be a PSGS Fellow, diplomate of the PBS actively practicing general surgery, and preferably a member of PATOS in good standing. Similarly, he/she can be the training officer in only one (1) accredited training program at any given time.

3.2.2 Consultant Staff

3.2.2.1 A minimum of three (3) PSGS and/or GS PCS Fellows who actively participate in the residency training program is required for eight (8) or fewer surgical residents.

An additional PSGS and/or GS-PCS Fellow must be added for every 2 additional residents. They must have appointments from the institution.

3.2.2.2 Only consultants who are PSGS and/or PCS Fellows or PBS Diplomates should be involved in the training of residents.

3.2.3 The Case Material

3.2.3.1 To ensure that all residents acquire mastery or proficiency in the pre-operative, intra-operative and post-operative management of surgical patients, a minimum volume and variety of surgical operations is required as listed in PSGS Form No. 2004 – 3.

3.2.3.2 A minimum of 100 major operations must be performed per 5 residents per year.

3.2.3.3 Similarly a minimum of 100 medium operations must be performed per 5 residents per year.

3.2.3.4 Only cases done under a qualified training staff will be considered as case materials.

3.2.4 Requirements for Graduating Residents

Each graduating resident should have performed 100 major operations and 100 medium operations of sufficient variety to be checked by the Chairman and Training Officer and verified by the Committee on Accreditation.
3.2.5. The resident is considered as the “surgeon” of a case in the following situation:

3.2.5.1. Operations wherein the consultant scrubs-in on the case, assists and allows the resident to perform the major and more important parts of the procedure.

3.2.5.2. Cases wherein the resident does the operation independently.

3.2.6. For private cases (both elective and emergency), a maximum of fifty percent (50%) of major surgical operations per category will be considered as residents’ cases and will form part of the case materials of the program, as long as article 3.2.5 is fulfilled. This will likewise apply to medium surgical operations per category.

Example A: If there are 10 private cases of major breast surgery and 9 cases were done by the consultant and the residents only did one, only one case of breast surgery shall be credited

Example B: If there are 10 private cases of major breast surgery and 9 cases were done by residents and only one was operated on by the consultant, 5 cases shall be credited

3.2.7. Cases performed during Surgical Outreach Programs may be credited as residents’ cases but are limited to a maximum of 10% of the total number of cases required in each category. These will include surgical cases performed outside the host institution, provided there is an adequate pre-op/post-op care and supervision of the residents by any member of the qualified training staff.

Example: If the required number of major head and neck cases is 20 and the required number of hernia cases is 30 (i.e. if there are 10 residents in a 5-year program), and the residents performed 50 thyroid surgeries and 20 hernia cases in surgical missions, only 2 (10% of 20) of thyroid cases and only 3 (10% of 30) of hernia cases may be credited.

3.2.8. The Philippine Board of Surgery Residency In-Training Examination (RITE) is required for residents of all year levels. However, by the time they graduate, residents must have taken at least 4 examinations.
3.2.9. Residents’ Logbook

3.2.9.1. The officially-prescribed PSGS logbook must be filled up regularly and conscientiously to prevent backlog of the cases, and to assure uniformity of reporting.

3.2.9.2. Entries/Data must be periodically checked (at least quarterly) and attested to as corrected by the training officer and/or chairman of the program.

3.2.9.3. Cases performed during rotations in other institutions (i.e. affiliation) must be authenticated and individually signed by the training officer or duly appointed authority (i.e. consultant-in-charge) of the host institutions. The same list of operations must be submitted separately to the Accreditation Committee for cross referencing.

3.2.9.4. Only cases done by residents under the service or supervision of a qualified training staff can be included in the residents’ logbook.

3.2.10. Annual Report

3.2.10.1. The Annual Report must be certified to be true and correct by the Training Officer and Chairman of the Department and noted by the Medical Director of the hospital.

3.2.10.2. It must follow the prescribed format (PSGS Form 2004 -3) and must be submitted on or before the last day of February.

3.2.10.3. Only one Annual Report will be accepted. No revisions will be allowed once it has been certified as true and correct.

3.2.10.4. The content of the Annual Report must be verifiable through pertinent documents during an accreditation visit.

3.2.10.5. A cumulative summary of cases (4-5 years covering the accreditation period) must be incorporated in the Annual Report.

3.2.10.6. The annual report must also include a separate listing of all major cases done by all senior residents (4th and 5th year residents).
3.2.10.7. Late submission of annual report or late payment of accreditation fee will result to downgrading of the present accreditation status by one level.

3.2.10.8. Non submission or non payment of accreditation fee 30 day after the deadline the program will be suspended.

3.2.11. The prescribed Accreditation Fee must be settled on or before the submission of the Annual Report.

3.3. STRUCTURED RESIDENCY TRAINING PROGRAM REQUIREMENTS

3.3.1. Resident Staff

For existing Training Programs, there must be a minimum of five (5) residents. If the number of residents is less than five (5), the program is given one year to correct these deficiencies from the time it was incurred.

For new programs, there must be a complement of residents who will satisfy the duration, rotation, case material requirements and activities of a structured residency training program.

3.3.2. Duration

The duration of General Surgical Training Program is five (5) years.

3.3.3. Rotations

GS Rotation should be at least 45 months.

Flexibility is allowed in rotations to provide adequate exposure by assisting in or performing surgical procedures in the following surgical specialties: Thoracic & Cardiovascular Surgery, Orthopedics, Urology, Neurosurgery, Pediatric Surgery, Plastic and Reconstructive Surgery.

Specialty rotations should not exceed 15 months. The duration and sequence of exposure will be the program’s prerogative. Rotation in Pathology is optional.
The first and last years of training must be spent in General Surgery in the mother institution. Rotations to affiliate institutions are not allowed during the first and last years of residency.

First year residents must not be assigned at the Emergency Room.

Rotation of residents to other institutions must not exceed 6 months/resident/year and must be covered by a notarized Memorandum of Agreement specifically stating the purposes of the rotation. All Memorandum of Agreements should have the approval of the PSGS Board of Directors. Cases done by residents not within the scope of the MOA will not be considered as case materials of the program.

3.3.4. Case Materials

The index of operations, volume and variety of case materials are prescribed in 3.2.3 and Appendix 3.

3.3.5. Conferences / Activities

3.3.5.1. The following conferences must be conducted at least once a month:

<table>
<thead>
<tr>
<th>Conference</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbidity / Mortality</td>
<td>6</td>
</tr>
<tr>
<td>Audit and Census</td>
<td>6</td>
</tr>
<tr>
<td>Pre-op / Post-op / Case Presentation / Grand Rounds</td>
<td>24</td>
</tr>
</tbody>
</table>

3.3.5.2. Journal Clubs must be held at least quarterly.

3.3.5.3. Tumor Conferences must be held at least quarterly.

3.3.6. The Internal Evaluation of residents must be implemented in accordance with the prescribed evaluation system (See The Curriculum for General Surgery 2007) at least annually.

3.4. Graduate Evaluation – Graduates of Accredited Training Programs are required to take the PBS Certifying Examinations. At least fifty percent (50%) of the program’s graduates who took the examination during the last five (5) years should be certified.
4. CONDUCT OF VISITS

4.1. When to Visit

4.1.1. Upon application for the accreditation.
4.1.2. Six to twelve (6-12) months before the expiration of programs with full accreditation.
4.1.3. At any time a program is warned, suspended or has a conditional accreditation.
4.1.4. Anytime problems are noted / identified in the submitted Annual Reports, the programs may be visited.

4.2. What to Evaluate during Visits

4.2.1. The CONTEXT within which the Program is being operated:

4.2.1.1. Administrative support to maintain a high quality of the training program.
4.2.1.2. Selection of residents.
4.2.1.3. Adherence to the stated missions of the institution.
4.2.1.4. Commitments to comply with the accreditation rules.

4.2.2. The Training Resources (INPUT)

4.2.2.1. The Hospital Facilities and Services
4.2.2.2. The Residency Training Programs
4.2.2.3. The Clinical Materials

4.2.3. The Implementations of the Training Program (PROCESS)

4.2.3.1. The structure, sequence and duration of rotations
4.2.3.2. The teaching-learning activities

- conferences
- rounds
- skills training

4.2.3.3. The internal evaluation system

- methods used:
  - written exams
  - oral exams
  - observational assessment of actual performance

- frequency

4.2.3.4. Resident performance at different levels of training as based on:

- Internal Evaluation
- External Evaluation
  - PBS Residency In Training Examination

4.2.3.5. Promotion System
4.2.4. The PRODUCTS of the Program

The Graduates:
   Performance based on the PBS Certifying Examination.

4.3. How to Schedule a Visit

4.3.1. The hospital should be notified at least 4 weeks in advance.
4.3.2. Rescheduling of visits will be entertained on a case to case basis, thru a written request.

4.4. Who will Visit

4.4.1. At least three (3) members of the Committee on Accreditation.
4.4.2. The Director – in – Charge and / or the Chairman may join any visiting team.

4.5. Expectations of the Visiting Team

4.5.1. The presence of the Department Chairperson, Training Officer, Consultants and Residents-in-training is required. The recently graduated residents should preferably be present or in his/her absence, the logbook must be available.

4.5.2. All necessary documents, current Memoranda of Agreement, logbooks and OR records (operative notes, procedures and anesthesia records) should be available for inspection and verification.

4.6. Expectations of the Hospital Staff

4.6.1. Schedule of visit should be sent at least 4 weeks in advance.
4.6.2. Systems and mechanics of the visit must be followed.

4.7. Interview

Separate interview with the training staff and residents.

5. THE STATUS OF THE PROGRAM

5.1 Full Accreditation. The training program is accredited for five (5) years.

5.2 Conditional Accreditation
5.2.1. Conditional accreditation is given to all newly accredited programs and is valid for a period of two (2) years from the date of approval.

5.2.2. Programs previously warned, suspended or terminated will be granted a two (2) year conditional accreditation once the requirements for accreditation are satisfied.

5.3. Warning. A warning is imposed on a program when significant deficiencies are noted during an accreditation visit.

5.3.1. A warning status shall remain in effect for six months after the approval by the PSGS Board of Directors.

5.3.2. The Accreditation status of the program shall remain in effect for the duration of the warning.

5.4. Suspension.

5.4.1. The Accreditation of a program will be suspended if it fails to significantly correct deficiencies within six (6) months after the issuance of a warning.

5.4.2. When the original deficiencies, for which a warning was issued, are corrected but new major deficiencies are noted during a subsequent visit, the accreditation will be suspended.

5.4.3. Suspension of Accreditation may be recommended without the benefit of a warning in cases of intellectual dishonesty with objective evidence to prove the same (ex. falsification of records, etc.)

5.4.4. Suspension of a previously warned residency training program will take effect upon approval by the PSGS Board of Directors and will be in effect for a maximum period of one year from its effectivity.

5.4.4.1. When the requirements for accreditation are fulfilled/deficiencies corrected, a written request for re-evaluation of the program may be submitted to the PSGS Board of Directors at anytime within a one (1) year period.

5.4.4.2. Suspension may be lifted at any time within the one (1) year period after the correction of the deficiencies are verified.

5.4.5. Rotation / time spent by the residents during the period of suspension or termination will not be credited.
5.5. TERMINATION

5.5.1. Accreditation of a suspended program will be terminated when it fails to comply with the PSGS requirements for accreditation after two (2) requested visits for re-evaluation which show a) failure to correct the deficiencies or b) new major deficiencies are noted.

5.5.2. Failure to request for re-evaluation within the one (1) year period from the date of suspension will cause the termination of the program’s accreditation.

5.5.3. Terminated programs may apply for re-accreditation only after one (1) year from the date of termination.

5.6. Disapproval.

Disapproval applies only to new applications for accreditation which fail to meet the PSGS requirements for accreditation.

Disapproved programs may re-apply only after one (1) year following the disapproval.

6. APPEALS

6.1. Appeals should be made in writing to the PSGS Board of Directors within 30 days following receipt of the Board’s decision.

6.2. Re-evaluation of Suspended Programs

The PSGS Board of Directors will decide if a suspended program’s request for re-evaluation requires a revisit. The Accreditation team re-evaluates the program and submits its recommendations to the PSGS Board of Directors.

6.3. The PSGS Board of Directors will decide whether to sustain, reverse, or modify the recommendations of the Committee on Accreditation.

6.4. The PSGS Board of Directors will notify the concerned institution of its final decision within one week after the last Board of Directors meeting.
7. PERIOD OF VALIDITY OF ACCREDITATION

Full accreditation will be five (5) years. This may, however, be revoked anytime in cases of non-compliance with the requirements for accreditation.

8. CONSORTIUM, AFFILIATION, LINKAGE

8.1. GUIDELINES FOR CONSORTIUM

A consortium may be formed by several tertiary* hospitals (maximum of 3) with a minimum of 100 beds per component hospital situated in geographic proximity with each other, whose individual training programs cannot meet the requirements for accreditation, following one (1) program with 1 chairman, 1 set of training staff and 1 set of residents (at least 2 per hospital).

8.1.1. Requirements

8.1.1.1. There must be a Notarized Memorandum of Agreement signed by the Hospital Director, Department Chairman and Training Officer of the institutions desiring to form, sustain and maintain a consortium. This MOA will contain the scope of involvement, functions and responsibilities of its member-hospitals. The effectivity of such agreement should not be less than 5 years.

8.1.1.2. The Training Program under the consortium shall be under the supervision and control of one Chairman, one Training Officer and one Training Committee to be selected from among the Consultant Staff of the participating hospitals.

8.1.1.3. There must be only one (1) set of Residents who will rotate among the member-hospitals. The number of residents in training will depend upon the capacity of the consortium. And there must be at least 2 Residents per component hospital.

8.1.1.4. There must be only one (1) Residency Training Program to be implemented by all participating member-hospitals.

* as defined by DOH

8.1.1.5. Before any consortium can be formed, the approval of the PSGS Board of Directors must be obtained, following the recommendation of the PSGS Committee on Accreditation.
8.1.2. Accreditation

The accreditation of the training program will apply only to the Consortium and not to the Department of Surgery of the member-hospitals.

The formation of a Consortium will cancel the present accreditation, if any, of the member-hospitals to give way to the new program it intends to create.

The initial period of accreditation of the Consortium will be for two (2) years (Conditional) with provisions for regular visits.

Should the member – hospitals in the consortium decide to seek separate accreditation, they will first have to officially dissolve the consortium before their application can be considered.

8.1.3. Monitoring

The Consortium must submit an Annual Report to the PSGS Committee on Accreditation and all other reports required by the Society.

The Committee on Accreditation will conduct a regular evaluation of the Consortium during the period of its Conditional Accreditation and thereafter as mandated by events.

8.2. GUIDELINES FOR LINKAGE

The bilateral exchange of residents coming from accredited residency training programs.

8.2.1. There must be a notarized Memorandum of Agreement signed by the responsible officers of the institutions desiring to form, and maintain a linkage. This will contain the scope of involvement, functions and responsibilities of the hospitals involved.

8.2.2 The training program/s of all the involved hospitals must be accredited by the Philippine Society of General Surgeons.

8.2.3. Before any linkage is implemented, the approval of the PSGS Board of Directors must be obtained.
8.2.4. No rotation to the other hospitals will be allowed on the 1st and last year of the resident’s training.

8.2.5. The resident/s will be governed by the rules and regulations of the host hospital.

8.3. GUIDELINES FOR AFFILIATION

This involves rotation by residents from any training programs to one or more institutions with accredited surgical residency programs. The host hospitals do not send residents in return.

8.3.1. There must be a notarized Memorandum of Agreement signed by the responsible officers of the Institutions agreeing to form and maintain an affiliation. This will contain the scope of involvement, functions and responsibilities of the hospitals involved.

8.3.2. The host hospital’s program must be accredited by the PSGS.

8.3.3. Before any affiliation is implemented, the approval of the PSGS Board of Directors must be obtained.

8.3.4. No rotations will be allowed on the 1st and last year of the resident’s training.

8.3.5. The resident/s will be governed by the rules and regulations of the host hospital.

9. STEPS TO AMEND THE REQUIREMENTS AND PROCEDURES OF ACCREDITATION:

9.1. Suggested changes must be coursed through the Committee on Accreditation.

9.2. The Committee shall make its recommendation/s to the PSGS Board of Directors for approval.

9.3. Any change/s approved by the PSGS Board of Directors should be immediately disseminated to all concerned.

9.4. Additional requirements may be added for implementation upon the recommendation of the Committee on Accreditation and approved by the PSGS Board of Directors.

10. ALL OTHER ISSUES, NOT COVERED IN THIS PSGS ACCREDITATION GUIDELINES AND THOSE ARISING FROM DIFFERENCES IN INTERPRETATION, SHALL BE DECIDED UPON BY THE BOARD OF DIRECTORS.

11. NO CHANGE/S IN THIS PSGS ACCREDITATION GUIDELINES SHOULD BE MADE EARLIER THAN 2011.
APPLICATION FOR ACCREDITATION
IN GENERAL SURGERY

I, ________________________________, by authority vested in me by the Governing Body or Director or Chief of Hospital of __________________________________________________________ (Name of HOSPITAL), hereby voluntarily apply for accreditation of our Residency Training Program in GENERAL SURGERY.

We are fully aware that this application is on a voluntary basis, that the hospital authorities submit unconditionally to the inspection, review and survey of items pertinent to accreditation including physical plant, facilities and working staff of the hospital and that the hospital authorities are committed to abide by the decision of the PSGS Board of Directors.

________________________
Signature

________________________
Printed Name - Chairperson
Department of Surgery

________________________
Signature

________________________
Printed Name - Chairperson of the Governing Board or Director or Chief of Hospital

DATE:
GENERAL SURGERY ACCREDITATION
INFORMATION SHEET
(To be accomplished in Triplicate by the Department applying for Accreditation)

HOSPITAL: __________________________________
DATE: __________________________________
TRAINING OFFICER: _________________________________
Signature: __________________________________
DEPARTMENT CHAIRPERSON: _____________________________
Signature: __________________________________
HOSPITAL DIRECTOR: _________________________________
Signature: __________________________________

1. HOSPITAL

1. Total number of beds excluding bassinets:______________________________

2. Existing Departments: ____________________
   *Indicate if program is accredited by respective Specialty Society.
   *Indicate if there is a separate department for:

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>ACCREDITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>( ) YES  ( ) NO ( ) YES ( ) NO</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>( ) YES  ( ) NO ( ) YES ( ) NO</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>( ) YES  ( ) NO ( ) YES ( ) NO</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>( ) YES  ( ) NO ( ) YES ( ) NO</td>
</tr>
<tr>
<td>Others:</td>
<td>Specify ____________________</td>
</tr>
</tbody>
</table>

3. Out-patient Department - ( ) YES ( ) NO
   Number of surgical consultations per year: ______________

4. Laboratory
   a) Name of Head: __________________________
   b) Examinations done:
      ( ) CBC, urinalysis, fecalisis, blood typing
      ( ) Blood Chemistry
      ( ) Serum Enzymes
      ( ) Microbiology (culture and sensitivity test)
      ( ) Others (Please indicate)
5. Radiology
   a) Name of Head ____________________________
   Name of other staff members:
      ____________________________
      ____________________________

   b) Diagnostic Services
      ( ) Chest x-ray
      ( ) Skull and skeletal survey
      ( ) Upper G.I. Series & Barium enema
      ( ) I.V.P.
      ( ) Portable x-ray
      ( ) Operative Cholangiography
      ( ) Angiography
      ( ) Ultrasonography
      ( ) Upper and Lower GI endoscopy
      ( ) FNAB
      ( ) Nuclear Medicine
      ( ) CT scan
      ( ) MRI

6. Pathology
   a) Name of hospital Pathologist ________________
   b) Frozen section   ( ) YES ( ) NO
   c) No. of autopsies done last year ____________

7. Facilities for blood processing / storage   ( ) YES ( ) NO

8. Ancillary Facilities
   a) Electrocardiogram   ( ) YES ( ) NO
   b) Heart Station   ( ) YES ( ) NO
   c) Surgical Care Facilities   ( ) YES ( ) NO
   d) Recovery Room   ( ) YES ( ) NO
   e) Rehabilitation Facilities   ( ) YES ( ) NO
9. Facilities for upper and lower GI endoscopy ( ) YES ( ) NO

10. Medical Library
   
   a) Textbooks
      Name of author    Edition
      ( ) Principles of Surgery
      ( ) Atlas of Operative Technique
      ( ) Anatomy
      ( ) Surgical Anatomy
      ( ) Physiology
      ( ) Pathology

   b) Journals
      Peer reviewed Journals like
      ( ) Philippine Journal of Surgical Specialties
      ( ) Foreign Surgical journal/s
      - Journal of the American College of Surgeons
      - Surgical Clinics of North America
      - Annals of Surgery
      - American Journal of Surgery
      - British Journal of Surgery
      Others: ____________________

   c) Information Technology with Internet access

11. Records Section ( ) YES ( ) NO
    Number of years charts are preserved ____________________

II. DEPARTMENT OF SURGERY

1. Total number of surgical beds
   a) Private beds ____________
   b) Service beds _______________

   Major operations per year, for the past two years - attach separate sheet. Medium operations per year, for the past two years - attach separate sheet.

2. Name of the Head of the Department and qualifications
   (please attach biodata)

3. Staff (Names & qualifications - please attach biodata)
4. Names of Training Officer and members of the Residency Training Committee and their qualifications.

5. Conferences
   ( ) mortality & morbidity, CPC
   ( ) case presentation
   ( ) lectures on surgical topics
   ( ) journal club
   ( ) grand rounds
   ( ) tumor conference
   ( ) Others (Please state)

   Frequency

6. Do your residents keep a record of operated and assisted operations? ( ) YES ( ) NO

Please submit a copy of the Annual Report for the last 2 years.

III. THE RESIDENCY TRAINING PROGRAM

1. Number of surgical residents

2. Names of Residents:
   1st year:
   2nd year:
   3rd year:
   4th year:
   5th year:
3. Description of Residency Training. For those submitting for the first time, take into consideration:

   a) Rotation/Clinical Exposure (what departments or sections, and for how long)

<table>
<thead>
<tr>
<th>JAN-MARCH</th>
<th>APRIL-JUNE</th>
<th>JULY-SEPTEMBER</th>
<th>OCTOBER-DECEMBER</th>
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<td>1ST YEAR</td>
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<td>3RD YEAR</td>
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<tr>
<td>5TH YEAR</td>
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</table>

   b) Duties and responsibilities
   c) Supervision
   d) Operative opportunities
   e) Others
ANNUAL REPORT OF
ACCREDITED GENERAL SURGERY TRAINING PROGRAMS

| HOSPITAL                                | : ______________________________ |
| Date                                    | : ______________________________ |
| TRAINING OFFICER                        | : ______________________________ |
| Signature                               | : ______________________________ |
| DEPARTMENT CHAIRPERSON                  | : ______________________________ |
| Signature                               | : ______________________________ |
| HOSPITAL DIRECTOR                       | : ______________________________ |
| Signature                               | : ______________________________ |

1. Breakdown of Operations

| a) Major Operations | ___________________________ |
| b) Medium Operations| ___________________________ |
| c) Minor Operations | ___________________________ |

Total Operations:
1. Elective
2. Emergency
   a) Trauma
   b) Non-Trauma
Major Operations done by Consultants
Major Operations done by Residents
   a) Private Cases
   b) Charity Cases
Medium Operations done by Consultants
Medium Operations done by Residents
   a) Private Cases
   b) Charity Cases
Minor Operations done by Consultants
Minor Operations done by Residents
MAJOR OPERATIONS - 100 major operations per 5 residents

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>SPECIFIC OPERATIONS</th>
<th>NUMBER OF OPERATIONS</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Service</td>
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<td>*Res</td>
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</table>

I. HEAD & NECK (15 cases)
   A. Thyroidectomy
   B. Parotidectomy
   C. Neck Dissection
      (Modified/Radical/Selective)
   D. Maxillectomy/mandibulectomy

II. BREAST (10 cases)
   A. Modified Radical Mastectomy
   B. Conservation breast surgery
      1. Wide excision with axillary node dissection
      2. Segmentectomy/quadrantectomy
   C. Total/Simple/Subcutaneous mastectomy

III. ESOPHAGUS, STOMACH, DUODENUM AND SMALL INTESTINES (10 cases)
   A. Gastrectomy with or without vagotomy
   B. Vagotomy with pyloroplasty
   C. Gastrojejunostomy
   D. Proximal gastric vagotomy
   E. Omental Patching
   F. Resection of small bowel
   G. Adhesiolysis for Bowel Obstruction
   H. Esophageal surgery

IV. COLON, RECTUM AND ANUS (10 cases)
   A. Colectomy
      1. Right Hemicolectomy
      2. Left Hemicolectomy
      3. Transverse Colectomy
      4. Sigmoid Colectomy
      5. Subtotal/Total Colectomy
   B. Low Anterior Resection
   C. Abdomino – Perineal Resection
   D. Colostomy/Closure of Colostomy

V. COMPLICATED APPENDIX (10 cases)

* Operation done by residents (3.2.6)
** Total number of operations credited to the residents
VI. HEPATOBILIARY, GALL-BLADDER, PANCREAS, SPLEEN AND PORTAL HYPERTENSION (25 cases)

A. Cholecystectomy
   1. Without CBD Exploration
   2. With CBD Exploration
   3. Laparoscopic

B. Biliary Enteric Anastomosis
   C. T-tube choledochostomy
   D. Sphincterotomy/Sphincteroplasty
   E. Cholecystojejunostomy
   F. Distal pancreatectomy
   G. Whipple’s operation
   H. Splenorrhaphy/Splenectomy
   I. Devascularization
   J. Shunting procedures
   K. Hepatic resection

VII. TRAUMA (10 cases)

A. Exploratory Laparotomy for intraabdominal injuries
   B. Thoracotomy
   C. Major vessel repair
   D. Amputation (limb)
   E. Neck exploration for trauma

VIII. OTHERS (10 cases)

Major sub-specialty surgeries

*Procedures done on pediatric cases should be classified under Pediatric Surgery

** A separate list of cases done on outside rotation must be submitted.
MEDIUM OPERATIONS – 100 medium operations per 5 residents per year

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>SPECIFIC OPERATIONS</th>
<th>NUMBER OF OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Service</td>
</tr>
<tr>
<td>I.  HEAD &amp; NECK (5 cases)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. <em>Tracheostomy</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Excision of branchial cleft cyst</td>
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<tr>
<td></td>
<td>C. Excision of thyroglossal duct cyst</td>
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<tr>
<td></td>
<td>D. Excision of Cystic hygoma</td>
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<td></td>
<td>E. cricothyroidotomy</td>
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<tr>
<td>II. HERNIA (15 cases)</td>
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<tr>
<td>III. APPENDIX UNCOMPLICATED (30 cases)</td>
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<td></td>
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<tr>
<td>IV. ANAL SURGERY (20 cases)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. <em>Hemorrhoidectomy</em></td>
<td></td>
<td></td>
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<tr>
<td>B. <em>Fistulotomy or Fistulectomy</em></td>
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<tr>
<td>C. I &amp; D of abscess</td>
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<td></td>
</tr>
<tr>
<td>V. THORACOSTOMY (15 cases)</td>
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<td></td>
</tr>
<tr>
<td>VI. OTHER SUBSPECIALTY PROCEDURE (15 cases)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Vascular access (AV Fistula, Scribner shunt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Pediatric cutdown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Excision of Bakers cyst</td>
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<td></td>
</tr>
<tr>
<td>D. Disarticulation (diabetic foot)</td>
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<td></td>
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<tr>
<td>E. Suprapubic cystostomy</td>
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<td></td>
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<tr>
<td>F. Tenckhoff catheter insertion</td>
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* Operation done by residents (3.2.6)
** Total number of operations credited to the residents
### MAJOR OPERATIONS DONE BY INDIVIDUAL 4TH AND 5TH YEAR RESIDENTS

<table>
<thead>
<tr>
<th>GENERAL DATA</th>
<th>DIAGNOSIS</th>
<th>PROCEDURE</th>
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2. Resident’s Status:
   2.1. Names of all residents, divided according to year level and schedule of rotations for the year.
   2.2. New residents appointed - date of appointment - its duration
   2.3. Names of residents who resigned and the reason for resignation
   2.4. Names of resident/s who took the In-Training Examinations of the Philippine Board of Surgery and their grades
   2.5. Name of residents from other institutions rotating in your program including duration of rotation (specific date), parent institution.
   2.6. Names of graduates of the program and their status

3. Conferences
   3.1. Type of conference
   3.2. Dates
   3.3. Speakers (state whether resident, consultant or invited guests)

4. Scientific Papers Produced
   4.1. Published
   4.2. Unpublished

5. Other Departmental Activities e.g. Postgraduate Courses Conducted

6. Rotations of Residents
   The rotation of the residents during their first and last years should be limited to general surgery.
The following schedule of rotations for residents should be followed:

<table>
<thead>
<tr>
<th>JAN-MARCH</th>
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<tr>
<td><strong>5TH YEAR</strong></td>
<td>GENERAL SURGERY</td>
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</tbody>
</table>

1. General Surgery Rotation
   45 months (General Surgery)
   15 months (Subspecialty Surgery)

2. Rotation in other surgical specialties
   Urology
   Thoracic and Vascular Surgery
   Plastic & Reconstructive Surgery
   Pediatric Surgery
   Neurosurgery
   Orthopedics
   Pathology (optional)

NOTE:
Annual Reports should conform with the prescribed format.
Appendix 4

The Residency Training Officer must be a PSGS Fellow actively practicing General Surgery. He is assigned, but not limited to the following tasks*:

1. Teaching
   - Enlightens the teaching staff and Residents in Training regarding the PSGS Guidelines for Accreditation in General Surgery.
   - Implements the standardized curriculum of the Program.
   - Monitors the Program.
   - Evaluates the Program.
   - Coordinates and evaluates all teaching-learning activities of the Department related to Residency training.
   - Evaluates and recommends the promotion of residents.
   - Attends and actively participates in continuing surgical education activities.

2. Research
   - Encourages and coordinates research activities of the Department.
   - Conducts activities related to research such as critical appraisal of literature and the like.


4. Administrative
   - Selects, evaluates, disciplines and recommends promotion of residents.
   - Identifies and recommends necessary training resources and support facilities.
   - Evaluates and recommends members of the teaching staff.
   - Coordinates with other training programs.

The Residency Training Committee is a group of PSGS / PCS Fellows chaired or headed by a Training Officer who is a PSGS Fellow, who have constituted themselves to supervise the training of residents. The Committee will have the same tasks as a Training officer.

* Adapted from “What is a Training Officer” A Workshop by the Philippine Association of Training Officers in Surgery.
Appendix 5

Workshops

1991 - PCS workshop on Standardized Surgical Curriculum. In 1995, this was adopted as a competency based Surgical Curriculum for General Surgery, defining the objectives of the training programs, the resources necessary to implement these programs and the required competencies of the surgical residents along with the PCS Standardized Evaluation System.

1994 - PCS Workshop on Accreditation Guidelines. This started the imposition of minimum requirements for accreditation in 1995, most stringent of which was the required number /variety of operations to be performed by the resident staff annually.

1995 – After a series of Workshops, the PCS published the Surgical Curriculum for General Surgery which contained the Standardized Evaluation System for Residents.

1998 - 2nd PCS Workshop on Accreditation Guidelines was held at the PCS multi-purpose hall to thresh out the perceived problems with compliance and to determine if the required index cases remained relevant. These guidelines were officially implemented in 2000.

2001 (September 26) - PSGS Workshop on Accreditation, New World Hotel, Makati City. In anticipation of the turn-over to the society of the accreditation functions of the PCS, this workshop identified problem areas for possible revisions upon the formal turnover of accreditation duties.

2002 (October 22) - PSGS Workshop on Surgical Training held at Century Park Sheraton Hotel. Residents’ External Evaluation Tool was proposed.

2002 (October 23) - PSGS conducted Workshop on Accreditation at Johnson & Johnson compound in Parañaque City.

2003 - The PSGS Committee on Accreditation and the Board of Directors addressed the problem areas identified in the 2002 PSGS Workshop. The current guidelines and criteria contained herein are based on the output of this workshop. The core guidelines have remained essentially the same. There are some changes in the style and form in the volume and variety of case material, annual reports and individual resident requirements but the essence remains the same. This current manual will be the first to be issued by the Philippine Society of General Surgeons.

2005 (November 19-20) – Workshop was held in Clark Field, Pampanga, to evaluate the existing accreditation guidelines and lay the groundwork for future workshops. Participants included PSGS BOD and CA members.
2006 (October 14) – PSGS-CST conducted a workshop at the PCS Boardroom to finalize the Surgical Curriculum. Participants included PSGS BOD, PATOS, CA and representatives from various training programs.

2007 (March 3-4) – A workshop sponsored by the CA was held to revise the existing accreditation manual. Participants included the PSGS BOD, CA members and the CST Chairman. Statistics of surgical procedures performed in the various accredited training programs in the last 5-6 years were presented. Index operations for each category were identified. Proposed amendments to existing provisions were initiated.
OPERATIONAL DEFINITIONS

1. **Adequate Exposure in the Subspecialties** – the program must be able to achieve the competencies listed in the Surgical Curriculum for General Surgery i.e. Appendix I-B, depending on the Year Level of training. Although ideal, it is not necessary that the Board Certified Specialist in the subspecialties must be the one to teach / train the residents.

2. **Affiliation** - Involves rotation of residents from any training program to one or more institutions with accredited surgical residency programs. The host hospital will not send residents in return.

3. **Cases Handled** – cases managed by residents either operatively (as surgeon or assistant) or non-operatively.

4. **Conferences** – as listed in 3.3.5 (p.6) of the guidelines, these activities must be conducted regularly as prescribed.

5. **Consortium** - A consortium may be formed by several hospitals whose individual training programs cannot meet the requirements for accreditation, following one (1) program with 1 chairman, 1 set of training staff and 1 set of residents. (8.1. pp14-15)

6. **Grand Rounds** – a teaching – learning activity or conference presided over by a Moderator with the specialists from the different medical disciplines in attendance.

7. **GS Rotations** – rotations in Trauma, ICU/CCU/SICU, ER and OPD are to be considered as GS rotations in the structure and design of the program.

8. **Journal Club** – the program must set aside a specific time for critical appraisal of journals. Articles utilized during the discussions of cases will not qualify as journal club entries.

9. **Linkage** - The bilateral exchange of residents coming from accredited residency training programs. (8.2 pp15-16)

10. **Medical Library** – an organized, systematized collection of medical and medically-oriented books, films, records, slides; their electronic analog or digital equivalents used for storage and retrieval of knowledge.
11. **Memorandum of Agreement** – a legally binding, notarized agreement entered into by two or more consenting parties to implement what is contained therein. Operations done by the resident(s) not within the context of the MOA should not be included in the determination of the Volume and Variety of cases performed in the Residency Program.

12. **Qualified Training Staff** – A PSGS Fellow, and/or PCS Fellow in any specialty, and/or PBS Diplomate who participated in the training of general surgical residents and/or PATOS member in good standing. The Training Staff must have an institutional appointment.

13. **Surgical Mission** – in order to avoid itinerant surgery, the program must participate in the preoperative, intraoperative and postoperative management of the patients. There must be evidence of a teaching-learning process.

14. **Training Materials** – consists of Histopathology reports, patients handled or managed by residents in training under the supervision of a qualified training staff and any other resources utilized for training purposes.

15. **Tumor Board** – a hospital Board that supervises activities and programs related to tumors.

16. **Tumor Conference** – a specific time set aside by the Department for an activity where a variety of malignancies, their diagnoses and management are discussed.
Appendix 7

DEFINITION OF GENERAL SURGERY

The Philippine Society of General Surgeons, Inc. defines General Surgery as requiring:

A basic knowledge of surgical anatomy, physiology, pathology, oncology, metabolism, wound healing, surgical bacteriology and sepsis, shock and resuscitation, immunology and organ transplantation, fluid and electrolytes, nutrition, burns and critical care.

A sound understanding of the principles of radiology, ultrasonography, CT scan, MRI, and other diagnostic aids including the use of radioactive isotopes and mammography.

An adequate practical experience in proctosigmoidoscopy and indirect laryngoscopy. The general surgeon must have participated in a variety of endoscopic examinations such as direct laryngoscopy, bronchoscopy, esophagoscopy, gastroscopy, choledochoscopy, colonoscopy and laparoscopy.

A comprehensive skill in diagnosis, preoperative, operative and postoperative care of patients with diseases of the a) alimentary tract, b) abdomen and its contents, c) the head and neck, d) breast, e) the vascular system, f) the endocrine system and g) skin and soft tissues.

Adequate knowledge and skill in all phases of care of the injured patient, including care provided in the Emergency Room and Intensive Care Unit. The general surgeon must show competence in the emergency management of trauma, including trauma to the head and neck, chest, abdomen and the extremities.

An appropriate clinical experience to include operative and nonoperative care of common problems in the special disciplines of thoracic and cardiovascular, gynecologic, neurologic, orthopedic, plastic, pediatric and urologic surgery and anesthesiology, acquired by exposure in these disciplines.
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