2023-2024

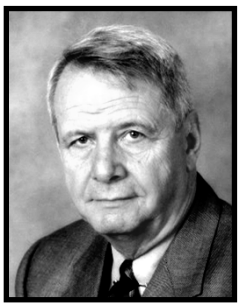
University of Louisville
The Hiram C. Polk, Jr., MD Department of Surgery
Surgical Resident Manual

University of Louisville's
Pioneers in Surgical Education

Kelly M. McMasters, M.D.

Chair, 2005-Present

Under Dr. McMasters' leadership, the nationally regarded surgery residency program boasts unsurpassed depth and breadth of operative and patient experience. A renowned surgical oncologist with a robust clinical practice, McMasters is a prolific researcher who directs a basic and translational science laboratory studying adenovirus-mediated cancer gene therapy and melanoma biomarkers. McMasters initiated The Sunbelt Melanoma Trial, at the time the world's largest melanoma study (involving more than 3,600 patients).



Hiram C. Polk, Jr., M.D.

Chair, 1971-2005

As chair, Dr. Polk's leadership ushered in a period of advanced surgical research and practice in the fields of Surgical Infection, Cardiac Surgery, Hand Surgery, Microsurgery, Trauma Service and Surgical Oncology.

R. Arnold Griswold, M.D.

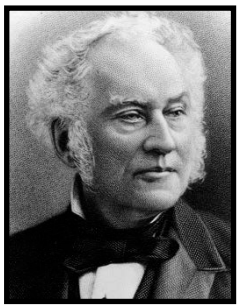
Chair, 1938-1952

Established the country's first "Accident Service" at Louisville City Hospital. He trained and equipped police to give emergency care en route to the hospital. Griswold also developed autotransfusion and was innovative in the treatment of fractures.

David Wendel Yandell, M.D.

Chair, 1873-1896

A protégé of Dr. Gross and one of the South's most prominent surgeons, he created the West's first clinic - the "Stokes Free Dispensary." The clinic treated indigent patients and educated students. Yandell was an early promoter of antiseptic techniques.



Samuel David Gross, M.D.

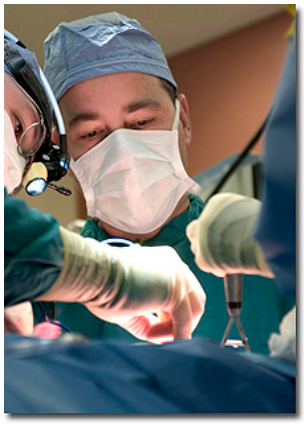
Chair, 1841-1856

North America's most influential and respected surgeon in the 19th century. In 1841 he performed a successful ligation of subclavian artery aneurysm. Gross established one of the first surgical laboratories and studied methods to study intestinal wounds and suturing.

Table of Contents

Foreword by Kelly M. McMasters, M.D., Ph.D.

Ben A. Reid, Sr. Professor and Chair



The University of Louisville, Department of Surgery, has a long and proud tradition of excellence. From its inception in 1837, when the University of Louisville served as the premier medical training ground for the western frontier of the United States, the Department of Surgery has been at the forefront of surgical education, patient care, and research. Samuel Gross, M.D., the foremost surgeon of his day, served as the Chairman of the Department from 1841-1856. Before going on to serve with distinction as the Chairman at Jefferson Medical College and establishing the famous Gross Clinic, he established one of the nation's finest surgery programs at the University of Louisville, renowned for excellence in patient care and education. He also founded an active and innovative surgical research laboratory – a rarity at that time.

Since that time, there has been a succession of great surgical practitioners, educators, and investigators at the University of Louisville, culminating in the era of Hiram C. Polk, Jr., M.D. During his term as chairman from 1971 to 2005, Dr. Polk became not only the longest reigning chair of a surgery department in the country, but one of the world's most well-known and respected surgeons. He also took the Department of Surgery to new heights. The Polk era is replete with great accomplishments, from development of one of the nation's most prominent trauma centers; groundbreaking research in surgical infection and host response; microcirculation; and surgical oncology; noteworthy achievements in artificial heart and ventricular assist device research; and development of the world's preeminent hand surgery program, including hand transplantation – to name a few. Despite these great accomplishments, Dr. Polk's greatest legacy is the impact he has had in surgical education. Dr. Polk has shaped the careers of countless students, residents, fellows, and faculty members during his long tenure at the University of Louisville. Many of these individuals have gone on to lead divisions, departments, hospitals, cancer centers, and other major programs around the country and around the world. Dr. Polk is equally proud of those surgeons he has trained who have gone on to elevate the level of medical care in their communities, from small towns in Kentucky and the surrounding region, to large cities across the U.S., to those engaged in missionary work around the globe.

These accomplishments in surgical education at the University of Louisville have been based on a simple philosophy. Excellence is not an accident. Excellence is most often achieved when it is expected. Mediocrity can occur anywhere. Excellence is demanded here.

The Department of Surgery at the University of Louisville remains committed to these principles. This involves continued development of outstanding programs in patient care and surgical research. But first and foremost, our goal is to consistently produce the finest surgeons in America. To do this, we must lead and teach by example, and continue to emphasize not only fundamental and advanced surgical skills, but also the primacy of the doctor-patient relationship. The awesome responsibility of a surgeon to his/her patient is not taken lightly. These lessons will continue to serve trainees at the University of Louisville in every field of endeavor.

The University of Louisville, Department of Surgery, will remain fundamentally focused on providing the best possible 5-year clinical training program. For those residents who are interested in specialty or academic careers, additional opportunities in basic and clinical research, or in specialized clinical training, will continue to be provided. This includes an extra year or more of training at the finest institutions in the world. Such tailor-made opportunities, designed to provide the best possible career opportunities for our trainees, will continue to be the hallmark of the University of Louisville program.

We know that excellence is not an accident. Excellence is expected. Excellence is planned. Excellence is deserved.

The University of Louisville
Surgical Resident Training Philosophy*

The methods of training general surgeons in the United States have been standardized over the last half century, the result of which has been the envy of the world and the highest standards of excellence realized. Specialization has been driven by technologic developments, increasing sophistication, and complexity of operations, and our ability to support older, ever more ill patients through the perioperative period. The training period of at least 5 years has been the most arduous in medicine, but it has produced the overall high standard of quality that presently exists broadly today. The core areas of general surgery have been defined by the American Board of Surgery, and required elements of the training program have been clearly spelled out by the surgery Residency Review Committee (RRC) of the Accreditation Council on Graduate Medical Education (ACGME). Certificates of additional training in vascular, surgical critical care, and pediatric surgery have only been available to those who have completed training in general surgery.

The physician workforce prognostications of the last 3 decades have clearly been wrong, in that, there is an enormous demand for general surgeons, particularly in less urban areas, and shortages have now been predicted for the upcoming decade. However, data on practice patterns following general surgery residency training from individual programs are inherently lacking, which would answer the question of what portion of these residents eventually practice general surgery.

Our program has emphasized broad-based training that potentially allows residents to pursue a variety of career paths, with or without additional surgical training. We offer diverse experiences emphasized through a variety of rotations, including a university hospital with a large trauma service, several tertiary private institutions, and suburban and rural experiences with private practitioners. Our faculty includes surgeons with both broad-based and narrowly focused practices.

Challenges to the highly evolved modern general surgical residency training system seem to abound now, prompted by demands for increased medico-legal, political, and financial accountability and permeated by major changes in lifestyle preferences by medical graduates. The institution of the 6 core competencies by the ACGME for all residency programs has compelled program directors to change curricular philosophy and search for appropriate evaluation tools. Restricted resident clinical and educational work hours will require increased training efficiency to accomplish the goal of training the competent general surgeon and will increase the cost of such training by the mandated hiring of physician extenders.

To understand where we are now and how to continue to accomplish our ultimate goal of the well-trained general surgeon, we must examine the evolution of clinical training in surgery and the events that have resulted in resident work-hour limitations. Graduate medical education has taken decades to approach uniformity across the country, particularly with regard to surgery and the surgical specialties. The American College of Surgeons was founded in 1913 with idea of limiting performance of surgery to those properly trained and to eliminate itinerant practice. However, this took more than another half-century and World War II to accomplish, with the founding of the American Board of Surgery in 1937 and the Residency Review Committee (RRC) for surgery in 1950. The RRCs together with other member organizations form the ACGME, which is responsible for the formal accreditation of individual residency programs and their sponsoring institutions. The pyramidal system essentially was phased out by applicants themselves, as these programs became less desirable. The current “rectangular system” with its built-in flexibility is well established, and although the American Board of Surgery requires only 5 clinical training years, many programs have a required laboratory year or 2 in addition to this time. Over the past decade, most hospitals have required at least completion of an accredited residency or timely certification for credentialing purposes in order for surgeons to be granted hospital privileges for particular procedures.

Operative case counting began in 1987, largely to measure potential competing fellowship effects on general surgery programs. This has now been standardized as a web-based program through the RRC site, but has undergone significant refinement over this time period. Boundary guidelines for the number of total major operations and those performed during the chief year have been set by the RRC for surgery and no deficiencies are allowed in any of the 15 major categories. We have strongly believed in broad-based training for general surgical residents, a philosophy melded to this program over 30 years ago. We believe that this

sets the foundation for a successful lifetime of practice in general surgery, pursuit of additional fellowship training to augment this, or a focused practice in various specialty areas.

Two hundred and twelve residents completed the program in General Surgery at the University of Louisville from 1971 through 2003, of whom 115 completed training from June 1987 through June 2003 during the case-counting era. Of the 115 during the latter period, 60 pursued fellowship training and 55 went directly into general surgical practice in 20 different states. Fifteen of the 29 residents who have had an elective laboratory experience are among those who have remained in academic careers. Two thirds of these 115 trainees currently practice general surgery, and 23 have pursued academic surgical careers.

The operative experience of our residents has been excellent and has remained above the 90th percentile nationally for total major cases (1090±42 total major; 240±21 surgeon chief). Experience did not vary, even though the number of graduating chiefs ranged from 5-8 per year, and there have been no deficiencies in RRC major case categories. The addition of specialty faculty in surgical oncology, colorectal, vascular, and hepatobiliary/ERCP surgery, who developed major referral practices, has increased the volume of complex index cases for the residents in their several areas of expertise. The addition of fellowships in trauma/critical care (1985), ERCP (1995), colorectal (1999), and minimal invasive surgery (2000) has not markedly impacted the operative experience of the general surgery chief residents.

There were 208 surveys distributed to all those who have completed the program in General Surgery at the University of Louisville; 184 were returned for analysis. Nine surgeons had retired and three were deceased. One hundred forty-eight were in group practice and 34 had a solo practice. Two were in a missionary practice in Jamaica and Ecuador. One hundred thirty-four surgeons were in private practice, an additional 10 were in a university-affiliated practice, and 40 were full-time faculty in an academic setting. The vast majority believed that they were very well trained (161) or well trained (21), and the majority felt that they were extremely (62) or very (82) satisfied overall with their current practice.

Although 104 undertook additional fellowship training, most continued to have broad-based practices. In fact, all but 12 responders have maintained their ABS certificate in general surgery, regardless of whether their current practice includes general surgery. We found that practice patterns are, in fact, much broader than would be indicated by Board certification status alone, and that general surgical practice does indeed constitute a wide variety of areas. The top 3 areas were general, oncology, and colorectal, followed closely by vascular, trauma, and thoracic. In fact, of the 116 who considered themselves as practitioners of general surgery, 109 said that they had either a broad-based or general practice of surgery.

It is reassuring to have had the high response rate as we did from the survey, and even more so, to find that the overwhelming majority believed their training well prepared them for practice. Despite the current climate in medicine, most were very satisfied with their current practice and many have broad-based practices consistent with their general surgery training. We believe that such training best prepares one to face the clinical realities of the disease spectrum seen by surgeons; and, in fact, one surgeon responded that he continued to be amazed by the number of new clinical problems seen on a regular basis. While many residents pursue fellowships, those who did not have achieved innately successful careers. Most continue to practice general surgery, indicating the value of complete training in this field. Clearly, for these surgeons, the personal and professional gratification of their chosen profession and practice outweigh the challenge of contemporary medicine. We continue to believe that broad-based surgical training is essential for residents in general surgery in a system of graduated responsibility and assumption of total care of the surgical patient.

Our program provides an extensive experience in critical care, endoscopy, catheter-based techniques, minimal access surgery, tertiary oncology, complex preoperative cases, trauma, burns, pediatric surgery, and vascular cases. The general surgery resident plays a primary role in patient management and assumes responsibility for both in-patient and outpatient care of the surgical patient.

*** Excerpts (with permission from Cheadle WG, Franklin GA, Richardson JD, Polk HC Jr.: "Broad-based general surgery training is a model of continued utility for the future." Ann Surg 2004; 239:627-636.)**

2023-2024 Surgical Resident & Fellow Directory

GENERAL SURGERY RESIDENTS

	Postgraduate Year V:	Pager	Medical School
	**Logan Bond** logan.bond@louisville.edu	209-1474	University of Louisville
	**Kelsey Cage** kelsey.cage@louisville.edu	209-1475	Louisiana State University
	**Michael Carr** micheal.carr.4@louisville.edu	209-1664	University of South Florida
	***Amelia Collings** amelia.collings@louisville.edu	209-1306	Thomas Jefferson University
	**Jahanzeb Kaikaus** jahanzeb.kaikaus@louisville.edu	209-1568	Rush University
	**Collyn Schafer** collyn.schafer@louisville.edu	209-1329	University of Missouri
	**Alyssa Simpson** alyssa.simpson@louisville.edu	209-1396	University of South Carolina
	**Ansley Smith** ansley.smith@louisville.edu	209-1545	University of South Alabama
	**Joseph Sweeney** joseph.sweeney@louisville.edu	478-0754	Wake Forest
	**Andrew Tumen** andrew.tumen@louisville.edu	209-1665	University of Tennessee

**Administrative Chief Resident*

Postgraduate Year IV:		Pager	Medical School
	**Matthew Acton** matthew.acton@louisville.edu	209-1307	Indiana University
	**William Allen** william.allen@louisville.edu	209-1448	University of South Florida
	**Sellers Boudreau** seller.boudreau@louisville.edu	209-1503	University of Alabama
	**Nicolas Cassata** **nicolas.cassata@louisville.edu**	209-1548	University of Texas-Houston
	**Seth Hall** seth.hall@louisville.edu	209-1643	University of Louisville
	**Brittany Hegde** brittany.wiseman@louisville.edu	464-7018	University of Tennessee
	**David Keeven** david.keeven@louisville.edu	209-1455	University of Kentucky
	**Matthew Woeste** matthew.woeste@louisville.edu	209-1366	University of Louisville

Postgraduate Year III:		**Medical School**
	**Pooja Avula** **pooja.avula@louisville.edu**	Western Michigan
	**Nicholas Caminiti** **nicholas.caminiti@louisville.edu**	University of Connecticut
	**Samuel Dacus** **samuel.dacus@louisville.edu**	University of South Carolina
	**Victoria Hammond** **victoria.hammond@louisville.edu**	University of Louisville
	**Mohammed Ranavaya** **mohammed.ranavaya@louisville.edu**	Marshall University
	**Brandon Ryvkin** **brandon.ryvkin@louisville.edu**	St. Louis University
	**Brittany Sims** **brittany.sims@louisville.edu**	University of Louisville
	**Alan Sumski** **alan.sumski@louisville.edu**	Ohio State University of

Postgraduate Year II:		**Medical School**
	**Joshua Crane** **joshua.crane@louisville.edu**	Georgetown University
	**Maggie Durci** **maggie.durci@louisville.edu**	Louisiana State University-Shreveport
	**Zach Hier** **zach.hier@louisville.edu**	University of Pittsburgh
	**Donya Jahandar** donya.jahandar**@louisville.edu**	University of Missouri-Kansas City
	**Joel Kramer** **joel.kramer@louisville.edu**	University of Washington
	**Grace Osagie** **grace.osagie@louisville.edu**	University of North Carolina-Chapel Hill
	**Thomas Touma** **thomas.touma@louisville.edu**	University of South Carolina-Columbia
	**Noah Whited** **noah.whited@louisville.edu**	Texas Tech

Postgraduate Year I:		**Medical School**
	**Madison Bulger** madison.bulger@louisville.edu	University of Missouri-Columbia
	**Rebecca Buster** rebecca.buster@louisville.edu	University of Louisville
	**Mackenzie Carroll** mackenzie.carroll@louisville.edu	University of Louisville
	**Stephanie Green** stephanie.green@louisville.edu	University of Texas-Houston
	**Aryana Jones** aryana.jones@louisville.edu	West Virginia University-Charleston
	**Quinn Losefsky** quinn.losefsky@louisville.edu	Anne Burnett Marion @ TCU
	**Gabrielle Manno** gabrielle.manno@louisville.edu	UTMB Galveston
	**Jordan Noe** jordan.noe@louisville.edu	University of Louisville
	**Karunesh Polireddy** karunesh.polireddy@louisville.edu	Emory
	**Evan Riggs** evan.riggs@louisville.edu	Southern Illinois University
	**Daniel Thomas** daniel.thomas@louisville.edu	University of Mississippi

Machenize Eason, Coordinator, General Surgery Residency Program
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-1895 ~ Email: m.eason@louisville.edu

SURGICAL RESEARCH RESIDENTS

Research Residents	Medical School	Research Years(s)
 **Hiley Cammock – PGY-3** **hiley.cammock@louisville.edu**	University of Cincinnati	2023-2024
 **Walter Donica – PGY-3** **walter.donica@louisville.edu**	University of Cincinnati	2023-2024
 **Toyokazu Endo – PGY2** toyokazu.end@lousiville.edu	University of Nevada	2023-2024
 **Alexandra Jones** alexandra.jones.1@louisville.edu	University of Oklahoma	2023-2024
 **William Risinger – PGY-3** william.risinger@louisville.edu	University of Louisville	2022-2024
 **Kyle Stephens – PGY-2** **kyle.stephens@louisville.edu**	University of New Mexico	2023-2024
 **Chinweotuto Uma – PGY-2** **vanessa.uma@louisville.edu**	Baylor	2022-2024

Machenize Eason, Coordinator, General Surgery Residency Program
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-1895 ~ Email: m.eason@louisville.edu

COLON & RECTAL SURGERY FELLOW

	Pager	Medical School	Fellowship Year(s)
 **Dylan Carroll** dylan.carroll@louisville.edu	478-1369	West Virginia University	2023-2024

Julie Watkins, Colon & Rectal Surgery Program Coordinator
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-4568 ~ Email: julie.watkins@louisville.edu

ERCP FELLOW

	Medical School	Fellowship Year(s)
Joshua Day, MD	UAB	2023-2024

Judy Slaughter, ERCP Coordinator
Norton Healthcare Pavilion
Phone: 629-2278 ~ Email: judy.slaughter@nortonhealthcare.org

HAND SURGERY

Brandon Collofello, MD
collofello@uky.edu
Galen "Rob" Cummings, DO
Cummings.g.robert@gmail.com
Michael Fish, DO
mfish07@mac.com
Omer Kaymakcalan, MD
kaymakcalan@gmail.com
Matthew Marr, MD
matthew-marr@ouhsc.edu
Matthew Pina, MD
mpina@uchc.edu
Matthew Shaheen
shaheen4ms@gmail.com
Rachel Thibodeau, DO
rachelth@pcom.edu

Jackie Hardwick, Education Coordinator, Fellowship Assistant
C.M. Kleinert Institute for Hand and Microsurgery – 225 Abraham Flexner Way, Suite # 850
Phone: 562-0312 ~ Email: jhardwick@kleinertkutz.com

PEDIATRIC SURGERY FELLOWS

Fellow	Pager	Medical School	Fellowship Year(s)
 **Jonathan Vacek** jonathan.vacek@louisville.edu	421-4350	St. George's University	2023-2025

Lisa Pantoja, Pediatric Surgery Fellowship Coordinator
Norton Healthcare Pavilion – 315 E. Broadway, Suite # 565
Phone: 629-8630 ~ Email: lredwa03@louisville.edu

PLASTIC & RECONSTRUCTIVE SURGERY FELLOWS

Independent Plastic Surgery:

Fellow Chief Year:	Pager	Medical School
 **Joshua MacDavid** joshua.macdavid@louisville.edu	209-1668	University of Nevada
 **Evan Westrick** evan.westrick@louisville.edu	209-1667	Indiana University

Fellow Second Year:	Pager	Medical School
 **Anthony Azzolini** anthony.azzolini@louisville.edu	209-1311	Rutgers
 **Jacob Katsnelson** jacob.katsnelson@louisville.edu	209-1322	Ohio State University

Fellow First Year:	Pager	Medical School
 **Wilson Huett** wilson.huett@louisville.edu	209-1334	University of Arkansas
 **Joshua Spiegel** joshua.spiegel@louisville.edu	209-1325	University of Tennessee

Integrated Plastic Surgery:

Resident Third Year:	Pager	Medical School
 **Candice Nguyen** candice.nguyen@louisville.edu	209-1669	University of Louisville
 **Mitchell Peake** mitchell.peake@louisville.edu	209-1647	University of Cincinnati

Resident Second Year:	Pager	Medical School
 **Shelby Graham** shelby.graham@louisville.edu	209-1323	Rush Medical College
 **Brian Paul** brian.paul@louisville.edu	209-1324	University of Iowa

Resident First Year:	Pager	Medical School
 **Arrin Brooks** arrin.brooks@louisville.edu	209-1302	Marshall University
 **Jon Bruce** jon.bruce@louisville.edu	485-5626	Texas Tech

Amory Alvey, Plastic and Reconstructive Surgery Residency Coordinator
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-6880 ~ Email: amory.alvey@louisville.edu

SURGICAL CRITICAL CARE/TRAUMA FELLOWS

Fellow	Pager	Medical School	Year(s)
 **Jeremy Badach** jeremy.badach@louisville.edu	502-209-1353	Rutgers	2023-2024
 **Kristen Burke** kristen.burke@louisville.edu	502-209-1354	U of Kentucky	2023-2024
 **Kali Kuhlenschmidt** kali.kuhlenschmidt@louisville.edu	502-209-1355	Indiana University	2023-2024

Samantha Oliver, Surgical Critical Care Fellowship Coordinator
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-6191 ~ Email: samanthan.oliver@louisville.edu

SURGICAL ONCOLOGY FELLOWS

Fellow	Pager	Medical School	Year(s)
 **Meredith Gunder** meredith.gunder@louisville.edu		University of Miami	2023-2025
 **Mackenzie Shindorf** Mackenzie.shindorf@louisville.edu		U of Toledo	2022-2024

Rachel Wietecha, Surgical Oncology Fellow Coordinator
Norton Healthcare Pavilion – 3rd Floor
Phone: 629-6950 ~ Email: rachel.wietecha@louisville.edu

VASCULAR SURGERY FELLOWS

Fellow	Pager	Medical School	Year(s)
 **Gina Roessler** gina.roessler@louisville.edu	502-209-1351	University of Pikeville	2023-2025
 **Keith Zoeller** **keith.zoeller@louisville.edu**	502-209-1352	University of Louisville	2023-2025

Monica Sivori, Vascular Surgery Program
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-0864 ~ Email: monica.sivori@louisville.edu

Master Schedule 2022-2023
General Surgery Rotations

"I had forgotten the renowned standards to which your residents are encouraged, and your faculty should be complimented upon the residents' professionalism, knowledge and compassion."

Professor Russell Strong - Brisbane, Queensland, Australia

Clockwise from Top: Norton Hospital, VA Medical Center, Jewish Hospital, Norton Children's Hospital, & University Hospital

General Surgery Master Schedule 2023-2024

University of Louisville Hospital	July 2023	August	September	October	November	December
Trauma I	Collings Ranavaya Touma Bulger Griffin (OMFS)	Collings Ranavaya Touma Green Jacob (ENT)	Carr Sims Kramer Jones Losefsky	Cage Ryvkin Osagie Riggs Byerly (Ortho)	Schafer Hammond Jahandar Noe Lawrence (OMFS)	Smith Ranavaya Kramer Polireddy Metzman (Ortho)
Trauma II	Bond Caminiti Crane Carroll French (ENT)	Bond Caminiti Crane Mattingly (EM) Hudson (EM)	Smith Sumski Hier Kukkala (ENT) Kelesis (EM)	Sweeney Avula Whited Tejuoso (Uro) Perling (EM)	Kaikaus Dacus Durci Ogunidpe (Uro) Williams (EM)	Tumen Sumski Touma Thomas Webb (EM)
Trauma ICU Day Float	Kramer Roberts (EM)	Jahandar Aiello (EM)	Osagie Daniel (EM)	Crane Ganshirt (EM)	Graham (PRS) Beard (EM)	Paul (PRS) Kushner (EM)
University General Surgery	Smith Sims	Sweeney Sumski	Bond Hammond	Schafer (1-15) Bond (16-31) Ranavaya	Collings Caminiti	Cage Ryvkin
Veterans Hospital						
VAMC Surgery	Cassata Dacus Durci Noe	Hegde Hammond Whited Buster	Simpson Ranavaya Crane Green	Kaikaus (1-15) Tumen (16-31) Sims (1-15) Hammond (16-31) Hier Carroll (1-15) Manno (16-31)	Keeven (1-15) Boudreau (16-30) Ryvkin (1-15) Sumski (16-30) Hier (1-15) Kramer (16-30) Green (1-15) Jones (16-30)	Hegde (1-15) Allen (16-31) Sims Durci (1-15) Whited (16-31) Bruce (1-15) Brooks (16-31)

Norton Hospital / Jewish Hospital General Surgery	July 2023	August	September	October	November	December
Acute Care Surgery (NH, JH) ***Norton Float Chief**	Cage Avula	Carr Dacus *Smith (16-31)	Kaikaus Ryvkin *Collings (1-15)	Simpson Sumski	Bond Avula	Schafer Dacus
Minimally Invasive Surgery **NH, Kehdy** **Robotic**	Boudreau	Cage	Schafer	Cassata	Hegde	Woeste
Williams Service (JH, Jewish East)	Woeste	Acton	Keeven	Allen	Hall	Boudreau
Norton Hospital Interns	Green Thomas Buster PGY2/3 (Supervisory)	Bulger Noe Brooks (PRS) PGY2/3 (Supervisory)	Manno Riggs Bruce (PRS) PGY2/3 (Supervisory	Jones Buster	Losefsky Polireddy	Carroll Riggs
Jewish Hospital Interns	Manno Ogundipe (Uro) Kukkala (ENT) PGY2/3 (Supervisory)	Losefsky Edwins (Uro) French (ENT) PGY2/3 (Supervisory)	Polireddy Tejuoso (Uro) Jacob (ENT) PGY2/3 (Supervisory)	Noe Bruce (PRS)	Bulger Riggs (1-15) Thomas (16-30)	Manno Buster
Norton Children's Hospital						
Norton Children's Hospital	Allen Whited Byerly (Ortho) Jacob (ENT)	Cassata Osagie Schmidt (Ortho) Kukkala (ENT)	Hegde Durci Bulger French (ENT)	Boudreau Paul (PRS) Metzman (Ortho) Green	Woeste Touma Sauder (Ortho) Carroll	Hall Hier Jones Losefsky

Jewish Hospital Specialty Services						
Transplant	Kaikaus Hier	Allen Durci	Acton Jahandar	Hall Touma	Tumen Crane (16-30)	Sweeney (1-15) Cassata (16-31) Jahandar
Thoracic	Acton Jahandar	Kaikaus Thomas	Sweeney Buster	Carr Durci (1-15) Graham (PRS; 16-31)	(Griffin) Osagie (1-15) Paul (PRS; 16-30)	(Griffin) Crane (1-15) Durci (16-31)
Cardiac				Acton	Carr	
CVICU	Carr	Smith (1-15)	Hall (1-15)	Woeste (1-15)	Acton (16-30)	

Elective Services	July 2023	August	September	October	November	December
Surgical Oncology	Sweeney Hall Hammond Osagie Jones Bruce (PRS)	Schafer Boudreau Avula Hier Carroll Polireddy	Tumen Woeste Caminiti Paul Noe Brooks (PRS)	Collings Hegde Peake (PRS) Kramer Thomas	Simpson Allen Nguyen (PRS) Whited Manno	Bond Acton Hammond Graham (PRS) Green
Colorectal Surgery	Tumen Ryvkin Losefsky Riggs	Woeste Kramer Jones Manno	Cage Whited Carroll Thomas	Keeven Jahandar (1-15) Caminiti (16-31) Bulger (1-15) Losefsky (16-31)	Cassata Crane (1-15) Ranavaya (16-30) Edwins (Uro)	Collings Osagie Tejuoso (Uro;1-15) Noe (16-31)
Vascular	Keeven Sumski Polireddy Tejuoso (Uro)	Simpson Sims Riggs Byerly	Boudreau Dacus Touma (16-30) Edwins (Uro) Schmidt (Ortho)	Smith Nguyen (PRS) Brooks (PRS) Polireddy (1-15)	Smith (1-15) Cage (16-30) Peake (PRS) Bruce (PRS) Buster (16-30)	Carr (1-15) Simpson (16-31) Caminiti Bulger
Plastics	Simpson Peake Nguyen Paul	Peake Nguyen Paul Graham	Peake Nguyen Graham		Brooks	Peake Nguyen
Bariatrics (Allen)	Schafer	Hall	Allen			
NH Audubon					Sweeney	

Mary and Elizabeth	Hegde (17-31)	Tumen	Avula (16-30)	Dacus(16-31)		Keeven
Rural General Surgery **Madisonville** **Owensboro*** **Africa**** **Missouri*****		Ryvkin *Keeven	*Cassata		Sims	Avula **Kaikaus
Vacation	Hegde (1-16) Maternity leave		Avula (1-15) Touma (1-15) Collings (16-30) Hall (16-30)	Kaikaus (1-15) Tumen (1-15) Hammond (1-15) Caminiti (1-15) Dacus (1-15) Graham (1-15) Manno (1-15) Losefsky (1-15) Bond (16-31) Schafer (16-31) Woeste (16-31) Sims (16-31) Durci (16-31) Jahandar (16-31) Carroll (16-31) Bulger (16-31) Polireddy (16-31)	Cage (1-15) Acton (1-15) Boudreau (1-15) Ranavaya (1-15) Sumski (1-15) Kramer (1-15) Paul (1-15) Jones (1-15) Thomas (1-15) Buster (1-15) Smith (16-30) Keeven (16-30) Ryvkin (16-30) Hier (16-30) Osagie (16-30) Green (16-30) Riggs (16-30)	Simpson (1-15) Allen (1-15) Cassata (1-15) Whited (1-15) Brooks (1-15) Noe (1-15) Carr (16-31) Sweeney (16-31) Hegde (16-31) Crane (16-31) Bruce (16-31) Tejuoso (16-31)

General Surgery Master Schedule 2022-2023

University of Louisville Hospital	January 2024	February	March	April	May	June
Trauma I	Simpson Caminiti Hier Buster Brooks (PRS)	Kaikaus Dacus Jahandar Carroll Bruce (PRS)	Sweeney Sumski Osagie Smith (Ortho) Griffin (OMFS)	Simpson Caminiti Crane Jones Riggs	Kaikaus Avula Hier Bruce (PRS) Sauder (Ortho)	Carr Sims Kramer Schmidt (Ortho) Lawrence (OMFS)
Trauma II	Carr Ryvkin Graham (PRS) Bulger Blair (EM)	Cage Avula Kramer Edwins (Uro) Marks (EM)	Tumen Sims Paul (PRS) Green Lyons (EM)	Schafer Ranavaya Durci Noe Taylor (EM)	Cage Hammond Whited Manno Coffman (EM)	Collings Ryvkin Jahandar Brooks (PRS) Harris (EM)
Trauma ICU Day Float	Whited Locke (EM)	Durci Gellert (EM)	Hier Stults (EM)	Osagie Huttner (EM)	Touma Wells (EM)	Osagie Studebaker (EM)
University General Surgery	Collings Dacus	Carr Sims	Cage (1-15) Bond (16-31) Ryvkin	Bond Avula	Simpson Dacus	Schafer Hammond
Veterans Hospital						
VAMC Surgery	Schafer Avula Durci Manno	Smith Caminiti Osagie Bulger	Hegde (1-15) Boudreau (16-31) Avula (1-15) Caminiti (16-31) Jahandar Jones (1-15) Thomas (16-31)	Keeven Sumski Touma (1-15) Whited (16-30) Manno (1-15) Bruce (16-30)	Carr Ryvkin (1-15) Sims (16-31) Kramer (1-15) Osagie (16-31) Carroll (1-15) Noe (16-31)	Boudreau Simpson (16-30) Sumski (1-15) Ranavaya (16-30) Touma Thomas (1-15) Green (16-30)

Norton Hospital / Jewish Hospital General/Acute Care Surgery	January 2024	February	March	April	May	June
Acute Care Surgery (NH, JH) ***Norton Float Chief**	Tumen Sims	Sweeney Touma *Collings (1-14)	Collings Hammond *Schafer (1-15)	Cage Hammond (16-30)	Sweeney Caminiti *Boudreau (16-30)	Tumen Crane
Minimally Invasive Surgery NH, Kehdy	Bond	Tumen	Keeven	Acton	Collings	Hall
Williams Service (JH, Jewish East)	Cassata	Hegde	Allen	Woeste (1-15) Hall (16-30)	Acton (1-15) Keeven (16-30)	Keeven
Norton Hospital Interns	Thomas Noe	Buster Tejuoso (Uro)	Bulger Noe	Green Losefsky	Polireddy Edwins (Uro;1-15) Green (16-31)	Manno Ogundipe (Uro)
Jewish Hospital Interns	Jones Polireddy	Green Noe	Losefsky Riggs	Carroll Brooks (PRS)	Losefsky Buster	Jones Polireddy
Norton Children's Hospital						
Norton Children's Hospital	Acton Jahandar Ogundipe (Uro) Smith (Ortho)	Keeven Crane Manno Polireddy	Cassata Kramer Brooks (PRS) Edwins (Uro)	Collings Graham (PRS) Buster Tejuoso (Uro)	Hall Durci Riggs Thomas	Acton Whited Noe Bruce (PRS)

Jewish Hospital Specialty Services						
Transplant	Woeste Crane	Bond Whited	Carr (1-15) Kaikaus (16-31) Touma	Cassata Hier (1-15) Kramer (16-31)	Woeste Graham (PRS)	Smith Paul (PRS)
Thoracic	(Griffin) Osagie	Allen Riggs	Simpson Durci (1-15) Carroll (16-31)	Smith (1-15) Hegde (16-30) Kramer (1-15) Polireddy (16-30)	Smith Jahandar (1-15)	Cage Riggs (1-15) Bulger (16-30)
Cardiac	Smith					Sweeney
CVICU				Hegde (1-15)	Boudreau (1-15) Allen (16-31)	Cassata (16-30)

Elective Services	January 2024	February	March	April	May	June
Surgical Oncology	Cage Keeven Ranavaya Touma Losefsky Riggs	Schafer Cassata Ryvkin Hier Jones	Smith Hall Dacus Whited Buster	Carr Boudreau Sims Jahandar Thomas	Tumen Hegde Sumski Crane Bulger	Kaikaus Woeste Caminiti Durci Carroll
Colorectal Surgery	Hegde Kramer Green	Hall Sumski Thomas	Acton Graham (PRS) Polireddy	Sweeney (1-15) Tumen (16-30) Paul (PRS) Bulger	Schafer Ranavaya Ogundipe (Uro;1-15) Brooks (16-31)	Allen Hier Losefsky Buster (16-30)
Vascular	Hall Hammond Carroll Metzman (Ortho)	Acton Ranavaya Sauder (Ortho) Losefsky (1-14)	Woeste Nguyen Crane (1-15) Carroll (1-15) Manno	Kaikaus* Allen Ryvkin Ogundipe (Uro)	Bond* Cassata Peake Jones	Hegde Avula Smith (Ortho) Green (1-15) Thomas (16-30)
Plastics	Peake Nguyen Paul	Peake Nguyen Graham Paul	Bruce	Peake Nguyen	Paul	Peake Nguyen

Bariatrics (Allen)	Sweeney					Bond
NH Audobon						
Mary and Elizabeth	Allen	Boudreau				Dacus (1-15)
Rural General Surgery **Madisonville** **Owensboro*** **Africa****	Sumski *Boudreau **Kaikaus	Hammond *Woeste	Ranavaya	Dacus		
Vacation		Collings (15-29) Losefsky (15-29)	Bond (1-15) Kaikaus (1-15) Boudreau (1-15) Caminiti (1-15) Thomas (1-15) Cage (16-31) Carr (16-31) Schafer (16-31) Hegde (16-31) Avula (16-31) Crane (16-31) Durci (16-31) Jones (16-31)	Tumen (1-15) Hall (1-15) Hammond (1-15) Whited (1-15) Bruce (1-15) Polireddy (1-15) Smith (16-30) Sweeney (16-30) Woeste (16-30) Hier (16-30) Touma (16-30) Manno (16-30) Brooks (16-30)	Allen (1-15) Keeven (1-15) Sims (1-15) Osagie (1-15) Brooks (1-15) Noe (1-15) Green (1-15) Acton (16-31) Ryvkin (16-31) Jahandar (16-31) Kramer (16-31) Ogundipe (16-31) Carroll (16-31)	Simpson (1-15) Cassata (1-15) Ranavaya (1-15) Buster (1-15) Bulger (1-15) Sumski (16-30) Dacus (16-30) Riggs (16-30)

Master Schedule 2022-2023
Plastic Surgery Block Diagram

"I was particularly impressed by the disciplined professional demeanor and succinct but lucid presentations of your residents, all of which is a reflection of your eminent leadership."

Dr. Michael DeBakey - Houston, Texas

Clockwise from Top: Norton Children's Hospital, Norton & Jewish Hospitals, & University Hospital

Division of Plastic Surgery ~ Rotation Schedule 2023-2024

University of Louisville School of Medicine - Division of Plastic Surgery

Updated 6.06.2023

RESDIENT ROTATION SCHEDULE 2023-2024

	July	August	September	October	November	December	January	February	March	April	May	June
Bruce PGY 1	Surg Onc Gen Surg	University Plastic	NH Gen Surg	Jewish Gen Surg	Vascular Gen Surg	VA Gen Surg	University Plastic	Trauma Gen Surg	VA Plastic	VA Gen Surg	Trauma Gen Surg	NCH Gen Surg
Brooks PGY 1	University Plastic	NH Gen Surg	Surg Onc Gen Surg	Vascular Gen Surg	VA Plastic	VA Gen Surg	Trauma Gen Surg	University Plastic	NCH Gen Surg	Jewish Gen Surg	Colorectal Gen Surg	Trauma II Gen Surg
Graham PGY 2	University Plastic	Recon II (LE) Plastic	VA Plastic	Thoracic Gen Surg	ICU - Float Gen Surg	Surg Onc Gen Surg	Trauma II Gen Surg	University Plastic	Colorectal Gen Surg	NCH Gen Surg	Transplant Gen Surg	Recon II (LE) Plastic
Paul PGY 2	Recon II (LE) Plastic	University Plastic	Surg Onc Gen Surg	NCH Gen Surg	Thoracic Gen Surg	ICU - Float Gen Surg	University Plastic	Recon II (LE) Plastic	Trauma II Gen Surg	Colorectal Gen Surg	VA Plastic	Transplant Gen Surg
Peake PGY 3	CMF Plastic	ENT Plastic	CMF Plastic	Surg Onc Gen Surg	Vascular Gen Surg	University Plastic	Recon II (LE) Plastic	University Plastic	Recon I Plastic	OMFS Plastic	Vascular Gen Surg	VA Plastic
Nguyen PGY 3	ENT Plastic	CMF Plastic	University Plastic	Vascular Gen Surg	Surg Onc Gen Surg	CMF Plastic	VA Plastic	OMFS Plastic	Vascular Gen Surg	University Plastic	Recon II (LE) Plastic	Recon I Plastic
Key	Plastics Rotation	GenSurg Rotation	Vacation									

University of Louisville School of Medicine - Division of Plastic Surgery

Updated 6.06.2023

FELLOW ROTATION SCHEDULE 2023-2024

	University	Hand	Recon	Recon II (LE)	VAMC	Head & Neck	Electives
July 23	Westrick Simpson Graham Brooks	MacDavid	Katsnelson	Paul	Spiegel	Azzolini	Peake (CMF) Huett (Ortho) Nguyen (ENT)
Aug 23	Azzolini Paul Bruce	Westrick	MacDavid	Graham	Katsnelson	Huett	Nguyen (CMF) Spiegel (Ortho) Peake (ENT)
Sept 23	Katsnelson Nguyen	Azzolini	Westrick	Huett	Graham	Spiegel	Peake (CMF) MacDavid (Occu)
Oct 23	Azzolini	Katsnelson	Huett	Spiegel	MacDavid	Westrick	
Nov 23	Kastnelson	Huett	Spiegel	Westrick	Brooks	MacDavid	Azzolini (CMF)
Dec 23	MacDavid Peake	Westrick	Huett	Spiegel	Azzolini	Katsnelson	Nguyen (CMF)
Jan 24	Azzolini Paul Bruce Hale (PR)	Spiegel	Katsnelson	Peake	Nguyen	Huett	MacDavid (Derm) Westrick (Occu)
Feb 24	Katsnelson Peake Graham Brooks Pritchett (PR)	MacDavid	Azzolini	Paul	Huett	Spiegel	Westrick (Anes) Nguyen (OMFS)
Mach 24	Spiegel Manus (PR)	Azzolini	Peake	Huett	Bruce	Katsnelson	MacDavid (Anes) Westrick (Derm)
April 24	Huett Nguyen Brandon (PR)	Katsnelson	Spiegel	MacDavid	Westrick	Azzolini	Peake (OMFS)
May 24	Spiegel Henderson (PR)	Huett	Azzolini	Nguyen	Paul	Katsnelson	Westrick MacDavid
June 24	Huett Loesel (PR)	Spiegel	Nguyen	Graham	Peake	Azzolini	Westrick MacDavid Katsnelson (CMF)

R = Resident F = Fellow PR = Podiatry Resident

University

- Responsible for University Ward Service Case, i.e. those that have been evaluated or will follow-up at ACB
- Covers University Trauma, Burn, and ER patients
- Direct Monday office hours at ACB clinic
- Cover ULH Consults Monday-Friday, 7am-5pm
- Cover Facial Trauma Calls during week
- Will discuss all new patients with the on-call attending that week to discuss treatment plan

Hand/University:

- Primarily works with Dr. Wilhelmi.
- Takes Hand Call on Tuesdays 7am – Wed 7am
- Monday - covers the ACB for hand follow-ups
- Tuesday - HCOC office
- Wednesday and Thursday - OR
- Friday - covers hand cases with Dr. Sheker, Dr. Tien, Kleinert or Orthopaedic Hand

Reconstructive I:

- Covers cases with Dr. Shapiro at Jewish, H&L, and Norton Hospitals
- Encouraged to attend office hours whenever possible
- Covers Facial Trauma call at Norton Children's Hospital

Reconstructive II:

- Covers cases with Dr. Tobin and Dr. Choo at Jewish, H&L and Norton Hospitals
- Encouraged to attend office hours whenever possible
- Assists the University rotation whenever possible

VAMC:

- At VAMC every day with Dr. Choo and Dr. Harter
- VA Clinic Monday-Wednesday
- OR Thursday and Friday

Head/Neck:

- Head & Neck Oncology and Reconstruction, Breast Reconstruction, Free Flaps, Extremity Reconstruction, Cosmetics
- Responsible for Dr. Little's private patients at Jewish, Norton Hospital, and Norton Children's
- Tuesday – works with Dr. Chariker – Pediatric Craniofacial
- Friday - covers Dr. Little's office hours.

Electives:

- Oculoplastic Surgery, Dermatology, Orthopedic Hand, Maxillofacial, Anesthesia and Elective

Hospital Information

Our residents will rotate throughout their training at the University of Louisville through five major teaching hospitals. These include ULH, VAMC, Norton, Norton Children's and Jewish Hospitals. This provides the resident trainee with a wide variety of patient population for which to learn broad general surgery. Each has its unique population with specific diverse entities and practice patterns. The surgical trainees are exposed to a variety of diagnostic preferences, technical variations, and overall clinical diversity because the attending staff members come from diverse schools of surgery. Surgical residents are expected to participate in pre- and post-operative care on all rotations and be responsible for completion of appropriate paperwork including history and physicals, daily notes, operative notes, and discharge summaries. It is expected that the attending surgeon will be consulted as consistent with both his/her moral and legal responsibility to the patient. Should your performance be particularly conscientious, you may reasonably expect to do part or all of some operations, under direct supervision, when the attending surgeon has had the opportunity to come to know your abilities. The volume and diversity of this surgical experience should be such that it will greatly increase the facility with which you learn surgery, including a greater depth of understanding of this challenging field. The assignment of full-time faculty to each institution has enhanced the value of the experience, with particular reference to continuity, conferences, and overall surgical education. Junior and Senior medical students are assigned to all of their hospitals and the general surgery residents supervise them on the surgical services.

University of Louisville Hospital

Ph: (502) 562-3000 / Operating Room: (502) 562-3504

University of Louisville Hospital is the primary teaching hospital for the University of Louisville School of Medicine. It is a 404-bed acute care, tertiary medical center providing a full range of diagnostic, therapeutic, emergency, and surgical services. Over 500 of the area's physicians are on the medical staff. Dr. J. David Richardson is Chief of Surgery at University Hospital, and Dr. Glen Franklin is Director of Surgical Education. Dr. Brian Harbrecht is Chief of Emergency Surgical Services. Private patients of other faculty are regularly hospitalized here. Three separate surgical services including two emergency general surgery, trauma, and burn services, and an elective general and thoracic surgical service are staffed by a full complement of residents and each directed by a chief resident.

The hospital is part of a 4-building complex that also includes an Ambulatory Care Building housing University Physicians Group, James Graham Brown Cancer Center, and the new UL Outpatient Care Building.

Veterans Affairs Medical Center

Ph: (502) 287-4000 / Operating Room: (502) 287-6808

The VA is located about 3.5 miles from the downtown medical center. Dr. Andrea Yancey is Chief of the Surgical Service and several attending surgeons are either part or full time there. The hospital has about 100 filled beds, and there are two resident surgical services. The spectrum of disease seen is typical of any VA and includes vascular disease, cancer, hernias, complex intra-abdominal cases, and complicated wounds. The surgery clinics are particularly efficient and include two general surgery clinics, two vascular clinics, and thoracic clinic. The electronic medical record is state of the art.

Mary & Elizabeth's Hospital

Ph: (502) 361-6000

This rotation will focus on comprehensive and broad-based general surgical training. A former University of Louisville graduate of the General Surgery Training Program will teach and supervise residents on this rotation. Residents will participate in a variety of basic and complex procedures, and experience a robust general, elective and emergency surgical practice. Resident will additionally have the opportunity to participate in vascular cases under the supervision of Dr. Nancy Clark, a University of Louisville vascular surgeon. The residents will also participate in an outpatient clinic experience at least one day per week.

Norton Audubon Hospital

Ph: (502) 636-7111

Surgical residents rotate through different specialty based services. This rotation focuses on general surgery, minimally invasive as well as routine surgery that imparts on important and enduring specialties in modern surgery. To provide comprehensive and broad based general surgical training, it is paramount that residents have sufficient exposure to a wide range of procedures and patient populations. Former University of Louisville graduate, Dr. Alex Maki, will supervise this rotation. The residents will participate in a variety of procedures, as well as a robust general and emergency surgery and an outpatient clinic experience at least one day per week. Many of the elective procedures on this rotation will be performed using advanced laparoscopic or robotic techniques.

Norton Hospital

Ph: (502) 629-8000 / Operating Room: (502) 629-7100

Surgical residents rotate through different specialty based services. These include general surgery, surgical oncology/endocrine, colorectal, and vascular services. Residents participate in caring for elective, emergency and well as complex, tertiary referral patients while on these services. Faculty expects residents to attend their private offices, operating room schedule allowing. Each service has a variety of conferences, to which attendance is mandatory.

There will be separate resident teams for each service. Chief residents will take primarily home call for their service, and will have predetermined days off. Junior residents will take rotating in-house overnight call covering all services. Junior residents will have days off according to their respective service. Dr. Farid Kehdy is Director of Surgical Education at Norton Hospital.

Norton Children's Hospital

Ph: (502) 629-6000 / Operating Room: (502) 629-4800

The Norton Children's Hospital rotation is a busy one with responsibilities for newborn surgery, children's trauma, care of patients on the oncology service, the burn service, and consultation in an active emergency room and surgical clinic.

The senior resident functions, with a pediatric surgery fellow, as a chief resident on the service and is supported by three to four junior residents. While on the Children's Service, the residents work closely with the attending pediatric surgeons to care for patients with a wide range of surgical illness from the newborn period to teenage years. While at Norton Children's Hospital, the residents participate in a weekly-scheduled resident teaching conference, student rounds presentations, and bi-monthly Pediatric Surgery quality improvement conferences as part of their total exposure to children's surgical care. Dr. Cynthia Downard is Surgeon-in-Chief and Director of Surgical Education at Norton Children's Hospital.

Norton Women's Hospital

Ph: (502) 893-1000

This rotation focuses on bariatric and advanced laparoscopic surgery. Though bariatric surgery is not a defined RRC rotational requirement, it is an important and enduring specialty in modern surgery. To provide comprehensive and broad based general surgical training, it is paramount that residents have sufficient exposure to bariatric procedures and the patient population. Former University of Louisville faculty member, Dr. Jeffrey Allen, will supervise this rotation. The residents will participate in a variety of bariatric procedures, as well as a robust general and emergency surgery practice as well as an outpatient clinic experience at least one day per week. Many of the elective, non-bariatric procedures on this rotation are performed using advanced laparoscopic techniques

Jewish Hospital/Kindred Hospital

Ph: (502) 587-4011 / Operating Room: (502) 587-4234

There are separate services of general surgery, thoracic, vascular surgery, transplantation, and cardiac surgery at this large teaching hospital. Residents are assigned to each of these services and all are under the supervision of the surgical staff members who are full time on clinical faculty members of this Department. Three surgical residents participate in the general surgical service under the supervision of Dr. Christopher Jones, who is Director of the Surgical Education and Chief of Transplant at Jewish Hospital.

Residents will also participate at Kindred Hospital, which is a subacute care facility located within Jewish Hospital. Residents will be responsible for the surgical needs of the hospital, which generally include chronic surgical conditions and wound care.

Rural Surgical Experience

Baptist Health Madisonville

Ph: (270) 825-5100 / Operating Room: (270) 825-5115

Residents, midway through their residency training, may be assigned to this rotation at the Baptist Health facility in Madisonville, Kentucky, which is located approximately 150 miles west of Louisville. Under the direction of Dr. Mohan Rao, Director of Surgical Education, residents will work under several general surgeons at this facility to obtain a rich operative experience in a community rural setting.

Owensboro Health Regional Hospital

Ph: (270) 417-2000 / Operating Room: (270) 417-5500

Residents may also be assigned to this rotation at the Owensboro Health Regional Hospital in Owensboro, Kentucky, which is located approximately 110 miles west of Louisville. Under the direction of Drs. John Falcone and Chris Glaser, Director(s) of Surgical Education, the residents will work under several general surgeons in their group to obtain a rich operative experience in a community rural setting.

Educational Goals and Objectives for the General Surgery Residency Program

The Core Competencies in General Surgery

The Accreditation Council for Graduate Medical Education (ACGME), including the Residency Review Committee (RRC) for surgery, has adopted a set of general competencies for all physicians who complete higher training programs. These have been adapted for each specialty. In the near future, all chief residents must be assessed as competent in these areas prior to receiving certification for completion of residency training and undertaking the American Board of Surgery examinations.

* * *

The 6 general competencies are:

Patient Care *that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Surgical residents must demonstrate manual dexterity appropriate for their training level and be able to develop and execute patient care plans.*

Medical Knowledge *about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Surgical residents are expected to critically evaluate and demonstrate knowledge of pertinent scientific information.*

Practice-Based Learning and Improvement *that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Surgical residents are expected to critique personal practice outcomes and demonstrate recognition of the importance of lifelong learning in surgical practice*.

Interpersonal and Communication Skills *that result in effective information exchange and teaming with patients, their families, and other health professionals. Surgical residents are expected to communicate effectively with other health care professionals, counsel and educate patients and families, and effectively document practice activities*.

Professionalism, *as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Surgical residents are expected to maintain high standards of ethical behavior, demonstrate a commitment to continuity of patient care, and demonstrate sensitivity to age, gender and culture of patients and other health care professionals*.

Systems-Based Practice, *as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Surgical residents are expected to practice high quality, cost effective patient care, demonstrate knowledge of risk-benefit analysis, and demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.*

* * *

The major educational goal of the General Surgery Residency Training Program in the Department of Surgery at the University of Louisville is to produce a board-certified surgeon capable of independently practicing general surgery of highest quality. On completion of the program, the surgeon should have a general knowledge, clinical judgment, the basic technical skills and personality attributes to establish rapport with patients and their families for the practice of general surgery, and be assessed as competent in the areas as outlined under the ACGME's 6 core competencies. These attributes will be acquired over at least a 5-year training period by acquiring new knowledge through clinical experiences, reading current literature and major textbooks, attending bedside rounds and conferences, and preparing reports for presentation and publication. Knowledge of the clinical course of patient disease will be acquired by managing surgical patients both as in- and out-patients, including management of the critically ill surgical patient. Most importantly, technical skill to perform operations and intra-operative decision-making will be acquired through observation and performance of a variety of surgical procedures within the realm of general surgery over the training period. The residents will record each operation performed or assisted, in an ongoing fashion, thereby preparing an operative log of case experience. This operative log will be entered directly onto the web-site provided by the RRC for Surgery. Each resident is responsible for his/her own resident data collection for the duration of his/her residency. The ability to convey the clinical course of given patients will be developed by case presentations during walk rounds and conferences. The ability to interact appropriately with referring physicians and consulting physicians will be acquired by periodic communication with such physicians throughout the training period.

During the **PGY-1** year:
The resident will become familiar with the fundamentals of management and pre- and post-operative care of the general, thoracic, pediatric, and transplant surgical patient. This goal will be achieved by performance of initial patient assessment including history and physical and interpretation of routine laboratory tests and imaging studies. Additionally, assistance with, or performance of, certain operations will be carried out. The PGY-1 resident will also acquire knowledge of post-operative patient care by daily assessment of in-hospital post-operative patients on the floor and, as needed, in the Intensive Care Unit. Further knowledge of post-operative care will be learned by attending clinics and management of the patient in an ambulatory setting. Technical skills including basic instrument techniques, suturing, and retracting shall also be learned during the PGY-1 year. It is our goal that residents will act as surgeon for some basic cases with proper supervision.

During the **PGY-2** year the resident will further enhance his/her skills of peri-operative and operative management by performing additional and more complex operations. These trainees have a primary role in the Intensive Care Unit at most of the major integrated and affiliated hospitals and should be facile with all invasive procedures relevant to ICU care. Skills in surgical specialty services not acquired in the PGY-1 year will be done in this year. PGY-2 residents will be responsible for presentation of patients during walk rounds at the VAMC and University Hospital unless otherwise directed by the chief resident on the service.

During the **PGY-3** year, initial patient assessment skills will be honed by seeing the majority of consultations on the Emergency Surgical Service at University Hospital, as well as the General Surgical Services at the VAMC. The PGY-3 resident will acquire a full range of technical skills regarding intestinal surgery, laparotomy for trauma, and major resuscitation of the trauma patient. The PGY-3 resident should have met all of the goals for the surgical specialties listed with the exception of the senior rotation in Pediatric Surgery.

The **PGY-4** resident should acquire the knowledge, skill and personal attributes to be chief resident of the major private services at Norton, Norton Children's, and Jewish Hospitals. The PGY-4 shall assign junior residents specific patients to follow in hospital, as well as specific patients to be attended to in the operating room. The PGY-4 resident will routinely communicate with the attending to discuss pre-operative and post-operative patient care and mutually participate in critical decision making. These residents should be able to perform most complicated operations by the end of this year.

The overall educational goal for the **PGY-5** year is to prepare the chief resident to assume independent responsibility for total care of the surgical patient. This will be accomplished through a variety of rotations on core surgical services where the **PGY-5** chief will be the team leader of the particular rotation. The chief residents will be responsible for supervising all in-hospital patient care and for supervising outpatient care in the clinics. The chief resident will be responsible for preparing the morbidity and mortality reports presented at the Quality Improvement Conference pertaining to their own patients, as well as determining the autopsy status on each death and the status of the transplanted organs from those patients; the latter will be done in conjunction with the transplant coordinator. The chief resident will become familiar with quality assurance issues by having a seat on the Quality Assurance Committee at University Hospital. The chief resident will develop clinical decision-making skills by interacting directly with the attending surgeon for critically ill patients and those undergoing operation. The chief resident will supervise and assist the junior residents in critical patient care, as well as in performing certain operations.

Rotation and PGY Level Specific Goals and Objectives for the Surgery Training Program

Residents at all PGY levels will be expected to supervise and teach both 3rd and 4th year medical students assigned to their respective services.

ELECTIVE GENERAL SURGERY SERVICE AT UL HOSPITAL

Goals: To become competent in the management of surgical diseases in largely indigent patient population who are prone to obesity, malnutrition, diabetes, end stage renal disease, and late stage cancer. This will be accomplished in large part by an initial outpatient visit and formulation of a differential diagnosis, followed by appropriate laboratory and imagining workup, and finally by an elective operation and subsequent post-operative care. The general surgery residents will assume primary management of these patients. The residents are responsible for attending the Elective Surgery on a weekly basis. When able, residents should also attend the private general surgery clinics.

OBJECTIVES: In the following competencies, the resident should display…

PGY-3:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on elective general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.

…become competent in the management of both in-patient and outpatient elective general surgery patients and supervision of junior residents and medical students

… To become competent in the operative management of routine elective cases such as cholecystectomy, colectomy, mastectomy, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the patho-physiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of common diseases such as inguinal hernia, breast, and gallbladder disease.

…To become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4: There are no PGY-4 residents on this service.

PGY-5 (Chief Resident):
Patient Care
…the skill of performing daily patient assessments documented as necessary, by making decisions regarding patient management appropriate on elective general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.
…become competent in the management of both in-patient and outpatient elective general surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases such as inguinal hernia, breast, and gallbladder disease.
…to become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

EMERGENCY GENERAL SURGERY, TRAUMA, AND BURNS AT UL HOSPITAL:
Goals: To become competent in the management of acutely injured or ill patients who will require urgent operations and critical care. This will be accomplished primarily by initial consultation through emergency room physician referral and involve resuscitation, workup algorithms, prioritization, operation, and peri-operative critical care. Competence in directing multi-specialty management of critically ill surgical patients will be achieved by developing a close working relationship with physicians in many different specialties. The general surgery resident will assume primary responsibility for patient management under direction of faculty surgeons with an interest in trauma and critical care. The residents are also responsible for attending the Trauma Surgery Clinic every Tuesday morning. When able, residents should also attend the private general surgery clinics.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-1 level on emergency general surgery patients, and trauma and burn victims.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level.
Medical Knowledge
… familiarity of the pathophysiologic basis of trauma and burns, and emergency surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions.
…to become familiar with suturing techniques, routine peri-operative care, including specific injuries such as blunt and penetrating trauma, burn wound debridement.
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate.
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-2:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on burn and trauma victims, and emergency general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.
…become competent in the management of trauma, burn, and emergency general surgery patients in the ICU including invasive hemodynamic monitoring, bronchoscopy, tracheostomy, ventilator management, use of vasoactive medications, and PEG placement
Medical Knowledge
… familiarity of the pathophysiologic basis of burns and trauma, and common emergency surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with suturing techniques, routine peri-operative care, including specific diseases such as incarcerated inguinal hernia, breast infections, acute cholecystitis, burns, and trauma
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate.
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient ICU admission and discharge with allied health personnel and nursing staff
…coordination of ICU bed status with nursing supervisor

PGY-3:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on trauma and burn victims, and emergency general surgery patients. This includes treatment plans for multiply injured patients simultaneously and responding to level one alerts in timely fashion

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.
…become competent in the management of both in-patient and outpatient trauma and burn victims, and emergency general surgery patients
… To become competent in the operative management of routine burn and trauma cases such as burn wound debridement, skin grafting, thoracotomy, laparotomy, and fasciotomy and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

… familiarity of the pathophysiologic basis of common emergency surgical diseases, trauma, and burn patients by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common diseases such as incarcerated inguinal hernia, tissue infection, splenectomy, and severe burns
…To become competent in the management of trauma and burn victims, and emergency surgical patients, and alternative therapies such as medical management and interventional catheter based techniques

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery
…the skill of appropriate patient triage from the emergency room to radiology, OR, and ICU

PGY-4: There are no PGY-4 residents on this service.

PGY-5 (Chief Resident):

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on burn, trauma, and emergency general surgery patients and responding to level one alerts in timely fashion
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.
…become competent in the management of both in-patient and outpatient burn and trauma victims, and emergency general surgery patients and supervision of junior residents and medical students

… to become competent in the operative management of complex trauma and emergency general surgical cases such as re-operative cases, major laparotomy and thoracotomy, neck exploration, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states
…to supervise the treatment of multiply injured patients simultaneously

Medical Knowledge

…familiarity of the pathophysiologic basis of common burns and trauma, and emergency surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of blunt and penetrating trauma, and emergency surgical disease such as small bowel obstruction, diverticulitis, liver and spleen injuries, cardiac and pulmonary trauma
…to become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery
…supervision of care coordination between various services

GENERAL SURGERY AT VETERANS AFFAIRS MEDICAL CENTER:

Goals: To become competent in the management of veteran patients with surgical diseases and multiple co-morbidities such as heart disease, peripheral vascular disease, cancer, diseases of the colon and rectum, and chronic lung disease in this predominantly elderly male patient population. This will be achieved by both an inpatient and outpatient experience in management, by participation in several specialty clinics with diagnostic workup, medical clearance, surgery scheduling, operation and post-operative care. The residents will achieve competency in clinical management by mastering risk assessment in this group of challenging patients by thorough understanding of co-morbid medical illness. Residents are responsible for attending clinics on Tuesday and Thursday.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-1 level on general surgery patients

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level

…participating in several ambulatory clinics at the VA

Medical Knowledge

…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, cancer, and vascular disease.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

…become competent in the management of general surgery patients in the ICU

…develop management skills for common thoracic surgical illnesses

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, cancer, and vascular disease

Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… To become competent in the operative management of routine elective cases such as cholecystectomy, colectomy, routine vascular and thoracic procedures, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common diseases, such as inguinal hernia, colon, and gallbladder disease.
…To become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4 and PGY-5 (Chief Resident):
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases such, as inguinal hernia, breast, and gallbladder disease
…to become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PLASTIC SURGERY AT NORTON, JEWISH, VA, and UNIVERSITY HOSPITALS:

Goals: Residents will become competent in the management of complex plastic surgery patients primarily in a tertiary referral setting. Residents on this service gain extensive exposure to the field of plastic surgery including pre and postoperative patient management, graduated operative experience, and a variety of conferences including didactics, journal club, and anatomy labs. Residents work closely with faculty and the plastic surgery fellows in all aspects of caring for these patients. Residents are responsible for attending plastic surgery clinics.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-1 level on plastic surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level.

…become competent in the management of both in-patient and outpatient plastic surgery patients and supervision of medical students

… To become familiar with the operative management of routine elective cases such as breast reconstruction, complex wound reconstruction, hand surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective plastic surgery diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of common plastic surgery indications such as breath reconstruction, complex wound management, flap reconstruction, etc.

…To become competent in the outpatient management, workup of routine elective plastic surgery patients

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, fellows, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on plastic surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective plastic surgery diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, and cancer

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, fellows, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.

…become competent in the management of both in-patient and outpatient plastic surgery patients and supervision of medical students

… To become competent in the operative management of routine elective cases such as breast reconstruction, complex wound closure, and flap reconstruction, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the pathophysiologic basis of common plastic surgery diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of common indications such as breast reconstruction, complex wounds, and hand surgery

…To become competent in the outpatient management, workup of routine elective plastic surgical patients

Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, fellows, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.
…become competent in the management of both in-patient and outpatient plastic surgery patients and supervision of medical students
… to become competent in the operative management of complex plastic surgery cases such as breast reconstruction, complex wounds, and hand surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
… familiarity of the pathophysiologic basis of common elective plastic surgery diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases complex plastic surgery cases such as breast reconstruction, complex wounds, and hand surgery
…to become competent in the outpatient management and workup of complex elective plastic surgery patients.
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, fellows, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of medical students and direct communication with attendings

Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-5: There are no PGY-5s on this rotation.

MINIMALLY INVASIVE SURGERY – APPRENTICESHIP (NORTON HOSPITAL)
Goals: To become competent in the management of general surgery patients with an emphasis on foregut pathology and utilizing minimally invasive surgical techniques. The residents will rotate with Dr. Farid Kehdy in an apprenticeship model. They will participate in patient rounds, operative and endoscopic cases, and weekly outpatient clinics.

OBJECTIVES*:* In the following competencies, the resident should display…

PGY-1: There are no PGY-1s on this rotation

PGY-2: There are no PGY-2s on this rotation

PGY-3: There are no PGY-3s on this rotation

PGY-4 & PGY-5 (Chief Resident):
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery.

…to become competent in the outpatient management, workup of complex elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

GENERAL SURGERY – APPRENTICESHIP (JEWISH HOSPITAL)

Goals: To become competent in the management of broad based general surgery patients. The residents will rotate with Dr. Russ Williams in an apprenticeship model. They will participate in patient rounds, operative and endoscopic cases, and weekly outpatient clinics.

OBJECTIVES*:* In the following competencies, the resident should display…

PGY-1: There are no PGY-1s on this rotation

PGY-2: There are no PGY-2s on this rotation

PGY-3: There are no PGY-3s on this rotation

PGY-4 & PGY-5 (Chief Resident):

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students

… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with the operative management of common diseases complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery.

…to become competent in the outpatient management, workup of complex elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.

…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, junior residents, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

ACUTE CARE SURGERY (NORTON AND JEWISH HOSPITALS)

Goals: To become competent in the management of acute care general surgery patients. The residents will provide care to surgical patients presenting to the emergency department, as a transfer from another facility, or as an inpatient consultation. Patients will be cared for at 2 distinct tertiary referral hospitals that are physically connected through walkways. They will participate in patient rounds, operative and endoscopic cases, and weekly outpatient clinics.

OBJECTIVES*:* In the following competencies, the resident should display…

***PGY-1*:** There are no PGY-1s on this rotation

***PGY-2*:** There are no PGY-2s on this rotation

PGY-3:

Patient Care

…the skill of performing daily patient assessments, documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.

…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students

… To become competent in the operative management of routine elective cases such as cholecystectomy, colectomy, and mastectomy, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of common diseases, such as inguinal and ventral hernia, colon, and gallbladder disease

…To become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4 & PGY-5 (Chief Resident):

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.

…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students

… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with the operative management of common diseases complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery.

…to become competent in the outpatient management, workup of complex elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.

…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, junior residents, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

<u>ROBOTIC SURGERY (UNIVERSITY, NORTON, and JEWISH HOSPITALS)</u>

Goals: To develop the preliminary skills necessary for competency in robotic surgery. The residents will participate in robotic cases on the downtown campus, though primarily at University Hospital. The emphasis will be on the bedside setup and operations of robotic surgery for a wide range of surgical diseases. Clinical duties will be paired with robotic simulation modules and training in preparation for console operations.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1: There are no PGY-1s on this rotation

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

…become competent in the bedside operations of robotic surgery

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with the basic operations of robotic surgery both at the bedside and at the console

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, residents, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3: There are no PGY-3s on this rotation

PGY-4: There are no PGY-4s on this rotation

PGY-5: There are no PGY-5s on this rotation

GENERAL SURGERY AT NORTON HOSPITAL:

Goals: To become competent in the management of elective, emergency, as well as tertiary-referral general surgical patients. The residents will also become competent in minimally invasive and catheter-based surgical techniques by close faculty supervision and extensive clinical experience. Competence in peri-operative management will be achieved by initial daily patient visits and close communication with faculty in the clinical decision making on this group of patients with complex surgical disease. Further exposure to critically ill surgical patients is also provided. Participation in outpatient offices and clinic is mandatory. Residents are responsible for attending private general surgery clinic on Tuesday and Thursday.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-1 level on general surgery patients

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level

Medical Knowledge

…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, and cancer

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

…become competent in the management of general surgery patients in the ICU

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, and cancer

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3:
Patient Care
…the skill of performing daily patient assessments, documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… To become competent in the operative management of routine elective cases such as cholecystectomy, colectomy, and mastectomy, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common diseases, such as inguinal and ventral hernia, colon, and gallbladder disease
…To become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4 & PGY-5 (Chief Resident):
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery.
…to become competent in the outpatient management, workup of complex elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

BARIATRIC AND ADVANCED LAPAROSCOPIC SURGERY AT NORTON WOMEN'S HOSPITAL:

Goals: To become competent in the management of bariatric surgical patients. This includes elective primary bariatric patients, as well as re-operative and tertiary referral bariatric surgical patients. The resident will become competent in minimally invasive bariatric surgical procedures by close faculty supervision and extensive clinical experience. Competence in peri-operative management will be achieved by daily patient visits and close communication with faculty in the

clinical decision-making on this group of patients. Participation in outpatient offices and clinic is mandatory. Residents will be responsible for attending pre-operative and post-operative clinics.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1: There are no PGY-1s on this rotation

PGY-2: There are no PGY-2s on this rotation

PGY-3 or 4:

Patient Care

... the skill of performing daily patient assessments, documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3/4 level on bariatric surgery patients

… the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3/4 level.

… to become competent in the management of both in-patient and out-patient bariatric surgical patients.

… to become competent in the operative management of routine bariatric surgery cases such as sleeve gastrectomy, gastric bypass, and gastric banding and in the pre-operative decision regarding the appropriate operation for the patient based on their disease state and comorbidities.

Medical Knowledge

… familiarity of the physiologic responses and consequences of common bariatric surgical procedures by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE modules and ACS questions.

… to become familiar with the operative management of the common bariatric surgical procedures.

Practice-Based Learning and Improvement

… the skills to access information in Pub Med and relevant surgical literature

… the knowledge of health care costs for common tests, imaging studies, and bariatric procedures

… attending quality improvement conference

Interpersonal and Communication Skills

… interaction with the attending surgeon, nursing staff, allied health professionals, and administrative staff

Professionalism

… timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

… the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

… the ability to arrange appropriate outpatient work-up bariatric patients and scheduling for surgery

PGY-5: There are no PGY-5s on this rotation

Norton Audubon Hospital:

Goals: To become competent in the management of basic and complex general surgical patients. This includes elective patients, as well as re-operative and tertiary referral surgical patients. The resident will become through close faculty supervision and extensive clinical experience. Competence in peri-operative management will be achieved by daily patient visits and close communication with faculty in the clinical decision making on this group of patients. Participation in outpatient offices and clinic is mandatory.

OBJECTIVES: In the following competencies the resident should display…

PGY-1: There are no PGY-1s on this rotation

PGY-2: There are no PGY-2s on this rotation

PGY-3 & PGY-4:

Patient Care

... the skill of performing daily patient assessments, documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3/4 level on general surgery patients

… the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3/4 level.

… to become competent in the management of both in-patient and out-patient basic and complex surgical patients.

… to become competent in the operative management of routine, basic and complex surgical procedures, and in the pre-operative decisions regarding the appropriate operation for the patient based on their disease state and comorbidities.

Medical Knowledge

… familiarity of the physiologic responses and consequences of basic and complex surgical procedures by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE modules and ACS questions.

… to become familiar with the operative management of the basic and complex surgical procedures.

Practice-Based Learning and Improvement

… the skills to access information in Pub Med and relevant surgical literature

… the knowledge of health care costs for common tests, imaging studies for both basic and complex surgical procedures.

… attending quality improvement conference

Interpersonal and Communication Skills

… interaction with the attending surgeon, nursing staff, allied health professionals, and administrative staff

Professionalism

… timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

… the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

… the ability to arrange appropriate outpatient work-up and scheduling patients for surgery

PGY-5: There are no PGY-5s on this rotation

UofL Health-Mary & Elizabeth Hospital:

Goals: To become competent in the management of basic and complex general surgical patients. This includes elective patients, as well as re-operative and tertiary referral surgical patients. The resident will become competent through close faculty supervision and extensive clinical experience. Competence in peri-operative management will be achieved by daily patient visits and close communication with faculty in the clinical decision making on this group of patients. Participation in outpatient offices and clinic is mandatory.

OBJECTIVES: In the following competencies the resident should display…

PGY-1 & 2: There are no PGY-1 & 2s on this rotation

PGY-3 & PGY-4:

Patient Care

... the skill of performing daily patient assessments, documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3/4 level on general surgery patients

… the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3/4 level.

… to become competent in the management of both in-patient and out-patient basic and complex surgical patients.

… to become competent in the operative management of routine, basic and complex surgical procedures, and in the pre-operative decisions regarding the appropriate operation for the patient based on their disease state and comorbidities

Medical Knowledge

… familiarity of the physiologic responses and consequences of basic and complex surgical procedures by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE modules and ACS questions.

… to become familiar with the operative management of the basic and complex surgical procedures

Practice-Based Learning and Improvement

… the skills to access information in Pub Med and relevant surgical literature

… the knowledge of health care costs for common tests, imaging studies for both basic and complex surgical procedures.

… attending quality improvement conference

Interpersonal and Communication Skills

… interaction with the attending surgeon, nursing staff, allied health professionals, and administrative staff

Professionalism

… timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice
… the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
… the ability to arrange appropriate outpatient work-up and scheduling patients for surgery

PGY-5: There are no PGY-5s on this rotation

GENERAL SURGERY AT JEWISH HOSPITAL/KINDRED HOSPITAL:
Goal: To become competent in the management of broad-based general surgery. This includes elective patients, as well as emergency and tertiary referral surgical patients. The resident will become competent through close faculty supervision and extensive clinical experience. Competence in peri-operative management will be achieved by daily patient visits and close communication with faculty in the clinical decision making on this group of patients. Participation in outpatient offices and clinic is mandatory.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-1 level on general surgery patients
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level
Medical Knowledge
…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, and cancer
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

…become competent in the management of general surgery patients in the ICU

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, and cancer

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.

…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students

… To become competent in the operative management of routine elective cases such as cholecystectomy, colectomy, and mastectomy, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of common diseases, such as inguinal and ventral hernia, colon, and gallbladder disease

…To become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4 or 5 (Chief Resident):

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery.
…to become competent in the outpatient management, workup of complex elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

THORACIC SURGERY AT JEWISH HOSPITAL:
Goals: To become competent in the management of thoracic surgery patients with both benign and malignant disease. The residents will also work closely with faculty and their private patients. Residents will perform upper endoscopy, bronchoscopy, mediastinoscopy, thoracoscopic surgery, robotic surgery, open thoracic surgery, benign esophageal surgery, and malignant esophageal surgery. Residents are responsible for attending Tuesday afternoon conferences and weekly private clinics.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-1 level on thoracic surgery patients
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level
Medical Knowledge
…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as lung cancer, esophageal cancer, benign esophageal disease, tracheal abnormalities
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-2:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.
…become competent in the management of thoracic surgery patients in the ICU
Medical Knowledge
…familiarity of the pathophysiologic basis of common thoracic surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as lung cancer, esophageal cancer, benign esophageal disease, tracheal abnormalities
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.
…become competent in the management of both in-patient and outpatient thoracic surgery patients and supervision of junior residents and medical students
… To become competent in the operative management of routine thoracic cases such as lung cancer, esophageal cancer, benign esophageal disease, tracheal abnormalities
Medical Knowledge
…familiarity of the pathophysiologic basis of common surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of specific diseases such as lung cancer, esophageal cancer, benign esophageal disease, tracheal abnormalities
…To become competent in the outpatient management, workup of routine thoracic surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4 or PGY-5:

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on thoracic surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.
…become competent in the management of both in-patient and outpatient thoracic surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex diseases such as lung cancer, esophageal cancer, benign esophageal disease, tracheal abnormalities

Medical Knowledge

… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of complex thoracic diseases such as lung cancer, esophageal cancer, benign esophageal disease, tracheal abnormalities
…to become competent in the outpatient management, workup of complex thoracic surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills
…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

SURGICAL ONCOLOGY AT NORTON, JEWISH and UNIVERSITY HOSPITALS:
GOALS: Residents will become competent in the management of complex surgical oncology patients primarily in a tertiary referral setting. Residents on this service gain extensive exposure to the field of surgical oncology including pre and postoperative patient management, graduated operative experience, and a variety of conferences including didactics, journal club, and tumor boards. This team consists of residents from every level. Residents work closely with faculty in all aspects of caring for these patients. Additionally, the clinical surgical oncology fellow functions as an apprentice under one of the attending surgeons for 2-3 months at a time. Participation in outpatient offices and clinic is mandatory. Junior residents will participate in the Norton call schedule.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-1 level on elective general surgical oncology patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level.
…become competent in the management of both in-patient and outpatient elective surgical oncology patients and supervision of medical students
… To become familiar with the operative management of routine elective cases such as breast biopsy, colectomy, mastectomy, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common oncologic diseases such as skin cancer, breast cancer, and colon cancer.

…To become competent in the outpatient management, workup of routine elective surgical oncology patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on general surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

…become competent in the management of general surgery patients in the ICU

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, cancer, and thyroid disease

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-3:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-3 level on surgical oncology patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-3 level.

…become competent in the management of both in-patient and outpatient elective surgical oncology patients and supervision of junior residents and medical students

… To become competent in the operative management of routine oncology cases such as mastectomy, breast biopsy, and colectomy for cancer, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of common oncological diseases such as skin cancer, colon cancer, and breast cancer

…To become competent in the outpatient management, workup of routine elective surgical oncology patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-4:

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on surgical oncology patients

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the resident level.

…become competent in the management of both in-patient and outpatient elective general surgery patients and supervision of junior residents and medical students

… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

… familiarity of the pathophysiologic basis of common oncological diseases treated by surgeons by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with the operative management of more complex oncologic diseases, such as sarcoma, melanoma, pancreatic cancer, and liver cancer

…to become competent in the outpatient management, workup of complex surgical oncology patients, and alternative therapies such as medical management and interventional catheter based techniques.

…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, junior residents and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-5 (Chief Resident):

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on surgical oncology patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.

…become competent in the management of both in-patient and outpatient surgical oncology patients and supervision of junior residents and medical students

… to become competent in the operative management of complex elective cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge
… familiarity of the pathophysiologic basis of common elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases such, as inguinal hernia, breast, gallbladder disease, thyroid disease, liver disease
…to become competent in the outpatient management, workup of routine elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

<u>COLORECTAL SURGERY AT NORTON, JEWISH AND UNIVERSITY HOSPITALS:</u>
Goals: Residents will become competent in the management of most colon and rectal surgery problems- including elective, emergent, indigent and tertiary referral patients. This involves exposure to the pre and postoperative evaluation and management of these patients, extensive operative experience and all division conferences. Further exposure to endoscopy and advanced laparoscopy as well as an introduction to robotic operations will be provided. This team will consist of a PGY-4 or PGY-5, PGY-1 or PGY-2, fellow, and attending colorectal faculty. Additionally, the colorectal fellow functions as an apprentice under one of these attending surgeons for one month at a time, while the chief resident works with the other attendings. These chief and fellow will alternate home call and weekend call. Residents are responsible for attending weekly private clinics.

<u>OBJECTIVES:</u> In the following competencies, the resident should display…

<u>PGY-1:</u>
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-1 level on colorectal surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level.
…become competent in the management of both in-patient and outpatient colorectal patients and supervision of medical students
… To become familiar with the operative management of routine elective cases such as colonoscopy, colectomy, and ano-rectal procedures, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the pathophysiologic basis of common colorectal surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common colorectal diseases, such as ano-rectal disease, inflammatory bowel disease, and colon cancer
…To become competent in the outpatient management, workup of routine colorectal surgery patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on colorectal surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.
…become competent in the management of colorectal surgery patients in the ICU

Medical Knowledge

…familiarity of the pathophysiologic basis of common colorectal surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as colorectal cancer, colonoscopy, and inflammatory bowel disease

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-4 or 5:

Patient Care

…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on colorectal surgery patients

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.

…become competent in the management of both in-patient and outpatient colorectal surgery patients and supervision of junior residents and medical students

… to become competent in the operative management of complex elective cases such as re-operative cases, advanced colorectal cases, complex peri-anal disease, and inflammatory bowel disease, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states. To gain experience in colonoscopy, laparoscopic colon procedures, and robotic colorectal procedures.

Medical Knowledge

… familiarity of the pathophysiologic basis of common oncological diseases treated by surgeons by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

…to become familiar with the operative management of more complex colorectal disease including cancer, inflammatory bowel disease, and peri-anal disease

…to become competent in the outpatient management, workup of complex colorectal patients, and alternative therapies such as medical or endoscopic management

…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills
…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

VASCULAR SURGERY:
Goals: Residents will become competent in the management of peripheral vascular disease including elective, urgent, and emergent cases. This will involve exposure to the pre and postoperative evaluation and management of these patients, extensive operative experience and all division conferences. Further exposure to arteriography and ultrasound techniques will be provided. This team consists of a PGY-4 or PGY-5, a PGY-2 or PGY-3, and PGY-1, and attending vascular surgeons. Residents are responsible for attending weekly clinics Tuesday-Friday.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-1 level on vascular surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level.
…become competent in the management of both in-patient and outpatient vascular surgery patients and supervision of medical students
… To become familiar with the operative management of routine elective cases such as vascular access, carotid endarterectomy, endovascular procedures, and open vascular bypass procedures, and in the pre-operative decision making such as whether and when to recommend operations to patients for their vascular disease.
Medical Knowledge
…familiarity of the pathophysiologic basis of common colorectal surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common vascular disorders
…To become competent in the outpatient management, workup of routine vascular surgery patients, and alternative therapies such as medical management and interventional catheter based techniques.

Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-2 or PGY-3:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY level on vascular surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY level.
…become competent in the management of vascular surgery patients in the ICU
Medical Knowledge
…familiarity of the pathophysiologic basis of common vascular surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as peripheral vascular disease and aneurismal disease
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

***PGY-4 or 5*:**
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on vascular surgery patients

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.
…become competent in the management of both in-patient and outpatient colorectal surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex vascular cases such as re-operative cases, advanced endovascular cases, complex aneurismal disease, and inflammatory bowel disease, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states. To gain experience in both endovascular and open vascular procedures

Medical Knowledge

… familiarity of the pathophysiologic basis of common vascular diseases treated by surgeons by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of more complex peripheral vascular disease including endovascular, vascular access, and open vascular cases
…to become competent in the outpatient management, workup of complex vascular patients, and alternative therapies such as medical management
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

<u>TRANSPLANT SURGERY AT JEWISH HOSPITAL</u>:

Goals: To become competent in the management of transplant patients and be familiar with the associated disease spectrum seen in this unique patient population. The residents will become familiar with clinical management of immunosuppressive agents in conjunction with specialty physicians. The residents will gain operative experience with both kidney and liver transplants, and organ harvests. Experience will also be gained in the acute and elective general surgical care of transplant patients. Residents will be responsible for attending weekly transplant clinics. Junior residents will take part in the Jewish call schedule.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY-1 level on transplant surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level.

…become competent in the management of both in-patient and outpatient transplant surgery patients and supervision of medical students

… To become familiar with the operative management of routine elective cases such as vascular access, kidney and liver transplants, organ harvest procedures, and common general surgical procedures in the transplant population, and in the pre-operative decision making such as whether and when to recommend operations to patients in need of transplants or other general surgical procedures.

Medical Knowledge

…familiarity of the pathophysiologic basis of end stage renal and liver disease by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions

… To become familiar with the operative management of transplant patients

…To become competent in the outpatient management, workup of transplant patients, and alternative therapies such as medical management.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature

…the knowledge of health care costs for common tests and imaging studies

…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate

…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff

…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PGY-2:

Patient Care

…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on transplant surgery patients.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.

…become competent in the management of transplant surgery patients in the ICU

Medical Knowledge
…familiarity of the pathophysiologic basis of end stage renal and liver disease by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of transplant patients
…To become competent in the outpatient management, workup of transplant patients, and alternative therapies such as medical management.
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-4 or PGY-5:
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on transplant surgery patients
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the Chief level.
…become competent in the management of both in-patient and outpatient transplant surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of liver and kidney transplants, organ harvests, vascular access, and more complex general surgery procedures in the transplant population, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.
Medical Knowledge
… familiarity of the pathophysiologic basis of end stage renal and liver disease treated by surgeons by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of liver and kidney transplants, and general surgical disease in this patient population
…to become competent in the outpatient management, workup of complex vascular patients, and alternative therapies such as medical management
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills
…interaction with the attending surgeon, junior resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attendings
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

PEDIATRIC SURGERY AT NORTON CHILDREN'S HOSPITAL:
Goals: To become competent in the management of pediatric surgical patients and develop skills necessary to professionally relate to parents and families of these children. This population will consist of patients requiring acute and elective surgical care such as those with pediatric disorders, peritonitis, skin and soft tissue infections, cancer, burns, trauma, and hernias. Residents will learn to perform appropriate bedside procedures on children. Residents will also interact with pediatricians, neonatologists, critical care and emergency medicine pediatricians, and residents in pediatrics to understand the special needs of children with surgical illness and of their parents. Residents will be responsible for attending weekly private clinics.

OBJECTIVES: In the following competencies, the resident should display…

PGY-1:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-1 level on pediatric general surgery patients
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-1 level
Medical Knowledge
…familiarity of the pathophysiologic basis of common pediatric surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia and hydrocele
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-2:
Patient Care
…the skill of performing daily patient assessments documented by patient histories and physicals, daily notes, discharge summaries, by making decisions regarding patient management appropriate for the PGY-2 level on pediatric general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-2 level.
…become competent in the management of general surgery patients in the ICU
Medical Knowledge
…familiarity of the pathophysiologic basis of common pediatric elective surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia, gallbladder disease, and cancer
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
Systems-Based Practice
…The ability to coordinate patient admission and discharge with allied health personnel and nursing staff

PGY-4 (Chief Resident):
Patient Care
…the skill of performing daily patient assessments, documented as necessary, and by making decisions regarding patient management appropriate on general surgery patients.
…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY-4 level.
…become competent in the management of both in-patient and outpatient general surgery patients and supervision of junior residents and medical students
… to become competent in the operative management of complex pediatric surgical cases such as re-operative cases, advanced hepatobiliary, oncologic, and colorectal surgery, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge
… familiarity of the pathophysiologic basis of common pediatric surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
…to become familiar with the operative management of common diseases including complex elective cases such as re-operative cases, advanced hepatobiliary, thoracic, oncologic, and colorectal surgery in the pediatric surgical patient
…to become competent in the outpatient management, and workup of complex elective surgical patients, and alternative therapies such as medical management and interventional catheter based techniques.
…the chief resident will serve as teaching assistant to junior residents on routine elective cases appropriate for the junior residents' experience
Practice-Based Learning and Improvement
…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference
Interpersonal and Communication Skills
…interaction with the attending surgeon, junior residents, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff
Professionalism
…timely completion of medical records and appropriate behavior towards colleagues
…supervision of junior residents and direct communication with attending(s)
Systems-Based Practice
…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

RURAL SURGERY ROTATION:
Goals: To become familiar with and become competent in the management of surgical patient disease seen in the rural setting. Residents will understand the kinds of patients and family interactions seen in both the clinic and hospital in a rural community and its referral base. Residents will be exposed to patients with different health issues and will have the opportunity to provide high quality surgical care in an alternative rural environment. This rotation offers one-on-one mentoring with broad-based general surgeons who care for a variety of surgical problems.

OBJECTIVES: In the following competencies, the resident should display…

PGY-3 and PGY-4:
Patient Care
…the skill of performing daily patient assessments, documented by patient histories and physicals, daily notes, by making decisions regarding patient management appropriate for the PGY level on general surgery patients in a rural setting of Trover Clinic and the Regional Medical Center.

…the skill of performing procedures as outlined in the supervisory lines of duty in the ambulatory setting, at the bedside, and in the operating room as appropriate for the PGY level.
…become competent in the management of both in-patient and outpatient rural general surgery patients and supervision of medical students
… To become competent in the operative management of routine elective and emergency cases such as mastectomy, hernia repair, cholecystectomy, laparotomy, colectomy, appendectomy, and splenectomy, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

…familiarity of the patho-physiologic basis of common general surgical diseases by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
… To become familiar with the operative management of common and more complex general surgical diseases commonly seen in a rural setting
…To become competent in the outpatient management, workup of routine elective general surgical patients, and alternative therapies such as medical management.

Practice-Based Learning and Improvement

…the skills to access information in Pub Med and relevant surgical literature
…the knowledge of health care costs for common tests and imaging studies
…attending quality improvement conference

Interpersonal and Communication Skills

…interaction with the attending surgeon, chief resident, and medical students as appropriate
…courtesy to the nursing staff, allied health professionals, and administrative staff

Professionalism

…timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

…the ability to coordinate patient admission and discharge with allied health personnel and nursing staff
…the ability to arrange appropriate outpatient work up of patients and scheduling for surgery

Revised: April 2021
Reviewed: June 2022
Reviewed: June 2023

Department of Cardiothoracic and Vascular Surgery Cardiac Rotation Expectations

Purpose: to enhance the educational experience of general surgery residents rotating on adult cardiac surgery service.

Expectations:

1. Will meet with either Dr. Slaughter or Pahwa before starting to discuss residents' goals while rotating and previous cardiothoracic operative experience
2. Resident will be assigned a case each day. Generally assignments are made in the evening so the patient's case can be reviewed and discussed
3. The general surgery resident will round on patients that they operated on during the week and discuss with attending surgeon
4. The general surgery resident will round 1 or 2 weekends a month.
5. The general surgery resident will take 1 night of "first call" per week (not required to stay in hospital).
6. The general surgery resident will have the opportunity to participate in post-op ICU care
7. The general surgery resident will attend Department weekly Tuesday Conferences from 1700-1800 in the Department of Cardiothoracic Surgery
8. Other meetings (TAVR, VAD/transplant selection) and possible CVICU call depending on residents interest

Added: January 2023

ACGME Program Requirements for Residency Education in Surgery

*FROM: **www.acgme.org***

ACGME Program Requirements for Graduate Medical Education in General Surgery: https://acgme.org/Portals/0/PFAssets/ProgramRequirements/440_GeneralSurgery_2020.pdf?ver=2020-06-22-085958-260

Special Requirements in Laparoscopy and Endoscopy

The following number of cases must be documented as a pre-requisite for application to the American Board of Surgery (ABS) for certification in general surgery:

Laparoscopy

Basic: ***100 total cases**

- Cholecystectomy
- Appendectomy

Advanced: ***75 total cases**

- Lap, Gastrostomy and Feeding Jejunoscopy
- Lap, Inguinal and Incisional Herniorrhaphy
- Bariatric Laparoscopy
- Lap, Anti-reflux Procedure
- Lap, Enterolysis
- Lap, Small and Large Bowel
- Lap, Renal and Adrenal surgery
- Lap, Donor Nephrectomy
- Lap, Splenectomy

Endoscopy: ***85 total**

- Upper endoscopy, including percutaneous endoscopic gastrostomy: *35 procedures
- Colonoscopy: *50 procedures

Department of Surgery
University of Louisville School of Medicine

Selection Process of Residency Trainees

Policy on Resident Selection

University of Louisville School of Medicine
Graduate Medical Education Programs

The sponsored residency training programs of the University of Louisville School of Medicine exist for the purpose of training the highest quality physician possible in each program's respective discipline. The following is the official policy for the selection of candidates for training. This policy is consistent with the Accreditation Council on Graduate Medical Education (ACGME) Institutional Requirements and the Commonwealth of Kentucky Medical and Osteopathic Practice Act Regulations and Statutes. Program directors and coordinators should also be familiar with the "Medical Licensure Policy for Residents" published in the Resident Policies and Procedures manual. Program directors and coordinators are strongly encouraged to call the Office of Graduate Medical Education if questions, problems or uncertainties arise.

1. Resident Eligibility
   Applicants with one of the following qualifications are eligible for appointment to accredited residency programs at the University of Louisville School of Medicine.

   a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

   b. Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).

   c. Graduates of medical schools outside of the United States and Canada who have current valid certificates from the Educational Commission for Foreign Medical Graduates (ECFMG). In addition, as of the 2009-2010 academic year, schools located outside the U.S. and Canada must:
      1. Be officially recognized in good standing in the country where they are located
      2. Be registered as a medical school, college, or university in the International Medical Education Directory
      3. Require that all courses must be completed by physical on-site attendance in the country in which the school is chartered.
      4. Possess a basic course of clinical and classroom medical instruction that is
         a. not less than 32 months in length; and
         b. under the educational institution's direct authority.

   d. Graduates from accredited dental schools who are enrolled in oral-maxillofacial surgery and general practice dentistry (GPR) programs. These programs are accredited by the Council on Dental Accreditation of the American Dental Association but are under the general auspices of the University of Louisville, School of Medicine,

Graduate Medical Education Programs. Candidates must obtain dental licensure through the Kentucky Board of Dentistry.

2. Resident Selection
   a. Programs should select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate should be considered in the selection. Personal interviews prior to selection are strongly encouraged.

   b. In selecting from among qualified applicants for first-year positions, sponsored programs must participate in the National Resident Matching Program (NRMP) when it is available.

   c. In selecting from among eligible applicants for positions other than the first-year positions, programs should select the most qualified candidates as listed in 2.a. above. Appointment to PGY2 (and above) positions is contingent upon candidates being issued Kentucky medical licenses prior to the beginning of the training year.

3. Non-US Citizens
   a. Applicants who are not citizens of the United States must possess or be eligible for one of the following:
      - J1 Clinical Visa
      - Valid Employment Authorization Document
      - Valid Permanent Resident Card

   b. The following are not accepted for residency or fellowship training:
      - J1 Research Visa
      - J2 Dependent Visa
      - H1B Visa

   c. Individual programs may limit the amount of time they will hold a position open for applicants to obtain appropriate immigration status.

All resident selection must be made without unlawful discrimination in terms of age, color, disability status, national origin, race, religion or sex, in keeping with University of Louisville standards as an Affirmative Action/Equal Opportunity employer.

The enrollment of non-eligible residents may be cause for withdrawal of accreditation of the involved program and/or the sponsoring institution.

Revision Approved by GMEC: 2/16/2011
Reviewed: April 9, 2018
Reviewed: June 2022

Department of Surgery
University of Louisville School of Medicine

Supervisory Lines of Responsibility

This document outlines policy and procedural requirements pertaining to the supervision of postgraduate residents. Attending surgeon refers to either full or part time faculty of the Department of Surgery at the University of Louisville, who is providing supervision to residents in the postgraduate training program in general surgery. All attending's should be board *certified (or eligible to be examined) in general surgery* or a surgical specialty, and have a specific interest in teaching residents in the general surgery residency program at the University of Louisville.

Supervision. For the purposes of this document, supervision refers to the authority and responsibility that an attending surgeon exercises over the care delivered to a patient by a resident. Such control is exercised by observation, consultation, direction and demonstration, and includes the imparting of knowledge, skills and attitudes by the attending surgeon to the resident. Supervision may be provided in a variety of ways, including person-to-person contact with the resident in the presence of the patient, person-to-person contact in the absence of the patient, and through consultation via the telephone, video linkages, or other electronic means.

Teaching Assistant. Teaching assistant refers to a resident, acting under the appropriate supervision of an attending surgeon, who is providing guidance and/or assistance to a less experienced resident(s) in any clinical activities including the performance of invasive procedures and surgical operations.

GENERAL PRINCIPLES: Within the scope of the training program, all residents, without exception, will function under the supervision of attending surgeons. A responsible attending must be immediately available to the resident in person *or* by telephone and must be able to be physically present within a reasonable period of time, if needed. Each surgical service will publish, and make available, "call schedules" indicating the responsible attending if needed.

The surgery residency program will be structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment throughout the course of their training. Each facility must adhere to current accreditation requirements as set forth by the University of Louisville, School of Medicine for all matters pertaining to the training program including the level of supervision provided. The requirements of the American Board of Surgery, the American Board of Medical Specialties, the Residency Review Committee for Surgery, the VA Resident Supervision Policy, and the ACGME will be incorporated into training programs to ensure that each successful program graduate will be eligible to sit for an American Board of Surgery examination.

The provisions of this document are applicable to all patient care services, including both inpatient and outpatient care settings, and the performance and interpretation of all diagnostic and therapeutic procedures. The attending and resident surgeons are responsible to assure continuity of care provided to patients.

Residents must, in all circumstances:

1. notify the appropriate attending physician of any critical changes in a patient's status;

2. notify the appropriate attending physician of any and all patients going to the operating room;

3. notify the appropriate attending physician of any patient seen during evenings, weekends and holidays.

ROLES AND RESPONSIBILITIES: The Department Chair and Program Director are responsible for implementation of and compliance with these requirements. The attending surgeon is responsible for, and must be familiar with, the care provided to the patient as exemplified by the following:

(1) Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.

Documentation of this supervision will be via progress note, or countersignature thereof, or reflected within, the resident's progress note at a frequency appropriate to the patient's condition. In all cases where the provision of supervision is reflected within the resident's progress note, the note shall include the name of the attending surgeon with whom the case was discussed and the nature of that discussion.

(2) Meet the patient early in the course of care and document, in a progress note, concurrence with the resident's initial diagnoses and treatment plan.

At a minimum, the progress note must state such concurrence and be properly signed and dated. If a patient is admitted for non-emergent care, a resident, who is authorized to act as a teaching assistant, may evaluate the patient and discuss the patient's circumstances with an appropriate attending surgeon. This discussion should be documented in the patient record.

(3) Participation in bedside rounds does not require that the attending surgeon see every patient in person each day but does require physical presence of the attending in the facility for sufficient time to provide appropriate supervision to residents. A variety of face-to-face interactions such as chart rounds, x-ray review sessions, pre-op reviews, or informal patient discussions fulfill this requirement.

(4) Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are:
   (a) medically indicated;
   (b) explained to the patient;
   (c) appropriately executed and interpreted; and
   (d) evaluated for appropriateness, effectiveness and required follow-up.

Evidence of this assurance should be documented in the patient's record via a progress note(s), or Countersignature thereof, or reflected within, the resident's progress note(s).

(5) Assure that discharge, or transfer, of the patient from an integrated or affiliated hospital or clinic is appropriate based on the specific circumstances of the patient's diagnoses and treatment. The patient will be provided appropriate information regarding prescribed therapeutic regimens, including specifics on physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by attending countersignature of the hospital discharge summary or clinic discharge note.

(6) Assure residents are given the opportunity to contribute to discussions in committees where decisions being made may affect their activities. Facilities are encouraged, to the extent practicable, to include resident representation on committees such as Medical Records, Quality Assurance, Utilization Review, Infection Control, Surgical Case Review, and Pharmacy and Therapeutics.

SUPERVISION OF MEDICAL STUDENTS: The residents will assist with the formal and informal instruction of medical students assigned to the surgery rotation. They will oversee medical student participation in patient care to include review and co-signature of chart notes, instruction and supervision of procedures (when appropriate), and mentoring of student-patient encounters. Under the direction of an attending physician, a resident may provide hands-on instruction to the medical students in the delivery of minor procedures.

The residents may assist with junior and senior medical student oral examinations in the Department of Surgery. These examinations take place approximately six times each year, and are always conducted with a paired supervising attending physician. Residents are also solicited to provide written feedback to the student coordinator regarding a medical student's performance during the surgery rotation.

Identified student problems will be brought to the attention of the attending physician, and/or the Student Program Director for the Department of Surgery, Dr. Sheldon Bond.

GRADUATED LEVELS OF RESPONSIBILITY:

(1) Residents, as part of their training program, may be given progressive responsibility for the care of the patient. A resident may act as a teaching assistant to less-experienced residents. Assignment of the level of responsibility must be commensurate with their acquisition of knowledge and development of judgment and skill, and consistent with the requirements of the accrediting body.

(2) Based on the attending surgeon's assessment of a resident's knowledge, skill, experience, and judgment, residents may be assigned graduated levels of responsibility to:
   (a) Perform procedures or conduct activities without a supervisor present; and/or
   (b) Act as a teaching assistant to less-experienced residents.

(3) The determination of a resident's ability to accept responsibility for performing procedures or activities without a supervisor present and/or act as a teaching assistant will be based on evidence of the resident's clinical experience, judgment, knowledge

and technical skill. Such evidence may be obtained from the affiliated university, evaluations by attending surgeons or the program director, direct observation, and/or other clinical practice information.

(4) Documentation of a resident's assigned level of responsibility will be filed in the resident's record or folder maintained in the office of the director.

(5) When a senior resident is acting as a teaching assistant, the attending surgeon remains available for the quality of care of the patient, providing supervision and meeting medical record documentation requirements as previously defined.

SUPERVISION OF RESIDENTS PERFORMING
INVASIVE PROCEDURES OR SURGICAL OPERATIONS:

(1) Diagnostic or therapeutic invasive procedures or surgical operations, with significant risk to patients, require a high level of expertise in their performance and interpretation. Such procedures may be performed only by residents who possess the required knowledge, skill, judgment, and under an appropriate level of supervision by the attending surgeon.

Attending surgeons will be responsible for authorizing the performance of such invasive procedures or surgical operations. The name of the attending surgeon performing and/or directing the performance of a procedure should appear on the informed consent form.

(2) During the performance of such procedures or operations, an attending surgeon will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending surgeon and is a function of the experience and competence of the resident, and of the complexity of the specific case.

(3) Attending surgeons will provide appropriate supervision for the evaluation of patients, the scheduling of cases, the assignment of priority, pre-procedural preparations, and the procedural and post-procedural care of patients.

EMERGENCY SITUATIONS: An "emergency" is defined as a situation where immediate care is necessary to preserve the life of or prevent serious impairment of the health of a patient. In such situations, any resident, assisted by hospital personnel, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending surgeon will be contacted and apprised of the situation as soon as possible.

POST-GRADUATE (PG) YEAR: After graduation from medical school, post-graduate levels designate the practice level for a physician within his/her designated program.

PG Year-1
The following are examples of activities or procedures appropriate for the PGY-1 year. Supervision is to be determined by the senior resident on service or appropriate attending surgeon.

- Take history and perform physical exam
- Start peripheral IV
- Insert central IV lines
- Insert Foley catheter
- Insert nasogastric tube

- Write orders for routine meds
- Write orders for routine diagnostic tests
- Write post-operative orders
- Assist in operative procedures
- Perform simple surgical procedures
- Insert pulmonary artery catheters
- Tap pleural space
- Tap or lavage peritoneal cavity
- Tap CSF
- Tap joint space
- Ventilator management
- Manage initial resuscitation from shock
- Manage initial resuscitation for burns
- Excision of superficial lesions
- Perform biopsies
- Close lacerations

May not:

- Perform technically complex diagnostic and therapeutic procedures of high medical risk.
- Provide treatments without direct supervision of attending surgeon or senior level resident.
- Be designated as teaching assistant.

PG Year-2

- Perform all of PGY-1 activities/procedures.
- May supervise routine activities of PGY-1.
- Attending surgeon or chief resident will determine which cases are suitable to perform or to act as a teaching assistant.

PG Year-3

- Perform all of PGY-1 and -2 activities/procedures.
- May supervise routine activities of PGY-1 and -2.
- Perform all routine diagnostic and therapeutic procedures performed by surgical sub-specialists.
- Attending surgeon or chief resident will determine which cases are suitable to perform or to act as a teaching assistant.

PG Year-4

- Perform all of PGY-1, -2 and -3 activities/procedures.
- May be assigned as teaching assistant for routine operative procedures.
- Perform technically complex or high risk procedures with attending supervision, at levels previously defined at attending surgeon's discretion.
- Attending surgeon or chief resident will determine which cases are suitable to perform or to act as teaching assistant.

PG Year-5

- Perform all of PGY-1, -2, -3 and -4 activities/procedures.
- Appropriate supervision for technically complex or high risk procedures at attending surgeon discretion.

Senior residents have primary responsibility for the management of each service to which they are assigned, under the supervision of the attending staff. He/she is responsible for the supervision of activities of the house staff members assigned to his/her service and for responding to surgical consultations to his/her service.

SURGICAL ONCOLOGY FELLOWSHIP PATIENT COVERAGE & CALL PROTOCOL:

Goal: To provide a cohesive framework for open communication between the residents and the surgical oncology fellows that permits smooth, efficient patient care.

Rounds: The fellow will be responsible for seeing all patients in the morning, afternoon, and working with the junior resident on call at that hospital. A phone call to the resident on call that day (prior to commencing with the day's operations/clinic) will facilitate patient care and communication. The in-house resident will take first call for patient matters, with the fellow being second call and working with the on-call resident for admission and emergencies related to their assigned attending. All treatment-related decisions on the fellow's patients are to be directed through the fellow. The junior resident who rounds on the fellow's patients in the morning should report any problems directly to the fellow before 7am. The 4th year residents will not make rounds on the fellow's patients except during coverage, when the fellow is off duty.

Emergencies: In the spirit of teamwork, any life-threatening emergencies will be handled through available personnel. If the fellow is available, he/she will participate in the care of that patient.

Weekend coverage: The fellow will round on their assigned attending's patients and directly communicate with the on-call resident regarding issues. The fellow will have one weekend off a month. On this weekend, the 4th year resident on call will round in lieu of the fellow. This philosophy pertains to all surgical fellows.

Revised July 2017
Reviewed April 2019
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Surgical Resident Responsibilities

I. Ward Rounds

Ward rounds will be made twice daily at times determined by the senior resident. Surgical residents should be familiar in detail with each patient on the ward to which they are assigned. Afternoon rounds will include a review of current x-rays, laboratory tests and, where appropriate, pathology slides. Rounds with the attending staff will be made at times designated by the attending staff surgeon. Junior surgical residents are responsible for the presentation of patients on ward rounds.

II. Preoperative Evaluation and Preparation

All patients admitted to a surgical service must have a complete history and physical examination by a physician. The most senior resident in attendance should write a note in the chart stating the reasons for the patient's admission, a summary of pertinent historical and physical findings, and a tentative plan of evaluation and treatment. The junior surgical residents assigned to each surgical patient will order diagnostic tests and therapeutic measures under the supervision of the chief resident and attending staff. The junior resident will assume the role of primary physician to ward patients, maintaining communication with patient and family and informing them of progress and future courses.

The operating surgeon is responsible for a handwritten pre-op note on the day of the operation. This note should include the pre-diagnosis, the indications for operation, and the proposed operation. The names of the attending staff surgeons should be given with a statement that the case has been discussed and there was agreement on the plan of action. A statement should also be included to the effect that the indications for operation, the type of surgical procedure, and its implications have been discussed with the patient, who agrees to the procedure.

If the patient desires, provision should be made to inform the immediate family of the condition of the patient immediately after the operation. The senior surgical resident is responsible for the scheduling of all operations with the operating room at U of L and VA hospitals. In every case, the procedure will have been cleared and scheduled with the appropriate attending surgeon. The chief resident should become familiar with the various plans for scheduling operations at the various hospitals as well as be considerate of the multiple obligations of the surgical faculty.

III. Operating Room

Sterile techniques and standard operating room policy must be followed at all times. Residents are to be in the operating room *10 minutes before a case is scheduled to begin and facilitate patient transfer, if necessary.* Complete cooperation and communication with the operating room team is imperative for the conduct of a safe operation. Careful planning before operation by the surgeon will eliminate problems during the operative period.

The resident will have x-rays displayed in the OR before starting his/her scrub. Surgical residents are responsible for filling out pathology sheets, writing post-op orders, and writing operative notes on the

patient's chart on each case on which they scrub. The pathology form is a request for consultation, and complete pertinent data should be provided.

Operative notes are equally vital parts of the record and a further essential part of your own professional qualifications which you must document for American Board of Surgery certification and American College of Surgeons fellowship. Operative notes are to be dictated immediately after operation by the operating surgeon, preferably in the operating room.

Each house staff member must keep a personal copy of all operations in which he/she participates, and accurate and timely entry of these records in the computer database is essential to your successful application with the ABS at the end of your residency

IV. Postoperative Management and Recovery Room

Surgical residents are responsible for respiratory care for their patients even while patients are in the recovery room, in collaboration with the anesthesiologist. In cases in which the primary indication for prolonged intensive (or special) respiratory care is anesthesia related, the anesthesiologist is responsible for such services until it is mutually agreed to transfer such care to the surgeon. The anesthesiologist is responsible for the discharge of patients from the recovery room. If the surgeons desire a patient to remain in the recovery room for an extended period of observation, they must discuss this patient with the anesthesiologist or indicate on the patient's chart their wish to be notified at the time the patient is discharged from the recovery room.

The prevailing attitude between surgeons and anesthesiologists in this program is one of excellent cooperation. It will remain such with your consideration. Differences between individuals representing vital aspects of the success of a surgical endeavor must be minimized, and cooperation is the anticipated standard.

V. Charts

The careful and accurate completion of medical records is an important physician responsibility. Developing good habits of record keeping serves 6 essential purposes:

(1) Your record is an ***aide-memoir*** when you next see the patient.
(2) A clear, accurate note is a guide for colleagues who may need a quick review when seeing the patient in years to come for continuity of care.
(3) The clinic summary should be a concise summation of the many hours of thought, investigation, and consultation that were spent with the patient and record review.
(4) It is a record of ***all*** diagnostic terms that are required for case retrieval in clinical investigations. Reference to the original pathology reports is essential in all tumor cases.
(5) It affords a justification of payment by third parties, particularly where significant diagnostic efforts have been made.
(6) All medical record notations should be dated and timed in compliance with medical staff by-laws. It should be made clear when an attending physician transfers patient care to another physician.

Chart completion (operative notes, discharge summaries, death summaries, etc.) is a regular and very important duty of a surgical house officer. The following is medical school policy concerning completion of surgical records: *A resident, who is identified as having delinquent medical records (any record greater than 7 days past hospital discharge) by a record department of an affiliated hospital, will be notified by that medical records department and given 14 days to complete records in question. Failure to comply means 14 days probation by the Dean, and if records still remain incomplete, the house officer is then suspended without pay by the Dean. Continued failure to comply will lead to dismissal from the program.*

VI. Discharge Summary

A special program of early discharge permits better utilization of all our beds and promotes professional conduct. Discharges to include medications and office/clinic follow-up visits should be written at the conclusion of *morning* rounds, when possible.

The discharge summary is a major source of medical information and may be the only source of information when a patient is transferred to another hospital. Thus, it is of the utmost importance that the discharge summary contains certain pertinent information. These include:

> The principal diagnosis and all relevant diagnoses established by the time of discharge, as well as all operative procedures performed, are compulsory information in the Discharge Summary. Precise delineation of the principal diagnosis is of special significance: *The principal diagnosis is defined as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.*
>
> It is recognized that for some episodes of care, particularly when the patient has multiple problems, it may be impossible to unequivocally state which diagnosis should be regarded as principal. For some patients no one diagnosis was of more significance than another; each may have contributed equally to the necessity for hospital admission. Nevertheless, a determination as to which diagnosis will be considered principal must be made.

The dates of admission and discharge, summary of pertinent H & P facts, lab values and admitting diagnosis should be included. The patient's hospital course should be summarized briefly with an explanation of outcome and complications. All procedures should be noted. All discharge instructions to the patient (including medication and activities, etc.) follow-up plans should be stated. A complete discharge summary will save you and your fellow resident's hours of reading through charts, and simplify and improve follow-up care of the patient. This important record must not be left to medical students or members of the surgical team not familiar with the case.

VII. Deaths

Surgical residents should notify families immediately after the death of a patient and contact the nearest of kin personally on arrival at the hospital. Permission for autopsy should be sought for each death. *Death summaries are to be dictated within 8 hours* on the operating dictaphones. Surgical residents should attend all autopsies performed on their patients. Residents may contact the Director of Surgical Education at each of the teaching hospitals for procedures regarding documentation of death.

VIII. Clinics

Surgical residents assigned to clinic coverage are to be present at each clinic promptly at the assigned time. Junior residents are responsible for evaluation of each patient and initial discussion of the patient with students. After formulation of a disposition, the patient should be presented to the senior resident or attending staff surgeon for final action.

IX. Conferences

Each surgical resident is expected to attend all pertinent conferences on the service to which he is assigned and to be present *before* the time the conference is scheduled to begin. The scheduled conferences are intended to be educational events, and sign-in sheets are available to confirm participation.

X. Teaching Responsibility

It is the responsibility of the surgical resident to discuss the work-up and management of patients assigned to medical students. Students should be given the opportunity to participate actively in the evaluation and care of patients to which they are assigned. Exceptional performance by residents in student instruction is especially appreciated.

XI. Consultative Requests

Each request of consultation to another service should be approved by the senior resident. Consultation request forms should contain a pertinent summary of the patient's illness, the reason for requesting consultation, and a provisional diagnosis of the condition for which consultation is sought. Consultation requests should be made on a personal basis whenever possible. X-ray requests are to be considered consultations for the above purposes.

XII. Radiologic Studies

Surgical residents are to review such studies for all patients to be seen each day. Requests for routine x-ray examinations must contain the examination requested and the pertinent clinical history of the patient. Radiologic examinations may be ordered on a routine, urgent, or stat basis. Request for special procedures and emergencies should be made on a personal basis with the radiologist.

XIII. Laboratory Service

Surgical residents should become familiar with routine and emergency lab tests performed by the laboratories of the various hospitals to which they are assigned, and be able to provide a definite indication for each laboratory test ordered.

XVI. Social Services

Social Service is available at each of the University of Louisville hospitals for assistance to patients and their families when requested by physicians or nursing staff. The social service staff has much experience, expertise, and compassion in often challenging situations.

XV. Dietetics

Consultation with trained dietitians is available to patients requiring special diets, or general nutrition assessment.

XVI. Release of Medical Information

Official statements regarding a patient's condition are to be released by senior residents only. All residents must undergo HIPAA training in order to comply with the Health Insurance Portability and Accountability Act.

XVII. Night Call

Night call varies according to the service. In accordance with prevailing concerns regarding fatigue, compliance with the ACGME duty hours is mandatory. Residents must leave the hospital prior to the 30 hour deadline and must not receive any new patients after 24 hours. Residents are expected to respond to all pages and care for all patients in house on the particular services they are assigned. Pagers must be handled according to the established hierarchy of resident supervision. Chief residents are to ensure call is equitably distributed amongst all junior residents on the service.

XVIII. Hours on Call

Surgical residents assigned to private hospital rotations are expected to remain in the house until appropriate work is completed or determined by the service chief and RRC guidelines. University standards will be expected of all surgical residents at all times in the University of Louisville hospitals. This refers to time on duty, patient care, and other interpersonal relationships.

XIX. Operative Records

The maintenance and reporting of the resident operative record is an integral part of your educational experience, and the accreditation of the residency program is dependent upon your fulfillment of that responsibility. Each resident will record each operation performed or assisted, in an ongoing fashion, thereby preparing an operative log of his/her own case experience. This operative log will be entered directly onto the ACGME web-site. Each resident is responsible for his/her own data collection for the duration of his/her residency. Therefore, completion of all records concerning your surgical experience (operative records as defined by the Residency Review Committee) is a requirement for your completion

of the Surgical Residency Program. This must be kept up-to-date; these data are essential to the Surgical Residency Program's accreditation and your application for certification by the American Board of Surgery. It is the resident's responsibility to be familiar with the CPT code list so that all countable cases will be entered, and will be reviewed on a quarterly basis by faculty.

XX. Dress Code

The following dress code applies to all hospitals:

- A well-groomed professional appearance inspires the confidence of patients, their families, and visitors.
- Clothing must be neat, clean, professional and moderate in style. Jeans, cut-offs, t-shirts, midriff tops, hip hugger pants, short skirts, revealing shirts, etc., are not acceptable clothing for professionals.
- Shoes should be closed-toed, medium or low heeled, clean and polished. Sandals are not allowed.
- Jewelry should be conservative and worn in moderation.
- Good personal hygiene is extremely important to patient care as well as the comfort of co-workers and is an integral part of a proper professional attire policy. Professionals should be clean and well-groomed at all times.

Operating room attire is to be *confined* to that suite and the recovery room. The appearance of physicians in scrub suits in formal teaching conferences and rounds is not compatible with professionalism and the highest goals of surgical education. OR attire, including shoes, is limited to that particular part of the hospital, with exception of night call.

PURPOSE STATEMENT(S):

To provide guidelines for surgical attire in the perioperative suite, corresponding to the three traffic zones within the surgical suite: Restricted, Semi restricted, and Unrestricted as defined by the AORN recommended standard.

POLICY STATEMENT(S):

All staff within the surgical suite will present a neat and professional appearance while at all times observing UofL Hospital employee dress code. All staff within the surgical suite will adhere to the dress code for each specific perioperative zone as described below. All members of the OR team will respect and follow the current policy for surgical attire as discussed in the guidelines below.

ZONE	ACTIVITIES	DRESS CODE
Unrestricted Zone	Unlimited Traffic Area - Main Hallway - Staff Lounges - Offices - Control Desk - Restrooms - Materials Office	Professional Attire, Surgical Attire or Personal Scrubs, Lab Coats, Scrub Jackets
Semi Restricted Zone	Traffic Limited to authorized personnel - Support Areas - SSPD - Sterile Storage - OR Hallway	Surgical Attire, Hair Covering
Restricted Zone	Traffic Strictly Limited to surgical team personnel and patients - OR Rooms - Sub Sterile - Core areas - Procedure Rooms	Surgical Attire, Hair Covering is required. Mask required when entering open room. Shoe covers recommended, but not required.

DEPARTMENTS AFFECTED:

All Operating Rooms, including but not limited to; Pre-operative area, PACU, Anesthesia, Environmental Services, CSR, and all support services.

Location: K:\OR Administrative Support\Surgical Services Policies\Surgical Services Revisions: 10/30/2019
Last reviewed with no changes:

GUIDELINES FOR RESTRICTED AREAS:

1. For the purpose of this policy, surgical attire will be strictly defined, as those articles of clothing that are facility approved by University Hospital for use by members of the surgical team.

   A. Scrubs:
      1. Only fresh facility laundered scrubs allowed
      2. They must be changed daily or:
         a) When penetrated by blood or other potentially infectious material
      3. Home laundering is NOT permitted unless:
         a) You have an allergy to the facility-laundered scrubs.
      4. Scrub top will be tucked or fit close to the body
      5. Long sleeved disposable warm up jackets may be worn by non-scrubbed personnel
      6. They may be buttoned or secured to decrease the possibility of contamination of the sterile field.
         a) They cannot be worn tied at the waist
      7. All personal clothing worn MUST be contained within the scrubs i.e. turtlenecks, long sleeves, & outside jackets must be covered with a disposable jacket.
      8. Personal clothing must conform to UofL Hospital standards.
      9. Disposable jump suits may be worn by temporary personnel i.e. guards, workmen, NICU personal, or visitors.

   B. Shoes
      1. Must be clean
      2. Low heeled
      3. Toe covered
      4. Nonslip soles
      5. Made of material that would protect from sharps and fluid penetration
      6. Shoe covers should be worn over all non-dedicated OR shoes.

C. Head covering
   1. The scalp and hair should be covered when entering the semi-restricted and restricted area and no recommendation is made by AORN for type of covering. Disposable and Non-disposable headgear, including hats, bonnets, hoods, and surgical caps may be worn.
   2. Disposed of by the end of the shift or when soiled
   3. Hats should not be removed until the end of the shift or have become contaminated due to presence of S. Aureus in hair and scalp.

D. Masks
   1. Must be worn in the restricted areas when sterile supplies are open as well as the sterile and sub-sterile cores.
   2. The surgical mask should cover the mouth and nose and be secure in a manner that prevents venting at the sides of the mask. Wearing surgical masks and face and eye protection is recommended by the Centers for Disease Control and Prevention (CDC) and is a regulatory requirement.
   3. Must be changed every case or when soiled or wet
   4. Should not be hanging from the neck at any time

E. ID badges
   1. Must be worn by all personnel
   2. Visible unless scrubbed.
   3. Cleaned if soiled

F. Jewelry
   1. Jewelry (eg, earrings, necklaces, rings, watches should be contained or confined within the scrub attire may be worn in the semi-restricted or restricted areas. Remove when scrubbing.

G. Stethoscopes
   1. Should not be worn around the neck
   2. Should be cleaned between procedures

H. Backpacks, duffle bags, or briefcases must not be taken to semi restricted or restricted areas

I. Hand Hygiene
   1. Fingernails must be kept short, no longer than 1/4". When viewed from the palmar surface the nails should not extend beyond the fingertips.
   2. Refer to Hospital policy on fingernail polish.

J. Personal protective equipment will be made available to all personnel and must be utilized. Environmental service personnel shall adhere to all surgical attire standards required of surgical staff.

REFERENCES:

1. AORN Perioperative Standards and Recommended Practices. (2015 Edition).
2. AORN journal, (2006). Recommended practices for traffic patterns in the perioperative practice setting, 83 (3), 681-686.
3. Arrowsmith, V., (2004). Removal of nail polish and finger rings to prevent surgical infection- a review. Cochrane Database of Systematic Reviews. 2, 1-16.
4. Hubbard, M., (1992). Reducing blood contamination and injury in the OR. A study of the effectiveness of protective garments and OR procedures. AORN Journal. 55 (1), 194-201.
5. Jeanes, A., Green J. (2001). Nail art: a review of current infection control issues. Journal of Hospital Infection, 49, 139-142.
6. O'Neale, M., (1994). Used sponge exposure, processing peel packages, flash sterilization, arm attire, and beverages in the OR. AORN Journal. 59, 504-506.
7. Porteous, J.,(2002). Artificial nails…very real risks. Canadian Operating Room Journal. 16-21.
8. Trick, W., Vernon, M., Hayes, R., Nathan, C., Rice, T., Peterson, B., Segreti, J., Solomon, S., Weinstein, R. (2003), Impact of Ring Wearing on Hand Contamination and Comparison of Hand Hygiene Agents in a Hospital
9. Hand Hygiene in a Hospital. 36 (1), 1383- 1390.
10. Williams, M. (2008). Infection control and prevention in perioperative practice. Journal of Perioperative Practice, 18(7), 274-278.
11. Winslow, E.H., Jacobson, A.F. (2000). Can a fashion statement harm a patient? Long and artificial nails may cause nosocomial infections. The American Journal of Nursing, 100 (9), 63-65.
12. Wynd, C., (1994). Bacterial carriage on the fingernails of OR nurses. AORN Journal, 60 (5), 796-805
13. https://www.aorn.org/guidelines/about-aorn-guidelines/evidence-tables

P.113, 124 ARON

Reviewed April 2019
Reviewed June 2022

The Role of Surgical Residents in the Education of Medical Students

Much of any resident's energy and effort is necessarily focused upon his/her own personal growth and education in his/her chosen field. Residents are inevitably role models, especially for *professionalism,* in this School of Medicine for all of the medical students with whom they come in contact. The relationship between on-call students and house officers is a uniquely close one; it provides unparalleled opportunities for one-on-one teaching. Small group education, whether it be didactic or demonstrational, such as with procedures both inside and outside the operating room, are good examples of such opportunity.

An important part of the educational process is optimizing personal *communication skills* with both students and patients, teaching them how best to communicate with one another.

Practice-based learning is one of the 6 competencies of contemporary graduate education, and it needs to be exemplified in the undergraduate years. When a house officer demonstrates exactly how he does something and why he does it, this often becomes a wonderful educational experience for any student and epitomizes practice-based learning. *System-based* practice involves a realization that the practice of medicine occurs in vastly complex social and medical systems in the United States. Understanding the greater context in which patients develop illnesses and/or in which patients seek corrective care or alleviation constitutes a very good example of system-based practice.

All surgery residents are expected to provide *objective evaluations* of the students' performances in ward work and will frequently be called on to testify to acquisition of certain technical skills. As principal evaluators of the largest component of the student grade, it is important that residents be both conscientious and objective.

Quarterly meetings with the Department Chair and the Director of the Training Program always focus on undergraduate student education and the discussion of changes in the curriculum, either planned or unplanned, and how they could best be dealt with. Students are requires to attend all general education conferences and rounds.

Resident participation, when requested, in the *oral examination* and *grading session* is important. The oral exams are the final component of the student evaluation process. More importantly, the grading session that follows allows residents' input into identification of remarkable accomplishments or special needs for some of our students.

It is also important that residents realize that, as the whole medical educational process merges with an 80-hour duty week, student education becomes innately very demanding. Residents must realize that often third-year student surgery rotations are the first time that students have really been asked to perform in a serious and sustained way at the bedside. Helping them through that and realizing how much a positive impact could have been made on one's own education will help residents become better role models.

There is a major expectation on the part of the Department Chair and faculty that all of our residents play vital and important roles in medical education. Your performance in that area contributes significantly to the decision regarding your own levels of higher seniority within the residency program. Formal teaching awards are awarded annually to residents who excels in this important area of student education.

Student Mistreatment Policy
(Appropriate Learner-Educator Relationships and Behavior)

The University of Louisville School of Medicine is committed to the need for mutual respect as an underlying tenet for how its members should relate to one another.

Definition of Student Mistreatment: *Mistreatment* arises when behavior shows disrespect for the dignity of others and unreasonably interferes with the learning process. Exclusion when deliberate and/or repetitive also interferes with a student's opportunity to learn. Disrespectful behaviors, including abuse, harassment, and discrimination, are inherently destructive to the student/teacher relationship.

To abuse is to treat in a harmful, injurious, or offensive way; to pressure into performing personal services, to attack in words; to speak insultingly, harshly, and unjustly to or about a person; and to revile by name calling or speaking unkindly to or about an individual in a contentious manner. Abuse is further defined to be particularly unnecessary or avoidable acts or words of a negative nature inflicted by one person on another person or persons. This includes, but is not limited to, verbal (swearing, humiliation), emotional (intentional neglect, a hostile environment), behavioral (creating a hostile environment), sexual (physical or verbal advances), and physical harassment or assault (threats, harm).

Harassment is verbal or physical conduct that creates an intimidating, hostile work or learning environment in which submission to such conduct is a condition of continuing one's professional training.

Discrimination is those behaviors, actions, interactions, and policies that have an adverse effect because of disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment due to gender, racial, age, sexual orientation or other biases.

In all considerations, the circumstances surrounding the alleged mistreatment must be taken into consideration especially with respect to patient care, which cannot be compromised at the expense of educational goals.

***Procedures for the Reporting and Handling of Alleged Student Mistreatment*:** Students believing they have been mistreated as defined in the Student Mistreatment Policy, have the following options for making their initial report:

Ad-Hoc Committee on Student Mistreatment:

a. Senior Associate Dean for Students and Academic Affairs
b. Assistant Dean for Student Affairs
c. Director, Medical Student Affairs
d. Coordinator, HSC Student Counseling Services
e. Assistant Director, HSC Special Programs
f. Designated Student Leader

The first inquiry can be informal and students may ask that the discussion go no further. An informal record of this interchange should be filed in a central "mistreatment file." Student's names will not be in this record if the student requests anonymity. If a student wants the issue pursued, and the

Ad-Hoc Committee member consulted concurs that mistreatment has occurred, the report will be forwarded to the Associate Dean for Faculty Affairs for issues involving faculty members or the Associate Dean for Graduate Medical Education for issues involving residents.

If the Ad-Hoc Committee member consulted does not believe the event constitutes mistreatment, but the student does, the student has the right to bring the complaint to the entire Ad-Hoc Committee. The Ad-Hoc Committee's decision is final with respect to this process. The student may still file a grievance using established University protocols. If the Ad-Hoc Committee believes mistreatment has occurred, it will forward information to the appropriate Associate Dean.

A central file of all complaints will be maintained in the Student Affairs Office. Complaints will be dated but student names will be optional. Files will be organized by Departments so that repeat offenders can be brought to the attention of the appropriate Associate Dean by the Student Affairs staff.

Chair's Involvement: Reports forwarded by the Ad-Hoc Committee to an Associate Dean will also be provided to the respective Department Chair of the alleged individual.

Time Limit: Complaints need to be filed with a member of the Ad-Hoc Committee within two months of the alleged action. However, a student may ask for the forwarding of the complaint to be deferred until after the student is evaluated by the involved faculty member/resident.

Reviewed June 2019
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Transfer of Patient Care Policy

DEFINITIONS:

Transition of Care

Transition of care is defined as when a physician transfers the care of a patient to another physician. This includes sign-out as well as sign-in. It also includes the transfer of a patient from one level of care to another, e.g. transfer of a patient from the wards to the ICU or vice versa. By definition, transition of care also occurs when a physician transfers the care of a patient at the end of a rotation and a new physician assumes the care of the patients on that service.

Proper Hand-Over of Patients

The proper hand-over of patients should include at least the following:

- The exiting physician must notify the attending and co-resident(s) who will be responsible for patient care that they will be leaving.
- The exiting physician must give a proper verbal checkout, which includes the patient's active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan.
- The exiting physician should also attempt to anticipate any events that may occur with his or her patient in their absence and give the best course of action.
- The exiting physician should also make aware any orders that have been or need to be placed.

This should all be done face-to-face to ensure accuracy and proper evaluation of the exiting physician's checkout to ensure patient care and safety as well as improving resident education.

RATIONALE:

Effective communication is vital to safe and effective patient care. Many errors are related to ineffective communication at the time of transition of care. In order to provide consistently excellent care, it is vitally important that we communicate with one another consistently and effectively when the care of a patient is handed off from one physician to another. This policy is meant to define the expected process involved in transition of care, and applies to each of our teaching sites where we provide inpatient and outpatient care.

All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. It is also essential for fellows and faculty members to do so by abiding by current duty hour policy.

SPECIFICATIONS:

I. Service Schedules

A. It is the duty of the Chief Administrative General Surgery Resident, to determine the call schedule at the beginning of every academic year. This schedule is posted in the Division offices and transmitted to each resident by email.

B. It is the duty of the Assistant Program Director to determine the call schedule for the faculty at least quarterly, in advance. This information is continuously updated at the

University of Louisville Hospital Switchboard and posted on the Division's bulletin board. It will also be transmitted to each faculty member and resident via email.

C. All vacations and times away from duties will be reported to the Chief Administrative General Surgery Resident who will inform the faculty and residents via email.

D. With the exception of vacations and illness, all residents will be available for discussions of patients with the on-call resident.

On-Call Principles

A. Weekend call begins on Friday at 7:00 pm and ends on Monday at 7:00 am.

B. The weekend hand-off will occur either in person or by telephone. This should not be by text message or email. A list of patients on all services must be transmitted by email or text message.

E. Hand-over information should include the following:
   1. Patient location (e.g. Bed # and Institution #).
   2. Active problems, including ongoing management plans.
   3. Tasks requiring completion or results/findings requiring follow-up.
   4. "Watch out for…"
   5. Emphasis must be given to critically ill or unstable patients.

III . End of Rotation/Off Service

A. On completion of an inpatient rotation, the resident physician must communicate with the resident physician that is coming on service to assume the care of his or her patients. This will ensure that each patient on the service continues to receive continuous, high quality care without interruption.

B. Communication must include an off-service note written by the resident rotating off service. The off-service note must briefly summarize the patient's course to date, and include any active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan.

C. Communication should also include a face-to-face hand off that provides an opportunity to discuss each patient and allow questions and clarification of any issues. If for some compelling reason this is not possible, then the residents should at least review the list of patients over the telephone and a patient list must be left by the resident rotating off service for the incoming resident in a prearranged location.

IV. Resident Evaluation

A. Residents will be verbally evaluated in person or by telephone on his or her transfer skills by the attending(s) and/or a senior resident weekly unless otherwise specified above.

B. A question will be added to the quarterly evaluations from attending and for peer evaluations to comment about resident's "transfer of care" performance.

Revised: January 2018
Reviewed June 2022

Resident Assignment/Election to Research/Fellowship Years

The University of Louisville, Department of Surgery, General Surgery Residency Training Program is a five-year program with the option to do one or more years of research or fellowship. All applicants to this program will be informed of this by posting on our website and in our house staff manual. The additional research or fellowship year is voluntary, and every effort will be made to match the request of the individual resident for their particular endeavor. This might include basic or clinical research, and for the pursuit of higher degrees in areas such as science, public health, or business. All residents are required to submit at least one manuscripts prior to completion of the training program.

PGY1, 2, and 3 residents will be surveyed periodically by the program director and the chairman to determine their interest in electing to do research or fellowship years, and a priority list established for each these particular classes. Upon completion of the period of research or fellowship (typically one or two years), the resident will re-enter the program at the appropriate class level to obtain the full 5 years of clinical training. This would usually be the PGY-4 year or less frequently the PGY-3 year. Residents will not be allowed to these activities after the PGY-1 or 4 years. Residents will choose or be assigned a mentor that will help them perform a research project with the goal of presentation and publication, before the end of their PGY-2 year.

The number of residents to be allowed to do such a year will vary from year to year, and will be determined in part, by residents returning to their clinical assignment after the completion of these years. In the event that not enough residents in a given class have expressed a desire to pursue additional research or fellowship years, the program director and chairman, in consultation with each of the residents in the particular class, will encourage some of these residents to take a research year or fellowship. If none so desire, then the program director will seek a temporary increase in resident complement from the RRC for Surgery to allow all residents in that class to finish in 5 years. Similarly, if more residents desire to do such years than can be accommodated, the program director and chairman will establish a priority list for each PGY year.

Reviewed April 2018
June 2019
June 2022

Department of Surgery
University of Louisville School of Medicine

General Surgical Resident Research Plan and Guidelines

This document will serve as a guideline for the general surgical residents interested in taking 1 or 2 years for research or special educational opportunities after either their PGY-2 or PGY-3 year. In some cases (e.g., PhD candidates) 3 years will be permitted.

General surgical residents who are interested in research/special educational opportunities must declare that intent in writing by the end of the PGY-1 year for those who wish to begin after their PGY-2 year, or by the end of the PGY-2 year for those who wish to begin after their PGY-3 year. The request for research/special educational opportunities should be sent to the Program Director (Dr. Benns) and the Vice Chair for Research (Dr. Martin) and must include:

1. Primary mentor and department
2. Career goals (fellowship interest, if any)
3. A statement describing how this time away from clinical residency training will enhance the applicant's career goals
4. Plans for advanced degree or formal course work
5. A description of the planned research projects or special educational opportunity goals and objectives

Reasonable productivity metrics for a resident taking 1 year of research would include at least 4 manuscripts submitted to peer-reviewed journals, at least 2 of which should be presented at regional or national surgical or scientific meetings. Residents taking 2 years of research would be expected to submit at least 8 peer reviewed manuscripts, and generally should pursue an advanced degree such as a Master’s degree.

Current research/special educational opportunities available at the University of Louisville include:

1. Surgical Oncology Research
2. Immuno-oncology Research
3. Colorectal Surgery Research
4. Trauma/Critical Care Research
5. Surgical Nutrition
6. ERCP Advanced Pancreaticobiliary Fellowship
7. Surgical Critical Care Fellowship

These opportunities will be made available only to those residents who demonstrate satisfactory or superior performance during the initial years of residency. Salary support for those performing research outside of the University of Louisville must be provided by the outside institution. Within the University of Louisville, resident salary support should be provided by the primary mentor's department if not in the Department of Surgery.

Revised: June 2018
June 2019
Reviewed June 2022

Monitoring Resident Stress/Fatigue

All General Surgery Residents will be observed for signs of fatigue, agitation, depression and other signs of stress on a daily basis by all attending staff who come in contact with them. Dialogue between attendings and residents is encouraged, and attending surgeons are empowered to seek means to relieve excessive stress, such as sending residents out of the operating room or home as needed.

General Surgery Residents are encouraged to seek appropriate support systems as needed and are told during orientation that they are encouraged to contact the Program Director or Department Chairman at any time to discuss issues of importance to them.

Chief residents are instructed to assure appropriate time out of the hospital and to use appropriate judgment to minimize stress in the working environment for the junior residents.

The Chair and Program Director are constantly available, including at home, (McMasters: 241-6613 / Benns: 435-2100) for advice and counseling.

Uber Transportation Program

The University of Louisville School of Medicine has an “Uber Transportation Program”, which is available to residents and on-call medical students, 24-hours a day. Residents who feel too fatigued to drive home or safely operate a vehicle should take an Uber. Residents will be given a ride home as well as back to their car. There is no limit to how many rides a resident can take, within reason. The Graduate Medical Education Office will review each ride to ensure this program is being used appropriately. Residents should act in a professional manner when in the vehicle. Uber will send an email to each resident so the GME office can pay for the Uber service when it is used and the resident is not held responsible for the fee. If you have any questions or concerns about the Uber program please contact Cheri Bingham at 852-5271 or cheri.bingham@louisville.edu.

Revised July 2018
Reviewed June 2019
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Faculty/Resident Mentorship Program

Mentorship is a hallmark of the University of Louisville, Department of Surgery. The training program has designed a formal process to provide residents with an opportunity to casually discuss the residency program in general. The purpose of the discussion is to focus on the needs of the resident during their training and not meant to be an evaluation session.

An assigned faculty member will meet with the appointed resident bi-annually; once in the late fall and once in the spring and any other time a specific problem may come up that the resident would like to address. These informal sessions will afford the resident an opportunity to discuss any questions or concerns the resident may have, will provide a confidential forum to seek advice with regard to their training and future career goals and to support them as they move through our residency program and develop into fully-trained, confident general surgeons.

Each resident will be assigned to a faculty member who will serve as his/her mentor. Residents will be partnered with a faculty mentor with similar areas of interest to offer support and counseling. Residents may have the opportunity to change mentors if another faculty member better suits their future career goals at any time. If the resident elects to change mentors, we ask that the residency office be notified so we may update our records.

Revised March 2018
Reviewed June 2019
Reviewed June 2022

Departmental Society Memberships

The Hiram C. Polk, Jr, MD Department of Surgery holds institutional memberships in:

- Association of Women Surgeons
- Society of Black Academic Surgeons
- Association of Out Surgeons and Allies
- Latino Surgical Society

Updated March 2023

Department of Surgery
University of Louisville School of Medicine

Moonlighting Policy

The policy set by the University of Louisville School of Medicine regarding moonlighting is adhered to by the Department of Surgery. The new duty hour requirements strongly constrict opportunities for such activity. Moonlighting will be restricted to vacation time, laboratory rotations, and select PGY 4 & 5 rotations, only with written, *pre-approved* consent of the Program Director.

.....

RESIDENT MOONLIGHTING POLICY
STANDARDS AND GUIDELINES
FOR THE SCHOOL OF MEDICINE
UNIVERSITY OF LOUISVILLE

1. Programs must not require residents to participate in outside employment activities (moonlighting).

2. Resident physicians who hold either a Regular or a Residency Training (RT) license in Kentucky shall be free to use off-duty hours in appropriate related activities, including engaging in outside employment activities, so long as the resident obtains the prior written approval of the Department Chair or Program Director for such outside employment activities, and so long as such activities do not interfere with the resident's obligations to the University, impair the effectiveness of the educational program engaged in, or cause detriment to, the service and reputation of the hospital to which the resident is assigned.

3. Each program must develop a moonlighting policy that is consistent with the Resident Moonlighting Policy of the University of Louisville. The policy must give guidelines for outside employment activities of residents, including defining the hours and rotations when such outside employment activities may be permitted, and under what circumstances permission may be denied for outside employment activities. Residents are required to comply with individual program policies.

4. The University does not provide professional liability insurance or any other insurance or coverage for resident off-duty activities or employment, and assumes no liability or responsibility for such activities or employment. Confirmation of professional liability insurance for resident off-duty activities or employment will be the responsibility of the moonlighting employer.

5. Residents who wish to moonlight must hold either a Regular or Residency Training license in Kentucky. Institutional Practice (IP) and Fellowship Training (FT) licenses are valid only for duties associated with the University training program for which these licenses are issued, and do not cover outside employment activities. Resident Training (RT) licenses permit moonlighting only in locations authorized and approved by the resident's Program Director.

6. Residents are not to represent themselves to moonlighting employers as being fully trained in their specialty. Further, residents who moonlight are not to present themselves as agents of the University of Louisville during moonlighting activities. University lab coats, name badges, and identification cards are not to be worn outside of the resident's training program activities. It is the resident's responsibility to assure the billing procedures of the moonlighting employer are conducted in an ethical and legal manner.

7. Resident physicians who hold J-1 or H-1B visas are not permitted to engage in activities or have additional income other than what is listed on their forms DS2019 (J-1 holders) or I-797C (H-1B holders). Federal regulations specifically prohibit outside or additional income for individuals with J-1 visas. Employment of H-1B holders is limited to the petitioner (employer) and activities listed on the I-797C.

8. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the University of Louisville School of Medicine Resident Agreement.

9. Program Directors are required to monitor and approve in writing all moonlighting hours and locations for residents and maintain this information in the resident's file.

10. Programs are encouraged to monitor all individual residents moonlighting hours each month to assure outside activity does not contribute to excess fatigue or detrimental educational performance. The Program Director reviews and monitors all work hour entries/reports utilizing the MedHub reporting system to ensure work activity does not contribute to excess fatigue or detrimental educational performance'.

11. Chief residents and research residents will be eligible to take TCV and VA call, which will fall under the moonlighting guidelines. The appropriate forms must be completed and submitted to the Program Coordinator(s) with the signature of the Program Director. All moonlighting policy guidelines apply. All work hours must be entered into the MedHub system. Duties performed outside of resident's assigned training hours must be within the ACGME duty hour restrictions (80 hours per week) and will be closely monitored by the Program Director via the MedHub work hour reporting system.

Approved by GMEC: 4/17/2000
Revision approved by GMEC: 3/21/01
Revision approved by GMEC: 5/21/03
Revision approved by GMEC: 2/18/04
Revision approved by GMEC: 11/15/06

Revised 5.7.20

Department of Surgery
University of Louisville School of Medicine

General Policies

I. Absences

When it is necessary for a house staff member to be, absent from duty, he/she must inform the senior resident, attending staff, hospital operators, and Machenize Eason, Coordinator at 852-1895.

II. Address and Phone Number Changes

It is important that Machenize/Lois (852-1895/852-8017) be notified of any change in address, email address, or phone number during the year. Their offices are the central location for such information for the Department and you.

III. Administrative Problems

All administrative problems, including those involving interdepartmental services and ancillary medical personnel, should be referred to the Chief Administrative Resident. Any questions concerning scheduling of rotations are to be made to the Administrative Chief Resident and if necessary, the Program Director.

IV. Changes to New Services

Changes to new services will be made at 7:00 a.m. on the first day of the month. Operations should be minimized on this day on ward services. In order to ensure continuity of good patient care, senior residents should make arrangements to become familiar with all patients on new services prior to the time of rotation changes.

V. Impaired Residents / Substance Abuse

Residents who exhibit signs of impairment due to substance abuse are referred to the Kentucky Physicians Health Foundation (KPHF) for evaluation in accordance with Kentucky medical licensure laws. KPHF evaluates and monitors impaired physicians for the Kentucky Board of Medical Licensure (KBML) under a formal contractual arrangement. The University follows the recommendations of this organization for the treatment and monitoring of impaired residents as well as the written policies of the University of Louisville Hospital. As residents begin training in University programs, they are required to complete a “Hospital Privileges Application,” which requires information about their personal health status and includes questions related to impairment due to alcohol and other drugs.

These applications are reviewed by the hospital Physicians Health Committee (PHC), which in turn makes recommendations to the hospital Credentials Committee. Residents who are in recovery are reviewed at quarterly meetings of the PHC. There is formal written exchange of information about the status of the resident’s recovery between the PHC and KPHF quarterly. Residents who are found to be impaired because of known and untreated substance abuse, or who violate the Kentucky licensure law are referred to the KBML as required by law.

Residents needing assistance or who have questions should contact their Program Director, the Medical Director of the Kentucky Physicians Health Foundation (Dr. Burns Brady at 425-7761), or the Chairman of the University of Louisville Hospital's Physicians Health Committee.

VI. Grievance and Academic Probation Procedures / (Due Process)

A uniform student (resident) procedure, based on the Redbook (the official document for the governance of the University), has been established for all academic units. This procedure is designated to provide means of dealing with medical student and resident complaints regarding a specific action or decision by faculty members. Please the policy for academic probation, and the grievance procedure, below:

*** * ***

ACADEMIC PROBATION AND DUE PROCESS POLICY FOR RESIDENTS

UNIVERSITY OF LOUISVILLE
SCHOOL OF MEDICINE

Residents in University of Louisville School of Medicine residency programs are classified as students (see item #7 in the Resident Agreement) and as such are covered by the Student Academic Grievance Policy and Procedures outlined in The Redbook, Chapter 6, Articles 6.6 through 6.8.14 (The Redbook is available at www.louisville.edu/provost). Article 6.6.3 grants each academic unit the responsibility and authority to make decisions in accordance with standards determined by the unit. Academic units are also responsible for seeing that the standards determined are in agreement with their respective RRC and Board requirements.

The procedure to be followed when academic probation is recommended by a unit is:

1. Program Director (or Residency Evaluation Committee) makes recommendation to the Department Chairman.

2. Department Chairman makes written recommendation to the Dean (copy to the Associate Dean for Graduate Medical Education). The written recommendation should include the reasons for the recommendation, the length of the recommended probation and the expected resolutions to the problems.

3. The Dean reviews the recommendation and informs the resident of the probation action.

4. At the end of the probationary period, the Department Chairman informs the Dean in writing (copy to the AssIVociate Dean for Graduate Medical Education) of the resident's progress, advising the Dean if the problem is resolved, if an additional period of probation is necessary or if dismissal is recommended. The Dean takes the appropriate action.

The Student Academic Grievance Procedure provides residents a fair means of dealing with actions or decisions, which the resident may feel to be unfair or unjust. The School of Medicine Student Academic Grievance Committee includes resident representatives.

*** * ***

GRIEVANCE PROCEDURES FOR RESIDENTS
UNIVERSITY OF LOUISVILLE
SCHOOL OF MEDICINE

Preliminary Procedures
To pursue a grievance concerning academic matters within the academic unit, the following steps of the grievance procedure should be observed:

1. The resident should first discuss the matter with the person involved and attempt to resolve the grievance through informal discussion.

2. If there is no resolution, the resident should discuss the matter with that person's supervisor or the person to whom such person reports, who should attempt to mediate a resolution.

3. If the resident still has not been able to obtain a resolution, he or she may request the Student Grievance Officer (S.G.O.) (Joseph Steffen, 852-7209) to attempt informal mediation of the problem.

Grievance Procedures
If the matter has not been satisfactorily resolved through the informal process, the resident shall submit a written statement of the grievance to the School of Medicine Grievance Committee through the Office of the Dean. The statement shall contain:

(1) A brief narrative of the condition giving rise to the grievance;

(2) A designation of the parties involved; and

(3) A statement of the remedy requested.

*** * ***

VII. Clery Act Notification

Sexual misconduct (sexual harassment, sexual assault, and sexual/dating/domestic violence) and sex discrimination are violations of University policies. Students experiencing such behavior may obtain **confidential** support from the PEACC Program 852-2663, Counseling Center 852-6585 and Campus Health Services 852-6479.

Disclosure to University faculty or instructors of sexual misconduct, domestic violence, dating violence, or sex discrimination occurring on campus, in a University-sponsored program, or involving a campus visitor or University student or employee (whether current or former) is **not confidential** under Title IX. Faculty and instructors must forward such reports, including names and circumstances, to the University's Title IX officer.

VIII. Mail

Individual mail files are provided for each house staff member in the Department of Surgery, Residents' Conference Room (ACB – 2nd Floor). It is the responsibility of each resident to pick up mail on a weekly basis. Email is the primary mode of communication for the Department of Surgery. Residents should check their Outlook email, to obtain important information about the Department and University.

For assistance with your Outlook account, contact the IT HelpDesk at 852-7997.

IX. Research Projects

Residents are required to engage in either clinical or bench laboratory research projects under faculty sponsorship. Independent research is also feasible in selected situations. Publication of any research is encouraged with appropriate faculty supervision. Modest financial and technical support is available to assist with manuscript preparation and abstract presentations for surgical society and specialty meetings.

All residents are required to submit at least one manuscript for publication to the Program Director by June 15th of their PGY-4 year. The form of such a project may be a review article, clinical or experimental paper, or book chapter. **A case report is not acceptable.** The manuscript must be considered suitable for submission for publication by the Department Chair and Program Director. A copy of the submitted manuscript must be uploaded to the resident's MedHub portfolio. The integrity of scientific publishing is protected by the following legal and ethical practices.

Copyright assignment: The copyright law is designed to protect original works of authorship. By signing the standard copyright assignment sheet, the author agrees that the submitted work is original, is not published elsewhere, and that exclusive copyright ownership is assigned by the author to the publisher.

Written permission to reproduce: Written permission from the copyright owner shall be obtained to reproduce copyrighted material such as figures, tables, and text over 400 words. The name and address of the copyright holder is usually located on the same page as the copyright symbol ©. Permission is usually granted but may involve a fee.

Duplicate or subsequent publication: Duplicate publication is the possibly unethical and probably unlawful practice of simultaneous submission or republication of essentially the same work, unbeknownst to the receiving journal editor or publisher. When in doubt about duplication or similarity, consult with the *Editorial Office* or the appropriate faculty advisor.

Preliminary release of scientific information: The public release of scientific information before it is published in a scientific journal violates the policies of many journals. Selected presentations, especially if local or statewide, are often permitted.

Quotations/references: Quotation marks are placed around verbatim passages, and references are used to attribute the source of original work.

Co-authors: As a courtesy, keep *all* co-authors apprised of all stages of your research project and discuss your concerns honestly. All co-authors must technically sign off on the final version of a submitted manuscript.

X. Vacation Scheduling

General Surgery residents receive 4 weeks of vacation. A vacation request form is emailed to all residents by the administrative chief resident in approximately mid-March. The dates will be determined by the administrative chief resident, who may also consult the Program Director. This vacation may be divided into 2 week segments. (See Resident Time Off Policy for more specific details).

* * *

XI. Social Media

Social medical includes (but is not limited to) blogs, Facebook, LinkedIn, Twitter, YouTube, Instagram and others. These guidelines apply whether posts are on personal accounts or the University of Louisville accounts.

1. Do not share confidential or proprietary information that may contain patient information under HIPPA protection or concerning patient confidentiality.
2. Write in first person where your connection to the University of Louisville is apparent, make it clear that you are speaking for yourself from your perspective and point of view and not that of the University of Louisville. When your connection to the University of Louisville is apparent, be sure to make your opinion clear. Use phrases like “these are my thoughts and not that of my employer nor do they reflect the views of my employer” or start and “About Me” section for these kinds of things.
3. Be professional and use your best judgement. Be honest and accurate using professional language and behavior in your communications. Try to avoid errors, omissions and anything that reflects badly on the University of Louisville.
4. Be sure that your social media communications do not interfere with your work and your work communications.
5. Unless you have prior approval from the University of Louisville, your user name, URL or handle should not include the University of Louisville logo and/or name in any way.

Should you fail to follow the guidelines listed above, it could result in probation or possibly termination from the University of Louisville, Department of Surgery.

Reviewed March 2018
Reviewed June 2019
Revised April 2018
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Resident Clinical & Educational Work Hour Policy

The policy set by the University of Louisville School of Medicine regarding resident clinical & educational work hours is adhered to by the Department of Surgery. The following guidelines are specific to the General Surgery Training Program.

.....

The educational goals of residency training in the General Surgery Program and the learning objectives of residents must not be compromised by excessive clinical service obligations.

1. General Surgery resident work hours must not exceed 80 hours per week averaged over 4 weeks. Resident clinical & educational work hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.

2. In-house call must occur no more frequently than every third night, averaged over a 4-week period. Residents must not be scheduled for more than six consecutive nights of in-house night call.

3. General Surgery resident assignments must not exceed 24 hours maximum continuous on-site duty with up to 4 additional hours permitted for patient transfer and other activities defined in RRC requirements. There must be no new patients assigned after 24 hours of continuous duty.

4. General Surgery resident time spent in the hospital during at-home call must be counted toward the 80 hours. At-home call, defined as call taken from outside the assigned institution by pager or phone, is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for residents.

5. All General Surgery residents, including those assigned at-home call, must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

6. Resident clinical & educational work hours will be monitored by the resident and the program director, to ensure that work hour limitations are not exceeded. Work hours are entered into the MedHub system. The program director reviews MedHub reports monthly to ensure the program demonstrates substantial compliance with the clinical and educational work hour requirement.

7. The Program Director has developed and implemented policies to prevent and counteract the effects of resident fatigue and stress. General Surgery Faculty and residents will be constantly on guard for signs of stress and fatigue – and will take appropriate action whenever needed.

8. The Program Director must ensure that General Surgery residents are provided appropriate back-up support when patient care responsibilities are particularly difficult or prolonged.

9. General Surgery Residents must at all times have appropriate support and supervision in accordance with current published ACGME, institutional and program requirements and with the School of Medicine GME Policy on Resident Supervision.

11. Moonlighting will be restricted to vacation and laboratory rotations, and only with advanced, written consent of the Program Director.

12. Residents should have eight hours off for rest and personal activities between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. Work hours will be monitored by the Program Director.

13. Work periods must not exceed 24 hours maximum continuous scheduled clinical assignments. Up to 4 additional hours may be used for activities related to patient safety, such as transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. In rare circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty. This should be justified by needed continuity of care in a single critically ill patient, the humanistic attention to the needs of a patient or family, or a uniquely academic event. The resident must hand over care of all other patients to the team responsible for continuity of care and document the reasons for remaining on duty. This documentation should be submitted via MedHub to the Program Director for every instance of overage. The Program Director must review each submission of additional service and track both individual resident and program-wide episodes.

Revised 7.1.2017
Reviewed 5.7.20
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Promotion Policy

(1) Each resident will be evaluated and promoted based on clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior and overall ability to manage the care of a patient within the six core competencies.

Formal evaluations will occur at the end of each of the resident's rotation in MedHub. These written evaluations will be discussed with the resident on a semi-annual basis and placed into the appropriate resident's file in the Program Coordinator's office.

The residents have ready access to their files and may review them on a regular basis.

(2) If at any time a resident's performance is judged detrimental to the care of a patient(s), action will be taken immediately to assure the safety of the patient(s). The Program Director will promptly provide written notification to the affiliate program director or department/division chairperson of the resident's unacceptable performance or conduct.

(3) The faculty will recommend whether promotion will occur at the spring semi-annual resident evaluation meeting. The Program Director and Department Chair will make the final decision on promotion based on the faculty recommendation. A score of less than 20% on the ABSITE may result in repetition of the current PG year and lack of promotion to the next PGY level.

(4) All residents are required to write at least one manuscript. The form of such a project may be a review article, clinical or experimental paper, or book chapter. The Department Chair or Program Director must consider the manuscript suitable for submission for publication before it is submitted to a journal six months before graduation. A case report is not acceptable.

A copy of the submitted manuscript must also be given to the Department Chair, Residency Coordinator, and Department Medical Editor.

Revised July 2017
Reviewed June 2019
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Probation, Suspension and Termination for Delinquent Medical Records

1. A resident who is identified as having incomplete medical records (any record greater than 7 days past hospital discharge) by any of the Record Departments of the affiliated hospitals will be notified by the respective Medical Records department and given 7 days to complete the records in question. At that time, the resident will also be notified that if he/she does not complete the medical records within 7 days that he/she will be recommended to be placed on probation.

2. If at the end of the 14-day period the records have not been completed, the Director of Medical Records will notify the Vice Dean for Clinical Affairs, who will recommend to the Dean that the resident be placed on probation. The resident will be notified in writing by the Dean of the probationary status.

3. Once placed on probation, the resident will be given 14 additional days to complete all additional records at all affiliated hospitals and notified that if records are not completed at the end of 14 days, the resident will then be recommended to be suspended.

4. The Medical Records Department of the appropriate hospitals will notify the Vice Dean for Clinical Affairs if the medical records in question have not been completed at the end of 14 days probationary period. The Vice Dean in turn will recommend to the Dean that the individual be suspended. The Dean will notify the individual resident of the suspension in writing. The Dean will notify the resident's Program Director and the Chairman of the Department.

5. Suspension will include the following conditions:
   A. Resident will be relieved of all clinical duties.
   B. The resident will receive no credit for training while in suspended status.
   C. The resident will receive no pay while in suspended status.
   D. The suspension will continue until all delinquent medical records are completed.

6. If at the end of 30 days suspension period the resident has failed to comply, a recommendation will be made to the Dean from the Vice Dean that the resident be terminated/dismissed from the training program.

7. All available medical records should be completed prior to a resident departing for a vacation, leave of absence, or any out-of-town or out-of-state rotation since the above probation, suspension, and dismissal process will apply in these cases.

8. Prior to a resident departing from a program and receiving any credit or certification for the period of training, all medical records must be completed at all affiliated hospitals.

Revised April 2018
Reviewed June 2019
Reviewed June 2022

Department of Surgery
University of Louisville School of Medicine

Faculty and Clinical Competency Committee
Evaluation of Residents

Surgery residents are evaluated on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior and overall ability to manage the care of a patient within the 6 core competencies:

- Patient Care
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal/Communication Skills
- Professionalism
- Systems-Based Practice

Utilizing the ACGME milestone process, formal evaluations occur at the end of each of the resident's rotation. These evaluations are completed by the faculty who worked with an individual resident on a specific rotation. Evaluations results are averaged and used as part of the resident milestone review process facilitated by the Clinical Competency Committee (CCC). Milestones are then uploaded to the ACGME WebAds bi-annually.

Numerous data points are collected (MedHub evaluations, ABSITE scores, conference attendance, SCORE Curriculum participation, Mock Orals, simulator training performance, nursing and patient evaluations/comments, case logs and other hospital-based data) on each resident to be reviewed and discussed by the Clinical Competency Committee (CCC). Based on these data points and resident evaluation averages, the Clinical Competency Committee determines and agrees upon a score for each milestone for the resident being evaluated. The CCC member meets with their assigned residents to discuss their evaluation results. The CCC faculty member then dictates a summary of the meeting with the resident. This formal summary letter is signed by both the CCC member and the resident. The summary letter is placed into the appropriate resident's file in the program coordinator's office. In addition, the summary is uploaded in the milestone portfolio module of MedHub. Residents are able to review their evaluations and their summary letter in MedHub at their convenience.

MedHub Residency Management Suite:
MedHub Residency Management Suite is web-based program is required by the University of Louisville Graduate Medical Education Office to assist with tasks such as scheduling, procedure logging, evaluations, monitoring conference attendance, duty hours, and general personnel tracking.

The Department of Surgery Faculty utilize MedHub to complete evaluations of surgical residents. Notification is sent to the faculty at the end of each rotation, prompting faculty to login to the system to complete their assigned evaluations. Evaluations are anonymous and password protected.

American Board of Surgery In-Training Examination (ABSITE):
Residents are required to take the ABSITE in January of each training year, unless a prior exemption has been granted by the Program Director. Each resident will be assigned to one of two scheduled sessions in the computer center for online completion of the ABSITE. Their assignment will be determined by their current rotation schedule in an effort to limit call night influences on performance as much as possible. Residents will be free of all duties during the examination. The Department of Surgery minimum standard of performance is at the **20 percentile.** Performance below this standard will be considered **out of compliance** with department's minimum standard.

Revised July 1, 2018

Evaluations Completed by Residents

Each resident will be given the opportunity to complete a formal electronic evaluation (louisville.medhub.com) of the appropriate attending surgeons and hospital/clinic rotations, addressing the provision of clinical supervision (e.g., availability, responsiveness, depth of interaction and knowledge gained) and work environment.

The evaluations will be reviewed by the Program Director and integrated into discussions with the clinical faculty during the Clinical Competence Committee Meetings. Evaluations will be completed at the end of the residents' rotation. The Program Director will strive to create an atmosphere which ensures that residents are comfortable completing evaluations of staff and hospital environment. All evaluations completed by residents on MedHub are automatically marked anonymous by the database.

MedHub Residency Management Suite: MedHub Residency Management System is an online computer program that is required by the University of Louisville Graduate Medical Education Office to assist with tasks such as scheduling, procedure logging, evaluations, monitoring conference attendance, works hours, resident portfolios and general personnel tracking.

Using MedHub, the department requires that all residents complete:

- **Rotation Evaluations**
- **Faculty Evaluations**
- **Program Evaluations**

These comprehensive evaluations completed by the residents are utilized by the Program Evaluation Committee (PEC) to ensure program improvement and in the development of action plans.

To log on to the site, (www.louisville.medhub.com) use your ULink username and password.
Please contact your coordinator for more detailed information on use.

Revised March 2018
Reviewed June 2019

Department of Surgery
University of Louisville School of Medicine

UNIVERSITY OF LOUISVILLE GRADUATE MEDICAL EDUCATION
RESIDENT LEAVE OF ABSENCE POLICY & PROCEDURE

BACKGROUND (INTENT)

As an Accreditation Council for Graduate Medical Education (ACGME) Sponsoring Institution, the University of Louisville's School of Medicine must have a policy for vacation and other leaves of absence, consistent with applicable laws (ACGME Institutional Requirement IV.G.1). **A separate policy document addresses resident vacation.**

DEFINITIONS (AS USED IN THIS POLICY)

Calendar day: all 365 days in a year, including weekends and holidays.

Resident: Any physician in a University of Louisville graduate medical education program recognized by the GME Office, including interns, residents, and fellows. The term "resident" in this document refers to both specialty residents and subspecialty fellows.

It is the responsibility of the resident and Program Director to discuss, in advance, information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations by the relevant certifying board(s).

- The GME sets parameters for paid time off limits; however, this does not guarantee that board eligibility will not be impacted by the duration of paid time off or the duration of paid or unpaid leave.
- Each program must consult the American Boards of each specialty to determine whether the resident remains Board eligible or whether a training extension is necessary. As guidelines vary widely across Boards, each Board must be consulted to ensure compliance.
- If total time away from training (within a given PGY or through the duration of the training program) extends beyond the maximum allowed by the specialty Board, and makeup time is required, the trainee's reappointment dates may be delayed by an amount equal to the makeup time (i.e., delay of promotion to the next PGY level or program completion). In effect, all future training years would become off-cycle by an amount equal to the makeup time. Any required makeup time will be paid and all fringe benefits provided.

1. Program Directors are responsible for assuring that all leaves of absence are granted in accordance with institutional, ACGME, and certifying board eligibility requirements. Should this policy be in conflict with the respective ACGME or Board Certification requirements, those requirements will take precedence.
    a. Any leave of absence must be in compliance with the ACGME Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program.

b. The leave must also be in compliance with the eligibility requirements for certification by the appropriate certifying board for the specialty.

2. Leaves of absence may require additional training time to fulfill ACGME and/or Board Certification requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. Program Directors must inform residents in writing, using the Resident Leave of Absence Request Worksheet, of any make-up time required.

    a. If residents are required to make-up, time missed, that time must be covered by a Resident Agreement, with the resident being paid at the appropriate Resident Level and all fringe benefits provided.

3. The GME Office sets parameters for paid time off limits. A leave of absence may be paid, unpaid or a combination of paid and unpaid. Pay status of the leave does not impact board eligibility nor if a training extension is necessary.
    a. Paid leave time may be taken intermittently following the initial leave event, at the discretion of the Program Director. A separate leave worksheet must be completed for each segment.

TYPES OF LEAVE

Caregiver Leave

1. Definition of Caregiver Leave: leave granted to care for the resident's spouse, child, or parent who has a serious health condition.

2. Eligibility:

    a. Must be taken for the purpose of caring for a spouse, child, or parent

    b. There is no minimum duration of service requirement and eligibility will start on the day the resident is required to report (orientation date or the first day of payroll for the resident).

    c. If the resident is also Resident/Family Leave eligible, Resident/Fellow Family Leave will run concurrently with Caregiver Leave.

3. Salary & Benefits:

    a. 100% of salary for up to six weeks (42 calendar days) is guaranteed only for the first instance of caregiver leave within a program. Subsequent leaves may be partially paid using any combination of eligible available vacation and program director discretionary leave. Once this time is exhausted, the resident may be permitted to take additional time off without pay up to a total of twelve (12) weeks of leave per academic year under Resident/Fellow Family Leave.

    b. Full health and disability insurance continue while the resident is on paid leave for six weeks (42 calendar days). Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck. Residents must check with U of L Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence and make arrangements for continuity of health insurance benefit coverage.

4. Funding: A resident may be paid during the leave by utilizing any unused vacation days (up to 21 calendar days per contract year). Additionally, residency Program Directors may allow up to two additional weeks (14 calendar days) of paid leave per contract year (Program Director's Discretionary Leave). One additional week of GME paid leave may be utilized. By utilizing 21 days of annual vacation leave and granted two weeks of discretionary time by the Program Director, and one week of GME paid leave, the resident can achieve a six-week (42 calendar days) paid leave
    a. If the resident has taken less than one-week of vacation time in the current academic year prior to the beginning of the leave, they will be eligible to take additional vacation days separate from the leave, up to the point where the one-week total of vacation has been taken during the current PGY.
    b. If one-week of vacation has been taken prior to leave, additional vacation time will not be granted.
    c. In the event the resident has taken more than one-week of vacation in the current academic year prior to their leave, the program should contact the GME Office for review and consideration of additional funding.

<u>Educational or Personal Leaves (Program Director Discretionary Leave) (if allowed by the RRC or Board)</u>

1. Definition for Educational or Personal Leaves (Program Director Discretionary Leave): leave granted for educational or personal reasons
2. Eligibility: At the discretion of the Program Director, a maximum of 14 calendar days of educational or personal leave may be granted to the Physician per academic year.
3. Salary & Benefits
    a. If approved by the Program Director, 100% of salary for up to 14 calendar days will be paid.
    b. Full health and disability insurance continue while the resident is on paid leave for up to 14 days.
4. Funding: a resident is paid during the leave at the normal stipend and PGY levels
5. Requests for personal leave of absence for a period longer than 14 calendar days must be approved by the Vice Dean for Graduate Medical Education.
6. Educational and personal leave may vary by program according to departmental guidelines, RRC/ACGME requirements, and/or board certification requirements.

<u>Medical (Sick) Leave, excluding Parental (Maternity/Paternity) Leave</u>

1. Definition: Medical (Sick) Leave shall be defined as any medical condition of the individual resident, including complications of pregnancy up to time of delivery, which necessitates an absence from a resident's training program.
2. Eligibility:
    a. Available to residents with a serious health condition that makes the resident unable to perform essential training functions.

b. There is no minimum duration of service requirement and eligibility will start on the day the resident is required to report (orientation date or the first day of payroll for the resident).

c. An additional period of paid medical leave for any prolonged injury or illness may be requested in writing by the Program Director and Department Chair and submitted for approval by the Vice Dean for Graduate Medical Education.

d. If the resident is also Resident/Family Leave eligible, Resident/Fellow Family Leave will run concurrently with Medical Leave.

3. Salary & Benefits:

   a. 100% of salary for up to 90 days is guaranteed only for the first instance of medical leave within a program. Subsequent leaves may be partially paid using any combination of eligible available vacation and program director discretionary leave. Once this time is exhausted, the resident may be permitted to take additional time off without pay up to a total of twelve (12) weeks of leave per academic year under Resident/Fellow Family Leave.

   b. Full health and disability insurance continue while the resident is on paid leave for 90 days.

   c. After 90 calendar days of total paid medical leave, leave of absence without pay will begin. Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck. Residents must check with U of L Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence, and make arrangements for continuity of health insurance benefit coverage.

   d. The Resident Disability Program begins its coverage 90 calendar days from the date of initial disability. Residents who require more than 90 calendar days for medical leave should apply for disability coverage as soon as they become aware that they will need more than 90 days. Applications for resident disability coverage should be requested from the Graduate Medical Education Office. If disability is denied or the individual requests leave of absence without pay, the University is not responsible for reimbursement while in this status.

4. Funding: A resident may be paid during the leave for a maximum of 90 days by utilizing any unused vacation days (up to 21 calendar days per contract year) and Program Director Discretionary Leave, and GME approved leave. The resident is expected to apply for disability coverage for leave beyond 90 days.

5. Residents on medical leave for more than seven consecutive calendar days must furnish a physician's or medical provider’s statement to the Program Director that he/she cannot work for medical reasons. The resident may be requested to provide additional statements at any time during the leave and upon return must furnish a physician or medical provider's statement that he/she is medically fit to resume residency training.

6. The Program Director must inform the Vice Dean for Graduate Medical Education in writing of any medical leave of more than seven (7) calendar days. This notification must include an explanation and a completed “Request for Leave” worksheet (available from the Graduate Medical Education Office).

7. Any modifications of duty assignment related to a medical condition or returning to duty after illness, will be at the discretion of the Program Director and Department Chair, but must conform to state and federal laws relating to disabilities, if any.

Military Leave*

1. Definition of Military Leave: A resident ordered to uniform service,
2. Eligibility: upon presentment of military orders to his/her program director, a resident must fill out a Resident Leave of Absence Request Worksheet and be placed on military leave.
3. Salary and Benefits: While on military leave, the resident shall receive up to 14 calendar days of paid leave in a federal fiscal year (This is equivalent to the Program Director's Discretionary time). All other military leave shall be unpaid.
    a. However, at the resident's option, the resident may request use of annual leave vacation time in order to remain in pay status. The resident may not be required to use vacation time.
4. While on military leave, the resident is entitled to reemployment without loss of position in the residency/fellowship program.
5. A resident requesting Military Leave should refer to the University of Louisville Policy on Military Leave. (https://louisville.edu/policies/policies-and-procedures/index_policies)

Parental (Maternity/Paternity) Leave

1. Definition of Parental Leave shall be defined as leave following birth to bond with a newborn, new adoption or foster placement of a child, or granting of legal guardianship of a minor child.
2. Eligibility:
    a. Available to birthing and non-birthing parents, adoptive/foster parents, surrogates, and legal guardians.
    b. Must be taken within one year of birth, adoption, foster placement, or granting of legal guardianship of a child.
    c. The birth, adoption, foster placement, or granting of legal guardianship must occur on or after the resident's report (orientation) date or first day on payroll.
    d. There is no minimum duration of service requirement and eligibility will start on the day the resident is required to report (orientation date, or the first day of payroll for the resident).
    e. If the resident is also Resident/Family Leave eligible, Resident/Fellow Family Leave will run concurrently with Parental Leave.
3. Salary & Benefits:
    a. 100% of salary for up to six weeks (42 calendar days), per event. Additional time may be approved by the Program Director and would be paid via a combination of vacation time, Program Director Discretionary Leave, and unpaid leave under the Resident/Family Leave Policy.
    b. Full health and disability insurance continue while the resident is on paid leave for six weeks (42 calendar days). Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck. Residents

must check with U of L Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence and make arrangements for continuity of health insurance benefit coverage.

4. Funding: A resident may be paid during the leave at their current stipend level for 42 calendar days. Residents may request additional leave time beyond 42 days by using approved vacation leave (up to 21 days), Program Director Discretionary Leave (up to 14 days), or unpaid days.
5. Residents requiring additional leave due to complications of pregnancy or delivery should refer to the Medical Leave section. In cases of extended Medical leave (90 days or greater) residents should contact the resident disability insurance carrier to initiate a possible claim, or request an application from the GME Office.

<u>Resident/Fellow Family Leave</u>

1. Definition of Resident/Fellow Family Leave: Similar to the Federal Family and Medical Leave Act (FMLA), the Resident/Fellow Family Leave program allows qualified residents (male or female) to take up to 12 weeks (84 calendar days) of unpaid leave each year with no threat of job loss.
2. Eligibility: Residents who have been enrolled in a training program for one year and have worked 1,250 hours in the 12 months prior to leave are eligible for resident/fellow family leave.
    a. Qualifying events include the birth of a newborn, the adoption of a child or newborn, taking a state-approved foster child into one's home, time off to care for a parent, spouse or child under 18 with a serious health condition, and time off to care for children who are older than 18 if they are unable to care for themselves, because of either mental or physical reasons. It will not, however, allow resident/fellow family leave time for the care of parents-in-law, or other relatives.
    b. Resident/fellow family leave does not cover time off for, among other things: the care of a parent-in-law; death in the family; cold, flu, earaches, upset stomach, minor ulcers, headaches other than migraine, routine dental and orthodontia problems, periodontal disease or cosmetic treatments.
3. A resident may take intermittent leave or work on a reduced leave schedule where he/she works fewer hours a day or week than normally scheduled. The schedule should be designed to cause the minimum amount of disruption to the training program as is possible.
4. Resident/fellow family leave cannot exceed 12 weeks (84 calendar days), but GME may also provide for situations that go beyond the 12 weeks (84 calendar days). Additional information about extended leave is available from the Graduate Medical Education Office. Any time that exceeds available vacation/PD discretionary time will be unpaid time.
5. **Exclusion:** If both spouses are enrolled in U of L training programs, they are entitled to only 12 weeks of graduate medical student leave combined for the birth and care of a newborn or the placement of a child in their home. Otherwise, they are entitled to 12 weeks each.

PROCEDURE

1. For any Leave of Absence, a **Resident Leave of Absence Request Worksheet or a Parental Leave of Absence Worksheet** (available from the Graduate Medical Education Office) must be completed and signed by the Program Director and resident (if available) and approved by the Vice Dean for Graduate Medical Education.
    a. Program Directors must inform residents in writing, using the Resident Leave of Absence Request Worksheet, of any make-up time required. If residents are required to make-up time missed, that time must be covered by a Resident Agreement,
2. After approval by the Vice Dean of GME, the Leave of Absence will be recorded in the institutional Residency Management System, MedHub, by the Administrator of the Program. The Leave of Absence will become part of the resident's official training record. MedHub allows for documentation of four types of resident absences: Vacations, Sick Days, Away Conferences, and Leaves of Absences. See Guidelines for MedHub Use document for more information.

REFERENCES & RELATED POLICIES

ACGME Institutional Requirements, Effective July 1,

2022, section IV.H. Resident Vacation Policy &

Procedure

APPROVALS

Approval of this policy will replace all prior leave policies. Approved by GMEC: April 1, 2019.
Revised January 20, 2021 to allow a medical provider statement under Medical Leave. Revised February 17, 2021 to clarify PD Discretionary Leave limitations.
Revised and GMEC approval March 24, 2022 effective July 1, 2022. Revision and GMEC approval May 15, 2023 effective July 1,
2023.

Revised: September 2018
Reviewed June 2019
Revised: August 2022
Revised: May 2023

UOFL GRADUATE MEDICAL EDUCATION LEAVE OF ABSENCE REQUEST WORKSHEET

NAME:_____PROGRAM:_____PG level_____

A. Number of calendar days requested (Sunday through Saturday) a.

B. REASON (Circle one) CAREGIVER EDUCATIONAL/PERSONAL MEDICAL MILITARY

	Anticipated	Actual
Start of Leave:	_____	_____
Last Day of Leave	_____	_____

C. Unused Vacation Days (maximum 21 calendar days per year) [1] b._____
Indicate # days advanced, from other years, if any____, included on line B.
Exact Dates_____

D. Program Director's discretionary personal/educational paid days
(maximum 14 calendar days per year) [2] c.
Exact Dates_____

E. Vice Dean for Graduate Medical Education
Additional Paid Days requested from GME office[3] (requires signature of Vice Dean for Graduate Medical Education)
Exact Dates_____ d._____

F. Number of Paid Days (add lines b + c + d) = e.
Exact dates: _____

G. Number of Unpaid Days (subtract line e from a) = f._____
Exact dates:_____

H. Amount of Time to be Made-up to meet Board Certification _____days.
Requirements[4]:
Dates:_____

_____ _____
Resident Signature Program Director/Chair Signature Date

_____ _____
Date Vice Dean for Graduate Medical Education Date

[1] Per the ACGME regulation providing residents/fellows with a minimum of one week of paid time off reserved for use outside of the first six weeks (42 calendar days) of the first approved medical, parental, or caregiver leave(s) of absence taken. Any leave that utilizes only vacation time should not be reported as a leave of absence.

[2] At the discretion of the Department Chair and Program Director, two weeks (14 days) of additional paid leave may be granted (Resident Leave of Absence Policy, Types of Leave, Program Director Discretionary Time).

[3] Additional paid leave may be requested by the Program Director and Departmental Chair and approved by the Vice Dean for Graduate Medical Education (Resident Leave of Absence Policy, Types of Leave: Medical).

[4] Resident Leave of Absence Policy item #2: Leaves of absence may require additional training time to fulfill ACGME and/or Board Certification requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. Program Directors must inform residents in writing, via this worksheet, of any make-up time required.

Worksheet Rev. 12/04/01; 05/20/2004/; 4/20/2005; 04/2007, 10/2010, 11/2010, 7/6/18; 4/1/2019; 3/11/2022, 5/9/2023

UOFL GRADUATE MEDICAL EDUCATION
PARENTAL LEAVE REQUEST
WORKSHEET

NAME:_____ **PROGRAM:**_____ **PG level**_____

A. Total number of calendar days requested (Sunday through Saturday) _____

	Anticipated	**Actual**
Start of Leave	_____	_____
Last day of leave	_____	_____

Number of Paid Days _____

Exact dates:_____

Number of Unpaid Days _____

Exact dates:_____

Amount of Time to be Made-up to meet Board Certification Requirements (if applicable) [1]

Number of days _____

Proposed Dates: _____

_____ _____
Resident Signature Program Director/Chair Signature Date

_____ _____
Date Vice Dean for Graduate Medical Education Date

[1] Leaves of absence may require additional training time to fulfill ACGME and/or Board Certification requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. Program Directors must inform residents in writing, via this worksheet, of any make-up time required.

Department of Surgery
University of Louisville School of Medicine

Resident Travel Policy

INSTRUCTIONS FOR RESIDENT TRAVEL

Please follow instructions below to ensure processing of reimbursements are completed in a timely manner with minimal issues.

Scientific Meetings:
Time off is readily granted when a resident is presenting a paper at a scientific meeting, but also needs to be approved. Please refer to the benefits and policies links below for additional details.

The basis for travel approval will be as follows:

- 2 night hotel stay (increased stay will be at the discretion of the Division Chief)
- Oral Presentations only (poster presentations may be approved on an individual basis)
- Registration **MUST** be paid through the Department
- Flight and hotel will be paid through the Department
- International travel will not be approved

1. There is a new University policy in place wherein you must use the University Travel Card to pay for all travel expenses with the except of personal meals. Please notify Lois **as soon as you submit a paper/poster**. There are several people who will need to approve the travel so the sooner you start the better chance of getting it approved in time for travel.

2. The resident MUST complete a Request for Resident Travel Approval Form and obtain the signatures from the **Faculty Sponsor and Executive Director** as soon as the paper is accepted for presentation. Once the project is accepted, travel arrangements can only be made if this form is on file. The completed form must be returned to Lois Inlow before any travel or registration can be paid/booked.

3. Lois will request registration information from the traveler (online registration link, login, and password if applicable) to pay for the registration through the department Accounting Office.

4. Once registration is complete, Lois will send the traveler notification and instructions for choosing a preferred flight/transportation as well as hotel preferences. Once the flight and hotel information has been chosen, she will begin booking through Anthony Travel and send all confirmations to the traveler.

5. Travelers must submit original receipts when possible. If an original receipt is not offered, an electronic receipt can be submitted in its place. All receipts must be submitted to Lois Inlow upon return for reimbursement. There will not be a per diem for meals; therefore, the traveler is required to submit original receipts for any food purchases acquired.

6. Once all receipts have been submitted, Lois will enter and process the reimbursement through the PeopleSoft Financials System. The traveler will be sent an email containing a link. The traveler must login and approve the expenses before the reimbursement can be processed. This must be done within 10 business days or the reimbursement will be deleted from the system. Once all signatures are obtained, payment will be sent to the bank account on file with payroll for the traveler.

7. Lois will submit a request for the traveler to apply for an UofL Travel Card. Once you have completed the necessary "quiz" you will be sent an application for the travel card. Please forward the application to Lois and she will obtain the necessary signatures and submit the application for you.

8. When you are not traveling, please return your UofL Travel Card to Lois. You will check the card in and out with Lois for travel as necessary.

9. If you receive any emails from the Controller's Office regarding processing of reimbursements, please forward those emails directly to Lois.

10. Personal credit cards **CANNOT** be used for travel and any expenses on your personal credit card other than meals will **NOT** be reimbursed.

Any and all travel and reimbursement questions should be directed to Lois Inlow at 852-8017 or lois.inlow@louisville.edu.

Reviewed August 2021
Reviewed April 2022

University of Louisville Surgery Department Travel Pre-Authorization Request

(This form must be completed and signatures gathered prior to making travel arrangements for all faculty, staff, and personnel)

Name: _____ Employee ID: _____ Date Completed: _____

City/State Destination: _____

Est. Departure Date: _____ Est. Return Date: __ Early Bird Registration Date: _____

Purpose of Trip (Check one): **Please include a copy of event materials that include dates*

Attend a conference as a presenter or speaker
Attend a conference as a workshop or meeting attendee
Attend meetings related to Professional Licensure
Other, please specify: _____

Name of conference/event: _____

Justification: _____

Method of Travel: Air Personal Vehicle Rental Vehicle

Below, list an estimate of expenses for the trip:

Transportation		
	Airfare: *(Round trip)*	$_____
	Vehicle: *(# of miles x current rate)*	$_____
Lodging		
	Total *(# of nights x nightly rate):*	$_____
Meal Expenses		
	All meals *(breakfast, lunch, dinner)*	$_____
Other Costs *(Please list)*	Registration Fee	$_____
		$_____
	TOTAL FUNDING REQUESTED	$ **0.00**

*****To be completed by the Division Leader or Authorized User/Owner of Speed Type(s)*****

APPROVED FUNDING

	Source	Amount
Speedtype#1	_____	_____
Speedtype#2	_____	_____
Total		$ 0.00

Authorized User/Owner Approval
**(If different than Division Leader)*

Signature: _____

Employee Printed Name	Employee Signature	Date Signed
Faculty Sponsoring Travel Printed Name	Faculty Sponsoring Travel Signature	Date Signed
Executive Director Printed Name	Executive Director Signature	Date Signed

Authorized User/Owner may not necessarily be the division leader (e.g. Grants/Clinical Trials, Individual RIFS, etc.)

Department of Surgery
University of Louisville School of Medicine

American Board of Surgery General Requirements

All applicants must complete **48 weeks of full-time clinical activity** in each of the five years of residency, regardless of the amount of operative experience obtained. The remaining four weeks of the year are considered non-clinical time that may be used for any purpose, such as vacation, conferences, interviews, etc. To provide some flexibility, the 48 weeks **may be averaged** over the first three years of residency, for a total of 144 weeks required in the first three years, and over the last two years of residency, for a total of 96 weeks required in the last two years. **All time away from clinical activity must be accounted for on the application form**.

Leave During a Standard Five-Year Residency

- For documented medical conditions that directly affect the individual (i.e., **not** family leave) residents may take an additional two weeks off during the first three years of residency, for a total of 142 weeks required in the first three years of training, and an additional two weeks off during the last two years of residency, for a total of 94 weeks required in the last two years of training. **No approval is needed for this option if taken as outlined.**
- The ABS will permit, **with advanced approval**, applicants to **extend their final year of training through the end of August** and still take that year's QE. Upon completion of training, a letter of attestation will be required from the program director stating that the individual has met ABS requirements. The attestation letter must be received before QE results will be made available and selection of a CE site permitted. In addition, prior approval from the RC-Surgery will be needed for the increase in complement.

Six-Year Option

- If permitted by the residency program, the five clinical years of residency training may be completed over six academic years. All training must be completed at a single program with advance approval from the ABS. In this option, an average of 48 weeks of full-time training is required in each clinical year as explained above. The first 12 months of clinical training would be counted as PGY-1, the second 12 months as PGY-2, and so forth. No block of clinical training may be shorter than one month (four weeks).
- Under this option, a resident may take up to 12 months off during the six-year training period. The resident would first work with his or her program to determine an appropriate leave period or schedule. The program would then request approval for this plan from the ABS. **Requests must be mailed or faxed on official letterhead to the ABS office (no e-mails).**
- Use of the six-year option is solely at the program's discretion, and contingent on advance approval from the ABS on a case-by-case basis. All requests must be made by the Program Director **(not the resident).** The option may be used for any purpose approved by the residency program, including but not limited to, family issues, visa issues, medical problems, maternity leave, external commitments, volunteerism, pursuit of outside interests, educational opportunities, etc.

Please visit the American Board of Surgery Website for more information.
http://www.absurgery.org/default.jsp?policygsleave

Approval Date: February 12, 2014
Revised: March 2018
Reviewed June 2019

American Board of Surgery Training Requirements

Training Requirements

- Below is a general overview of the training requirements for general surgery certification. For complete details, please refer to the ABS Booklet of Information - Surgery (pdf).
- Applicants who will not complete residency training by June 30 of their chief year must notify the ABS. All training must be completed by end of August to be eligible for that year's General Surgery Qualifying Exam.

Program and Time Requirements

- A minimum of 5 years of progressive residency education satisfactorily completed in a general surgery program accredited by the ACGME or RCPSC. (See also Osteopathic Trainees Policy)
- The 60 months of training at no more than 3 residency programs. If credit is granted for prior foreign training, it will count as one program. See also Limit on Number of Programs and Credit for Foreign Medical Education.
- At least 48 weeks of full-time clinical activity in each residency year, regardless of the amount of operative experience obtained.
  The 48 weeks may be averaged over the first 3 years of residency, for a total of 144 weeks required, and over the last 2 years, for a total of 96 weeks required. See our Leave Policy for further details; all time away from training must be accounted for on application form.
- A categorical PGY-3 year completed in an accredited general surgery residency program. Note that completing three years at PGY-1 and -2 levels does not permit promotion to PGY-4; a categorical PGY-3 year must be completed and verified by the ABS' resident roster. The only exception is in cases where 3 years' credit has been granted for prior foreign graduate training.
- At least 54 months of clinical surgical experience with increasing levels of responsibility over the 5 years, with no fewer than 42 months devoted to the content areas of general surgery.
- No more than 6 months assigned to non-clinical or non-surgical disciplines during all junior years (PGY 1-3).
- No more than 12 months allocated to any one surgical specialty other than general surgery during all junior years (PGY 1-3).
- The final two residency years (PGY 4-5) in the same program.

Specific Requirements

- Completion of the following programs: Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support® (ATLS®) and Fundamentals of Laparoscopic Surgery™ (FLS). Applicants are not required to be currently certified in these programs; they must only provide documentation of past certification.
- Completion of the ABS Flexible Endoscopy Curriculum, effective with applicants graduating residency in the 2017-2018 academic year. The curriculum contains several levels; the final level includes successful completion of the Fundamentals of Endoscopic Surgery™ (FES) program. Documentation of current or past FES certification will be required for application approval.
- At least 6 operative and 6 clinical performance assessments conducted by the program director or other faculty members while in residency. The ABS will not collect these forms, but will ask the program director to attest they have been completed.

Chief Resident Year

- Acting in the capacity of chief resident in general surgery for a minimum of 48 weeks over the PGY-5 and PGY-4 years, per the definition below. Note that the RC-Surgery requires prior approval for chief rotations in the PGY-4 year.
  The term "chief resident" indicates that a resident has assumed ultimate clinical responsibility for patient care under the supervision of the teaching staff and is the most senior resident involved with the direct care of the patient.
- The entire chief resident experience in either the content areas of general surgery or (noncardiac) thoracic surgery, with no more than 4 months devoted to any one area. All rotations at the PGY-4 and -5 levels should involve substantive major operative experience and independent decision-making.

Operative Experience

The following operative requirements are effective with applicants graduating residency in the 2017-2018 academic year. The previous operative case numbers are noted in parenthesis — applicants who graduated before the 2017-2018 year will be required to meet those numbers.

- At least 850 (previously 750) operative procedures as surgeon over 5 years, with at least 200(previously 150) in the chief resident year. Teaching assistant cases may count toward the 850 total; however, these cases may not count toward the 200 chief year cases.
- At least 40 (previously 25) cases in surgical critical care, with at least one in each of the seven categories: ventilator management; bleeding (non-trauma); hemodynamic instability; organ dysfunction/failure; dysrhythmias; invasive line management and monitoring; and parenteral/enteral nutrition.
- At least 25 cases as teaching assistant by the completion of residency.
- At least 250 operations by the beginning of PGY-3 year, effective with applicants who began residency in July 2014. The 250 cases can include procedures performed as operating surgeon or first assistant. Of the 250, at least 200 must be either in the defined categories, endoscopies, or e-codes (see below for info on e-codes). Up to 50 non-defined, cases may be applied to this requirement.
  E-Codes: General surgery residents can use e-codes to receive ACGME case log credit for vascular surgical procedures. E-codes allow more than one resident to take credit for an arterial exposure and repair. The resident who accomplishes the exposure should add an "E" to the case ID for the system to allow credit for a second procedure on the same patient. The relevant CPT codes to use are: 35201 (Repair blood vessel, direct; neck); 35206 (upper extremity); 35216 (intra-thoracic without bypass); 35221 (intra-abdominal), and 35226 (lower extremity). Four categories are available under Trauma for residents to enter arterial exposures.

For specific inquiries regarding ABS training requirements, please send an email to the ABS coordinator.

Department of Surgery
University of Louisville School of Medicine

Application for Examination by the American Board of Surgery

The American Board of Surgery (ABS) is updated on your progress through the residency by various reports submitted by the program on a yearly basis. In March of your chief year, the ABS will send instructions to your Residency Administrator on how to submit your application and operative case log online. Standards exist nationally and locally for the contents of your operative log. Maintaining your records is mandatory.

Candidates will communicate with the Board in order to complete their education requirements *no later than* **early April***,* if they wish to be considered for the Part 1 examination (Qualifying Examination) to be given in **July** of that year. The qualifying exam will be given at several testing centers and are taken online at these centers. Application forms must be reviewed and approved by the Program Director and Department Chair before submission.

The acceptability of a candidate does not depend solely upon the completion of an approved program of education, but also upon information available to the Board regarding a resident's professional maturity, surgical judgment, technical competence, and ethical standing. A candidate who has submitted an Application for Examination will be notified by the Board administrator as to his/her admissibility for examination.

The application for the American Board of Surgery (ABS) is online www.absurgery.org. Logon information will be e-mailed to the Program Administrator for dissemination.

Medical License is NOT required for the written Boards if you apply within 6 months of completing residency.

You MUST have a full license to sit for the Oral Boards.

CASE LOG for ABS Application:

Defined Category Targets set by the Department of Surgery:

- SBBN +65
- Breast +40
- HN +25
- ALTR 180
- AB 250
- Liver +5
- Pancreas +5
- Vascular 75
- Endo +25
- Operative Trauma 30-40
- Non-Op Trauma 80-100
  (20 as Team Leader)
- Thoracic +25
- Pediatrics +75
- Plastics +10
- Surgical Critical Care +40
- Lap-Basic 100
- Endoscopic +100
  Upper Endoscopy 50
  Colonoscopy 50
- Lap-Complex 70
- Total Major 1300
- Total Chief 220
- Total Teaching 100-120

40 Critical Care (managing 2 of 7 categories for each - see index below)

Critical Care Index:

1. Ventilator Management
2. Bleeding (>3units)
3. Hemodynamic Instability
4. Organ Dysfunction/Failure
5. Drhythmias
6. Invasive Line Management
7. Nutrition

Intern Survival Guide 2023

General Advice:

• **Always call for help if you feel in over your head**. Patient care and education are the main goals. Your seniors/midlevel residents can't help you with either of those if we don't know what's going on.
• There are two types of interns: those who **write things down** and those who mess things up.
• Read about the operation/procedure you are about to do before you do it
• Be nice to the nurses, PCAs, scrub techs, RTs, pharmacists, and basically just everyone. This should go without being said. They have been doing this longer than you have (typically) and know a lot. Treat them with respect. They will save your butt several times. That being said, **trust but verify**. We are all part of the team with a common goal – providing the best patient care possible. If you are having a problem with a certain ancillary staff member, do not yell/scream/throw things. Be respectful and address it with one of your superiors if needed.
• **Don't lie**. Just don't. If you don't know the answer to a question, just say "I don't know, but I will find out." – and then find out the answer. It is not a problem to not know every single thing; the problem is if there is a pattern that emerges of repeatedly not knowing the answers and failing to address the issue.
• If someone pages you two or more times about the same issue on a patient that hasn't been addressed, it is usually a warning sign. Be wary that the patient may be in worse shape than you realize.
• A good rule of thumb is to try two moves, then phone up the ladder. I.e. improving pain control, and then bolusing a tachycardic patient who remains tachycardic afterwards.
• Keep your team in the loop.
• There are several broad goals that are important for intern year:

1. Figure out what a sick patient looks like
2. Learn how to "load the boat"
3. Bedside procedures
4. Communicate like a doctor
5. Gathering accurate and complete information

• You are a doctor. Congratulations. Be proud. You have worked hard to get here, but the hard work is just beginning. You are going to have really crappy days. It is important to remember why you are here and why you are doing this. Develop a routine (as much as possible) and don't lose touch with whatever support system you have at home. **If you are having problems, talk to someone** – your midlevel, your chief, your co-residents. We are a family and have to watch out for each other.

    • If you feel "stuck" or can't figure out a solution to a problem you're having, talk to someone because almost certainly someone else has been through the same issue and we probably will have a way to work through it

• You will have medical students to teach. You are their closest contact and they will look up to you. It is normal to feel like you barely know more than they do. Let them help you with things. However, they are not your slaves. You were very recently in their shoes, so try not to lose sight of what you wish your interns/residents would have taught you as a medical student.
• Several services have nurse practitioners that function in different capacities. They are very helpful when they are around; however, they do not answer to you and you are not in charge of them, so please treat them with the respect they deserve as important team members. Much like the floor nurses, they have the ability to save your butt or throw you under the bus; don't be a jerk.
• Some services PM round as a team (run through the list, see sick patients together), on others you should do your own PM rounds to ensure everything is tidied up before checking out.
• For the first few months, you should be asking your upper level before ordering blood transfusions. Always recommend it in your plan and your reasoning if that's what you think the patient needs.
• In an emergency, remember to **take your own pulse first**. You can't help anyone if you can't think straight.

• Make sure you are able to access all hospital EMRs and remotely as well. Multitasking by preop-ing a patient at one hospital while filling out post op orders on another patient at another hospital will save you invaluable time.
• To access the EMR from home/other hospitals
ULH/Jewish: myapps.ulh.org
Norton: Myresources.nortonhealthcare.org or 502a.org
You will need to set up/download the Duo Mobile apps to verify your identity before it will let you log on: https://nortonhealthcare.com/pages/remote-access-setup.aspx

HELPFUL INFORMATION:
• Replacing electrolytes:
Potassium (K) 10meq=0.1. 40mEq
- Oral KCl can be absorbed q4h; it makes patients nauseated. Alternatively you can give up to 40mEq KCl IV (4 runs) and then recheck/replace as needed. Potassium burns.You can include lidocaine (per pharmacy) at Jewish only. Be careful replacing K in burns and renal failure patients.
- Goal is 4.0.

Magnesium (Mg) = magnesium sulfate or magnesium oxide. 1.5-1.8 and taking PO = mag ox 800mg
- <1.5 or not taking PO = mag sulfate 1mg or 2mg. Recheck/replace as needed.
- Goal is 2.0.

Phosphorus = sodium phos, potassium phos, or PhosNAK.
- Give Sodium phos if Na<140, typically 15mmole phos 2.5-2.9, 30mmol 2.0-2.5 recheck/replace as needed.
- Give Potassium phos if K <3.5, 15mmol phos 2.5-2.9, 30mmol <2.5 recheck/replace as needed.
- Goal is 3.0.

Calcium – remember to account for hypoalubuminemia prior to replacing.

Hyperkalemia – recheck BMP. Most common cause of hyperkalemia is a hemolyzed sample. If still high, 1g calcium gluconate first (stabilizes cardiac membranes), 1amp D50, 10u insulin (IV or subQ, it doesn't matter) then recheck K after 1 hour. Get EKG. If patient is in renal failure, contact the renal service because they may just need dialysis. Renal team should be managing their electrolytes, but clarify who is doing what so you don't overdose/underdose the patient.

• General daily stuff:
o Look at the drains and the wounds every single day
o Make sure your NG tube is functioning every single day
o If a nurse calls you twice with concerns about the same patient, go see the patient
o Every day you should be looking for ways to advance your patients care. As their diet advances postop, you should be adding PO pain meds, decreasing IV pain meds, d/c'ing IV fluids. PT/OT consults on POD1. Assess the need for lines and tubes. Beginning thinking about rehab consults in early postop period. Assess home meds and when/if they should be restarted on POD1.
o Incentive spirometry and pulmonary toilet → every patient should have an IS at bedside and know how to use it
o Talk to/consult social workers and case management on disposition plans. Frequently patient require insurance precertification (precerts) prior to being approved for rehab/nursing homes/home health. It is best to get this process started early.
o Always check to see if DVT prophylaxis is prescribed/needs to be added. At minimum SCD/TED hose. Typically Lovenox (30mg BID for trauma patients, 40mg daily for neurosurg patients and

everyone else as long as they aren't actively bleeding) or subQ heparin (5000u q8h). No lovenox for patients in renal failure/Cr >1.2.
o Dressings should be taken down on POD2 unless otherwise instructed.

• Overnight advice:
o Never advance a diet; never remove a foley
o Never give sleep aids; Never give 2mg IV Dilaudid; Never give 2mg Ativan. Melatonin is usually safe to give most people if you need something.
o Don't give Benadryl or Phenergan to people over the age of 60
o If you get called for "anxiety" or "confusion," go see the patient. Often "anxiety" is actually caused by hypoxia.
o Always perform a "**Night of Surgery**" check on every day of surgery patient and document it. Take note of vitals, UOP, abdominal exam, and pain control. For these as well as other visits to patients, **if you don't document it, it didn't happen**. Get in this habit for every time you see a patient. It also certainly helps those cross covering who have never seen a particular patient before and have no idea what their exam is like.
o Additionally, be careful when cutting and pasting. Make sure it is accurate before finalizing it.
o If you are unsure about something, call someone higher up than you.

• Procedures:
o During bedside procedures, (central lines, art lines, chest tubes, etc) go over the steps in your head prior to setting up. Always have a back-up plan. Even after you get "checked off," you should not be doing these procedures alone without a nurse or other assistant in the room to help if needed.

o **Central lines**:
▪ If at Norton, ensure the attending on call has been contacted by the RN and approved the line
▪ Ask for coags, ultrasound, central line kit and ask RN to call when it is all collected and coags resulted. Attendings vary on placing lines in patients with underlying coagulopathies. Some will say place a groin line and some will say don't place a line. When in doubt, ask your chief or attending before placing it. You don't want to be put in a position holding pressure on a line you couldn't get for hours because the patient's INR is 5 and their platelet count is 10.
▪ At Norton and Jewish, RN gets consent for you. At University, get your own consent.
▪ Regardless, talk to your patient or the patient's power of attorney about what you are going to do, risks/benefits, etc. It is INFORMED consent, so inform accordingly.
▪ Be smart about site placement. No subclavians unless instructed. Usually IJ unless coags abnormal. If emergent, femoral.
    • Subclavians need to be preserved in renal failure patients because if they go down, it severely impacts your ability to create an AV fistula for long term dialysis access.
    • When possible, go to the University ICU when your second years are doing lines in order to learn how to place subclavian lines (preferred in trauma patients).
▪ CXR after IJ/subclavian to **confirm placement** and **check for a pneumothorax**. This needs to be emphasized—pneumothorax is rare but does happen. Many residents before and many residents after you will drop lungs. Make sure the patient knows this risk.
▪ If you stick an artery, remove your needle and hold pressure.
▪ Never attempt a central line on the opposite neck/chest until you have a confirmatory chest X-ray showing that you did not cause a pneumothorax (AKA don't try on the right and then immediately try on the left). Worst case scenario is that you drop both lungs without knowing it and then the patient is in really bad (dying) shape.
▪ Always know where your wire is/have hold of it. Do not leave a wire in a patient. If the wire is left for whatever reason in a patient, call the chief/attending immediately.

▪ **Types of lines**: central lines (7F, triple lumen, basic central line); Shiley (12F, for dialysis access/plasmapheresis, sometimes double lumen and sometimes double lumen with a "pigtail"); Niagara (13.5F, for dialysis access. Have someone who has placed on before help you the first time because the catheter set up is a little different from Shiley/central lines); Cordis (7-9F, used in trauma for quick access, the dilator comes inside the sheath so have someone who has placed on before help you your first few times; this is the catheter to use for Swan-Ganz lines too)

o **Chest tubes**:
▪ If at Norton, call attending prior to placement. At ULH, call wedge (PGY3).
▪ Check coags if able.
▪ Need: 28 French (usually) chest tube, atrium, suction tubing, chest tube kit, suture, lidocaine and needles, prep, vaseline gauze, 4x4, foam tape
▪ In a controlled situation, chest tube insertion should take 15-30 minutes. In a code/room 9 situation, it should take 30-60 seconds.

o ***Document, document, document. If you don't document it, it didn't happen.***

• Initial workup of basic things:
o When getting calls on acute issues, go see the patient.
o If during the day, see the patient and contact someone higher up with a plan.
o If at night, see the patient, document your findings/plan in the chart, contact higher up if anything abnormal/concerning/you aren't sure what to do.

o **Tachycardia**
▪ Common causes: hypovolemia, sepsis, anastomotic leak, pulmonary embolus, pain, lack of home medications (especially beta blockers)
▪ First questions to ask RN when called for tachycardia: baseline HR, BP, O2 sats, UOP
    ▪ Low UOP? Ask if they have a foley → is it flushable? How much on bladder scan? You don't want to bolus someone who just has urinary retention, as it makes patients very uncomfortable.
        ▪ If low on bladder scan →Try fluid bolus if hypovolemia and reassess (be careful in renal failure, CHF, COPD)
    ▪ Recent surgery with anastomosis? possible leak →abdominal exam
        • Get flat/upright abdominal films AKA acute abdominal series
    ▪ Shortness of breath/concern for PE → ABG, CXR, pulse ox
        ▪ TALK TO SOMEONE FIRST →but may need lower extremity duplex, CT PE protocol, heparin gtt
    ▪ Cardiac history → EKG, troponins, BMP/Mag/Phos
    ▪ New onset A fib in a patient with a recent bowel resection → Think anastomotic leak.
        ▪ Afib is very common after thoracic surgery. Beta blockers can often put the patient back in
        sinus rhythm. However, check the vitals prior to doing this. Usually, metoprolol 5-10 mg Q5 min x 1 or 2 doses can correct this. If this does not work, notify your upper level. Also, the thoracic staff usually wants to be notified about this.
    ▪ If you are ordering an ABG on a patient on the floor, you should also be alerting your wedge/chief and have possible ICU transfer in the back of your mind.
        ▪ An ABG is a fantastic lab test that gives you lots of information. You should never feel bad for getting an ABG in a patient that is not doing well.
o **Dyspnea**
▪ Common causes: hypoxia, PE, MI, fluid overload, pain control, anxiety
▪ When RN calls: note vitals, O2 requirement now and at baseline, PMH (COPD, CHF), fluid

balance (fluid overloaded?)
▪ Hypoxia → Check O2 sats, ABG, CXR. May need nasal cannula, non-rebreather, intubation (be wary of bipap).
- Oxygen delivery stats:
  - Room air 21%
  - Nasal cannula 24-44%
    - 1-2L = 24-38%
    - 3-4L = 30-35%
    - 5-6L = 38-44%
  - Face mask 35-65%
    - 8-12L
  - Nonrebreather (facemask with bag) 60-100%
    - 6-15L
    - Consider upgrading status to ICU
  - Venturi mask (set O2 rate) 60-100%
    - Consider upgrading status to ICU
  - Hi-Flow nasal cannula
    - Up to 35L, up to 60%
  - CPAP/BiPAP – common home regimen for OSA

▪ PE? → O2 sats, ABG, CXR. → may need duplex low extremities, CT PE protocol, heparin drip.
- Call your wedge/upper level before ordering heparin drip or CT PE.

▪ Fluid overload? BNP, lytes, UOP, fluid balance.
- May need lasix (check first). Check what IV fluids are running at.

o **Confusion**
▪ Common causes: sun-downing, hypoxia, sepsis, EtOH withdrawal
▪ HYPOXIA until proven otherwise
▪ When RN calls: vitals, UOP, home meds, PMH (dementia)
▪ Sepsis? Cultures (UA, Blood, CXR), CBC. May need antibiotics (check first)
▪ Hypoxia? O2 sats, CXR, ABG. May need nasal cannula, non-rebreather, intubation.
▪ Sun-downing? Supportive care, minimize narcotics and sedatives, lights off during night and on during day. Make sure they have their home hearing aids, glasses, family support at bedside if available.
▪ EtOH withdrawal? EtOH history, tachycardia, hypertension, new onset anxiety.
- Call upper level. May need CIWA protocol (ativan, etc.) and transfer to ICU.

o **Hypotension**
▪ Common causes: hypovolemia, hemorrhage, sepsis, MI
▪ Check a manual BP. If patient has a vascular/cardiac history, check BP in multiple extremities.
▪ Get a CXR. You don't want to miss a tension pneumo.
▪ Call someone above you, may need ICU transfer, **no pressors without someone higher up knowing** (usually levophed first), may need central line and arterial line
▪ Ask RN/look in chart: recheck BP first, then note BP, HR, UOP, PMH
▪ Low UOP? Try fluid bolus and reassess (be careful in renal failure, CHF, COPD)
▪ Recent surgery/possible hemorrhage? CBC, type and cross, fluid bolus, call someone!
▪ Sepsis/anastomotic leak? Abdominal exam, fluid bolus, CBC/ABG (for base deficit)
▪ Cardiac history? EKG, troponins, electrolytes
▪ If a patient is receiving pressors, they should be going through a central line. Prolonged pressors through peripheral IVs can result in gangrenous extremities requiring amputations, so if they need pressors, think about dropping a central line or getting a PICC.

o **Indications for dialysis**: AEIOU. Acidosis, electrolyte imbalance, intoxication, overload (fluid), uremia.

Trauma Rotation

• Service setup:
  - o Two teams (trauma I and 2) that alternate call every other day
  - o An elective team takes calls on Tuesday and Friday nights
  - o Team consists of: interns, PGY2 (ICU), PGY3=wedge (ER/floor), chief, fellow, NPs (Trauma 1 – Karina Pentecost and Diana Blevins, Trauma 2 – Kim Broughton-Miller and Michelle Frisbie)
  - o Trauma I attendings: Franklin, Smith
  - o Trauma II attendings: Harbrecht
  - o Attendings that switch: Coleman, Bozeman, Miller, Nash, Benns, Pera, Marshall
  - o Where you spend your time: trauma workroom on the second floor beside the ORs
  - o Clinics are every Tuesday (even team one week, odd week the next) on 7th floor of HCOC building (Panera building). You are expected to be there after morning rounds.
  - o ORs: 2nd floor
  - o *Pick up your level one pager in the Trauma Institute on the basement floor by the cafeteria.
  - o EMR: Cerner

• You are the first call for floor problems. There is a 2nd year that runs the ICU. Your 3rd year will be running the ER/OR. The 5th year oversees everything. People that are admitted from the ER will come to the floor. Your 3rd year (wedge) will try to tell you about them, but this is not always possible in a timely manner, especially during the busy trauma season. Be patient. Look in the chart.
  - • Review all of the final reads of the imaging for new trauma admits. Sometimes final reads change from initial reads. At the minimum, review imaging the morning after admission and the day of discharge to ensure all issues have been resolved.
  - • Make sure all of the consulting services that have been called have actually seen the patient.

• Keep a list of the things in your patients: Foleys, trachs, chest tubes, IVs, central lines, PICC lines, etc and how long each of them have been there. This will make your life easier when knowing when they need to be changed.

• When downsizing a trach, have a wedge/second year/NP/chief help you the first few times

• **Come to every Level 1**. This is very important for learning how to apply the ABCs you have learned about to real life. Take initiative. This is a good time to see how code/trauma lines/tubes/intubations are done.

• Learn by watching then ask the wedge to take you through it **in less critical patients**

• Go to the OR any time you can. Take initiative to know when/what cases are going on. This is hard to do sometimes with all of the floor things that need to be done. Once you get all of your floor tasks done, you should be reading/operating/learning how to do procedures

• Burn debridements are family affairs – the whole team is expected to be there.

• At night you will cover all the floor patients for the other surgical services. Cross-covering is hard, no doubt. You will be essentially responsible for a bunch of patients who have had procedures you are not yet familiar with and that you do not know very much about. The trauma interns are fortunate that they have several resources in house – the 2nd, 3rd, and 5th years. Use these resources when you have questions or concerns.

• Complete the night of surgery visits on a timely manner. This should include wound check, urine output, vitals, pain control, diet (or NPO status), if IV fluids are running (or not supposed to be), having IS at bedside, and seeing if the nursing staff has any concerns.

• A good rule of thumb is to not change too much for the services you are cross-covering unless absolutely necessary. This includes downgrading their status (TCU to med/surg), removing Foleys/NG tubes, advancing diets, etc.

▪ You will get these phone calls. Do not get bullied into doing things you aren't sure need to be done in the middle of the night.

• Go see patients you get called about
• Don't give benzos on the floor without asking first
• Watch out for older patients. They can get sick very fast without much warning. They have little reserve.
    • Medicines to be careful about giving: Benadryl, phenergan, promethazine, ativan, ambien, seroquel, haldol, dilaudid, morphine, amongst others. These can have a lot more negative side effects than they are worth at times, especially in older patients. Just because you get called asking "for something to help them sleep," doesn't mean you have to prescribe something.
• You may get called about direct admits to the floor for other services at night. You may not have a "heads up" from signout if the attending accepts a transfer at night. Go see them when you get called about them. If you have any questions about the patient, run it by your wedge, otherwise, call the chief/fellow for that service and they will guide you on what admission orders they need.
▪ Go see any floor consults you get called about. Then present them to your wedge in a timely manner. You don't want the team to just be finding out about patients you have know about for hours on morning rounds the next day.
• I've attached a PDF on chest tube management. I highly recommend reading it.
• Harbrecht: if he asks a question, he probably already knows the answer. Don't bullshit him. He wants to see your thought process.

VA Rotation

• <u>Service Setup:</u>
    o Team consist of: chief, two midlevels (one covers thoracic and one covers vascular), intern, NP (Jane Kittle)
    o Gen Surg attendings: Gaar, Franklin
    o Vascular attending: Yancey, Davis
    o Thoracic attending: Wrightson
    o OR cases MWF;
    o Gaar Rounds on Tues am where he will do mock oral board type questions and walk you through theoretical cases
    o Minor procedure clinic on Tues am – intern and upper level take out small lumps/bumps under local
    o Endoscopy with Gaar on Thurs am
    o Clinics – Tues pm Gaar clinic, Thurs am Franklin clinic, Thurs pm Vascular clinic. EVERYONE is expected to go. They are located on the first floor.
    o Where you spend your time: workroom on 4th floor next to the surgery waiting room (Room 402, code: 55363)
    o call rooms are hidden on the 3rd floor (have a 2nd or 3rd year show you where).
    o ORs: 4th floor

<u>• Paperwork:</u>
    o Contact Security about getting a parking pass.
    o Make sure your login and access codes/passwords work a week prior to starting; there inevitably is something that has been reset and it's a very slow process
    • Codes:
    o ICU 123#
    o Locker rooms: 46808
    o ER 309*

• Chiefs are your main go-to. You will call them about the new consults you get.
• If you need something done on the floor, you should just go ahead and do it yourself. It is difficult to count on the nursing staff.

• Please help to preop patients. This includes marking, H&P, iConsent, and a brief narcotic form. Your team will be able to show you how to complete these initially.
• Complete your discharges ASAP. Discharge planners will call you every morning around 0730. There is a whole discharge process that has to be initiated prior to discharge. This will be in your VA paperwork.
• Get into the OR as much as possible. This is the rotation where you have time to operate, so take advantage.
• Teach your medical students
• Food options are limited; the canteen/starbucks during the day, nothing at night. I recommend just bringing your own food. There is a refrigerator and microwave in the lounge.

Norton General Surgery
• Service Setup:
    o There are two teams: ACS chief and midlevel, Kehdy chief, and 2 interns (cover both services), NP (Stacy Block)
    o Attendings: Kehdy, ACS/trauma faculty
    o Where you spend your time: the “nerve” is on the second floor in the service building
    o ORs: basement
    o ICUs: 4B, 4F, 5B, 5F, 5H
    o ER: lower level
    o Cafeteria: first floor; MD lounge 2nd floor has free food available too
• Norton call is hard. Prioritize your to do list. You will inevitably get called about new lines/consults when you are swamped.
• Lines/consults should be called into the attending by the consulting service or nurse prior to being called to you (excluding codes).
• Go to all of the code blues and help provide airway/access/management as needed
• Make sure to read the Martin Manifesto in the nerve. Basically it’s very specific things for Dr. Martin i.e. no zofran, no diuretics, must have IS/be out of bed, etc. He is very particular. Ask the surg onc chief/fellow if you have questions regarding his patients.
• To reach Dr. Vitale at night, you may need to call his house if he does not answer his cell
• To reach Dr. Dwivedi, your best bet is his pager, but your first call for vascular should be chief/fellow
• When you get called to put in central lines, make sure you know the indication for the line, anticoagulation status, what their INR/PTT/platelets are, if they have AV fistulas or some other contraindication to a particular side, and that the attending has been called about the line.
• Dr. Kehdy has specific instructions for his postop paraesohpageal hernias and Nissen, which are listed in the Nerve.
• There are several “dot phrase” notes already created for H&Ps, central lines, art lines, consults, etc. Ask your upper levels to share these with you.

Jewish General Surgery
• Service Setup:
    o There are two teams: ACS chief and midlevel, Williams chief, and 2 interns (cover both services)
    o Attendings: Williams, ACS/trauma staff
    o Where you spend your time: OR lounge on 2nd floor; call rooms on 3rd floor by 3E/transplant offices
    o OR: 2nd floor
    o ER: 1st floor
    o Cafeteria: first floor; MD lounge: first floor (breakfast and lunch provided)
• Codes:
    o Call rooms: 75337 (our rooms are 3rd on the left 1221 and third on the right 8477)

- o ER 1234*
- o Endoscopy 4080*
- o Dialysis 4688

• Much of the information above (from Norton) applies
• Thursdays are Dr. Williams' busiest day; two rooms and constant. Expect to be swamped. It is called Russellmania for a reason.
• Williams likes to round at night, so if you are the night resident, be familiar with his patients from checkout. Preferably see your night of surgeries prior to walking around with him. Also, make sure you have access to scripts for narcotics in the event he wants to send people home at night.

Norton Children's

• Service Setup:
- o Team consists of: fellow, chief, PGY2, 2 interns, NP (Katie Cecil)
- o Attendings: Fallat, Bond, Foley, Downard, Wright, Carter
- o Where you spend your time: 8th floor OR lounge; call room on 5W (code 15)
- o Elevator code to 8th floor OR: 8621
- o OR: 8th floor
- o ER: Lower level
- o Clinic: Thursday afternoon and every other Tuesday afternoon

• There is always an attending/chief/fellow in house.
• Present your consults to the attending as soon as you see the patient. Downard will want to know (in order) – patient's name, birthday, location, reason for consult, HPI, exam, imaging, plan. The others are more laid back in terms of presentation expectations.
• There are two lists: one on EPIC and an excel spreadsheet on one of the computers in the MD lounge on 8. Everyone goes by the excel spreadsheet list. This should be your first priority when updating the lists.
- • Add new patients to both lists (EPIC and the excel list) as soon as possible. NO list fails.

• You have to do ER Trauma training each time you rotate at Kosair. It gets really old but we all have to do it.
• Be as patient as possible with the pediatric residents and nurses. It is hard some time. You will get written up on this service. Be overly nice to everyone. Patience is key. If you get frustrated just say, "Thank you. I'll see the patient/address the issue/discuss with my chief/fellow/attending" and walk away. Try to remember that when kids are sick, people's anxiety goes up and this includes parents, nurses, and other residents. You are used to taking care of very sick people, they are not.
• Don't put in orders on PICU/NICU patients; write recommendations in your notes and discuss with the primary team. This is a HIGH COMMUNICATION rotation.
• IV fluid calculations are very important: 4/2/1 rule
• It is your job to help preop patients in the mornings and help discharge the outpatients
• Make sure consulting services fill out a "line sheet" for central line requests
• Pretty much every little procedure will be done in the OR (abscesses, lines). Do NOT do procedures out of the OR without your attending present.
• Make sure to read the handbook (provided at start of rotation) for specific Norton Children's information

Transplant

• Service Setup:
- o Team consists of: chief, PGY2
- o Attendings: Jones, Eng, Adamson
- o Where you spend your time: Jewish; OR lounge, call rooms on 3E
- o Hospital: Jewish

• All transplants get postop labs and an ultrasound within 4 hours of transplant; ALWAYS follow this up promptly and update chief and attending on results
• Always try to do the organ back table during a transplant. Double scrub the transplant if your other responsibilities are completed.
• This month can be very busy or very slow. If busy, just keep up. If slow, double scrub as many cases as possible. Go to transplant clinics throughout the week. Read/study for ABSITE…
• Immunosuppression levels and adjustments are made by pharmacist and attending during the week. You follow up levels and call attending for adjustments over the weekend. Know the level today, the level yesterday, and the dose they are on.
• Attendings are very involved and particular about the care of their patients. Run things up the chain before making any big moves.
• **A specific template must be used for all Transplant notes**. This will be sent to all residents prior to the start of the academic year.

Surg Onc (SO):
• Service Setup:
  o Team consists of: PGY 5/4/3/2/1, ERCP Fellow, Surg Onc Fellows x2 (2nd year is clinical, 1st year only has a couple clinical months), NP (Ashley Higdon)
  o Attendings: McMasters, Scoggins, Martin, Philips, Ajkay, Egger, Javid, Quillo
  o Hospitals: University, Jewish, Norton
  o SO Fellowship is apprenticeship style. The fellows will primarily round and take night calls on the patients for the attending they are with that month.
  o ERCP fellow will cover night calls for Vitale's patients, but team is responsible for rounding on them in the morning.
• Can be a very busy service. Get access to the online calendar and check the OR boards before leaving each day.
• Endocrine (thyroid/parathyroid) patients all get calcium, ionized calcium, magnesium, and phosphorus levels drawn the night of surgery. The night intern follows these up and texts them to chief on call.
• McMasters: always wear the headlight. Always hand tie knots (don't instrument tie). Don't put the plastic cap on the end of the radiation probe. Know the cut-off for taking nodes (10% of radiation signal of sentinel node). Know margins for melanoma. He is the primary author of the Sunbelt Melanoma Trial, so please know this like your birthday.
• Scoggins: don't suction Bovie smoke. He likes small bites on deep dermals. Don't palm the needle driver (leave fingers in the holes). Milk of mag is his first line bowel reg of choice. Pay attention to ROS and PE on all H&P and Consult notes. He likes 12 components on ROS with 2 items each, and 10 components on PE with 2 items each—he is in charge of most fiscal matters within the department so he knows documentation requirements for billing like the back of his hand. If you mess it up, he will text you about it. Also, document that imaging and labs were reviewed in your Assessment/Plan.
• All Surg Onc patients: gentle fluids. Don't just bolus if low UOP but look at EBL from the operation and consider sending urine lytes or giving lasix. Call/text chief if you are ever uncertain
• Ajkay: know his breast cancer algorithm (can get from midlevel resident or chief). Don't scrub without first knowing the patient's story. He likes large deep dermal bites, and instrument ties most of the time (in contrast to Scoggins/McMasters).
• Martin: very particular about the care of his patients, and there is a proverbial method to his madness. Please understand his preferences and the reasons for them. If you are unsure about the "why," ask your chief/fellow or Dr. Martin. They will be happy to explain.
• Vitale: often requires a resident to physically be sitting next to him and ask to run the list and discuss plans about his patients to avoid having this happen later in the evening. For many of his chronic pancreatitis patients, admission comprises NPO, IV fluids, serum amylase, and possibly a CT A/P with IV contrast (pending discussion with Dr. Vitale). Please be patient with his chronic pancreatitis

patients. They have a complex problem with few good solutions. Be mindful of this and compassionate when you start to get frustrated.
• As a general rule of thumb, ask up (chief, attending) before making move on Surg Onc patients because they can be very particular (attendings) and fragile (patients).
• Lots of clinic; have dress clothes in the call room/car. Carry a phone charger with you.
• Check clinic schedule. Some are HCOC, some BCC
    o Martin Monday
    o Phillips Tuesday
    o Scoggins Thursday, Ajkay Thursday
    o McMasters Friday

Colorectal:
• Service Setup:
    o Team consists of: fellow, chief, midlevel, intern, NP (Janice Fietcher)
    o Attendings: Galandiuk, Farmer, Jorden, Kavalukas, Simon
    o Hospitals: University, Norton, Jewish
• Examine drains, incisions, and ostomies and pay close attention to abdominal exams daily.
• As a general rule of thumb, ask your chief/fellow/attending before making major changes on these patients given their complexity.
• Enhanced recovery (ERAS) order sets are available and used for many patients on this service. Please be familiar with their components and use them during all phases of care (preop AND postop) when appropriate.
• Lots of clinic; have dress clothes in the call room/car. Carry a phone charger with you.
• Case conference: Monday and Tuesday 0700, Polk Conference Room
• Clinics throughout the week on HCOC 7th floor
• Please help prepare patients for the operating room when able. At University Hospital, patients should be consented as early as possible, ideally before running the list, since they must have consent prior to epidural placement.
• These patients, particularly those with IBD, can be challenging. Like Dr. Vitale's chronic pancreatitis patients, they have a **complex, debilitating problem with few good treatments**. Be mindful of this and **compassionate, particularly when you start to get frustrated**.

Vascular:
• Service Setup:
    o Team consists of: fellow, chief, midlevel, intern, NP's cover Jewish Hospital only
    o Attendings: Dwivedi, Wayne, Sigdel, Clark, Cheadle
    o Hospitals: University, Norton, Jewish
    o Consults at Norton and Jewish go to the attending consulted during the day and the on call person at night; consults at University go to the attending on call.
• Very busy service that covers all three hospitals.
• You need to preop cath labs cases each day. Also, you are responsible for cath lab discharges after outpatient procedures. Help keep up with preoping OR cases as there are often more than one room going and attendings will hop from room to room.
• You usually run the list in the cath lab each morning. Dr. Dwivedi will run by around 630-7am and run the list with you. Get orders, discharges, and Shiley consults done efficiently.
• If there is a new consult for a procedure that can be done the same day, they will want to do it the same day. Immediately see and preop new consults for procedures (tunneled lines, Shileys, IVC filters, EKOS, etc).
• Carry around marking pens and a Doppler with you during morning rounds.
• Check pulses and wounds every morning. Mark sites for surgery during morning rounds to expedite things downstairs later.

• All cath lab patients at Norton will need a Sedation Document note. Ask your upper level to share this with you.
• Sigdel clinic Tuesday mornings, Dwivedi clinic Wednesday and Thursday mornings, Wayne clinic Friday mornings. All in HCOC 7th floor.

Most of all, try to have a good time! We know it's daunting, but you have a lot of support if you ask for it. If you need anything, you are welcome to contact us. We put this together with the help of the other residents to help you; it is by no means all inclusive. *Good luck!*

Revised May 2023

University of Louisville School of Medicine

Resident Stipend Rates
2023-2024

PG Level	Annual
PG Level **1**	$59,488.12
PG Level **2**	$61,711.24
PG Level **3**	$63,703.79
PG Level **4**	$66,581.66
PG Level **5**	$69,808.68
PG Level **6**	$72,959.56
PG Level **7**	$75,995.13
PG Level **8**	$80,034.62

Fringe Benefits

Professional Liability Insurance

Malpractice coverage is provided by U of L, VAMC, and/or private affiliated hospitals under terms of your contract. However, *this coverage does not apply to any off-duty activities of employment.* Questions regarding malpractice coverage should be directed to the Risk Management Office (852-4652).

Medical/Hospitalization Insurance

Single and family coverage is available to all residents. You may sign up for insurance at House Staff Orientation. For more information, call 852-6555.

Life and Accident Insurance

Each resident receives, free of charge, life insurance for the value of twice the annual salary. Workers compensation, accidental death and dismemberment insurance are also provided. For details, please contact U of L's Human Resources Department (852-6258 / HRhelp@louisville.edu).

Mental Health Services

Confidential counseling or psychiatric consultation provided at no charge to the resident through a contractual arrangement between the Dean's office and the Campus Health Services Office. Residents desiring or in need of personal counseling, psychiatric consultation and/or treatment should contact the HSC Campus Health Services Office, located on the 1st floor of the Health Care Outpatient Center (HCOC); phone 852-6446. Residents may also contact the following individuals directly:

Dr. Gordon Strauss
Psychiatrist
Office 852-7256
Belknap

Dr. Jessica Reis
Psychiatrist
Office 852-7256
Belknap

Dr. Erik Goodwin
Psychiatrist
Office 852-7256
Belknap

Shivaun Nafsu
HSC Counselor
Office: 852-6446

Dr. Angela Pyle
Education Learning Specialist
Office 852-0755
HSC

Miscellaneous Benefits

Each member of the house staff has the following privileges:

1 - Kornhauser Health Sciences Library / Ekstrom Library – U of L's Main Campus

2 - Discount for higher priced seats for U of L athletic events.

3 - Use of:

- U of L swimming pools (852-0948; 852-6648)
- Fitness facility at Student Activities Center (852-7850) on Main Campus
- HSC Fitness Center (852-3115) on Chestnut Street
- Bass Rudd Tennis Center (852-1682) on Main Campus

4 - Free annual PPD may be obtained from the General Internal Medicine Clinic/Student Health Services (ACB – 1st Floor), every weekday except Thursdays, 8:30 a.m. to 11:30 a.m. and 1:00 p.m. to 4:00 p.m.

5 - Free U of L parking permits for the Chief Residents. All other PGY levels will receive a parking pass through the GME office. *(details at General Orientation)*.

In order to receive fringe benefits 1-5, a resident **must have a University identification card – "Cardinal Card," which is issued during GME new resident orientation. Please note that there may be a membership fee required for the use of some of the University's facilities, such as the Wright Natatorium.*

If you need to obtain a replacement Cardinal Card, stop by the security station on the 1st floor of the Abell Administration Building on Tuesdays between 2 and 4 pm. Should you have any questions, please call the Cardinal Card Office on main campus at 852-7520.

6 - White coats provided for each resident by the Department of Surgery.

7 - Computers for residents are available for use at all times – located in the Resident Education Room, the Resident Conference Room, the Laparoscopic Skills Lab, the Trauma Call Room, and in all integrated hospitals.

8 - Laparoscopic Skill Trainers are available 24-hours a day for surgery residents to hone their laparoscopic techniques.

9 - The J David Richardson Memorial Library and the Polk Conference Room (ACB – 2nd Floor) house a collection of textbooks and journals in general surgery and its specialties. Residents are welcome to borrow these materials. The lending procedure is based on the honor system.

Revised March 2020
Reviewed March 2020

Department of Surgery
University of Louisville School of Medicine

KY Medical Licensure Requirements

All residents, PGY 2 and above, must be licensed in Kentucky by July 1st of each year. There is no exception under KRS 311.560 of the Kentucky Statutes. Certification of charts, death summaries, etc., cannot be legally signed until you have your license. After obtaining licensure, all address changes must be reported to:

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Telephone (502) 429-8046

All residents must take and pass Step 3 before December 31st of PG-1 year.

Kathy Sandman from the GME will schedule a time to meet with all PGY-1 residents to complete the initial licensure paperwork. Kathy can be reached at 852-3135. The training licensure fee will be paid by the department for all residents remaining in the program. If at any time during training, a resident applies for a regular license, the resident will be responsible for all fees.

**When you receive your Kentucky license number, please report the number to Machenize Eason at 852-1895 and/or Lois Inlow 852-8017*.*

Types of Licenses

Regular - United States medical school graduates must have successfully completed 2 years of post-graduate training approved by the Accreditation Council for Graduate Medical Education (ACGME) and the USMLE Steps 1, 2, 3 (United States Medical Licensing Exam).

Temporary Permit (TP) - A temporary permit is issued to an applicant who meets the statutory requirements for a regular license. Applicants must have a completed application on file with the Board and must need to begin working in Kentucky before the next meeting of the Board. This permit is issued for a period not to exceed 6 months.

Institutional Practice Limited License (IP) - Applicants must have successfully completed 1 year of accredited postgraduate training in the United States or Canada. Applicants must have passed the USMLE Steps 1 and 2. Applicant must be accepted into the accredited training program. The IP license does not permit moonlighting.

Residency Training License (R) - Applicants must have successfully completed 1 year of accredited postgraduate training in the United States or Canada. Applicants must have passed the USMLE Steps 1, 2, and 3. Applicant must be accepted into the accredited training program. The RT license will permit authorized moonlighting and possession of a DEA number. The Program Director must recommend that a resident training license be issued to you.

Fellowship Training Limited License - Issued to foreign medical school graduates who do not meet the requirements for a regular license or institutional practice license and are entering a fellowship-training program in Kentucky. These physicians have no previous postgraduate training in the United States and have not taken any licensing exam (i.e., FLEX). This license is issued for a period not to exceed 1 year.

Department of Surgery
University of Louisville School of Medicine

FACU LTY CLINIC SCHEDULES

TRAUMA/ELECTIVE CLINICS

Monday
Harbrecht – PM

Tuesday
Trauma – AM
Elective – AM (2 week)

Wednesday
Benns – PM
Bozeman – PM
Miller – AM

Friday
Coleman – AM
Nash – AM

NORTON CLINICS

Tuesday/Thursday
Kehdy – AM

VA CLINICS

Tuesday/Thursday AM/PM

NORTON CHILDREN'S CLINICS

Monday
Foley – AM

Tuesday
Wright – AM

Wednesday
Bond – AM/PM

Thursday
Fallat – AM
Downard – PM

Friday
Carter – AM

TRANSPLANT CLINICS

Monday
Kidney/Pancreas – AM/PM

Wednesday
Liver & General Surgery – AM/PM

Thursday
Kidney/Pancreas – PM

THORACIC CLINICS

Monday
van Berkel –AM
Black – AM

Wednesday
van Berkel –AM/PM
Fox – AM
Black – PM

Thursday
Fox – PM

Friday
Fox –AM

SURGICAL ONCOLOGY CLINICS

Monday
Martin – AM/PM
Scoggins – PM*
(*2nd Monday)
Ajkay – PM (HCOC)

Tuesday
Philips – AM
Vitale – PM
Egger – PM (MCNE) (2nd T)
McMasters – AM
Philips – 8:30-12 (MCNE) (2nd T)

Wednesday
Martin – 8-10 (NCI)

Thursday
Vitale –AM
Ajkay – AM/PM
Scoggins – AM/PM

Friday
Egger – AM/PM
Philips – PM (Alternating weeks)
Martin – 8-10 (Audubon)
Philips – 8:30-12 (Bowling Green) (Last Friday)

COLORECTAL CLINICS

Monday
Jorden – PM (MCNE)
Kavalukas – PM (MCE 2nd & 4th)

Tuesday
Galandiuk – AM/PM
Kavalukas – AM/PM

Wednesday
Jorden – AM/PM

Thursday
Farmer – AM/PM

VASCULAR CLINICS

Monday
Clark – AM/PM

Tuesday
Sigdel – AM (1st Tuesday)
Sigdel – Jewish - PM

Wednesday
Dwivedi – AM
Wayne – Jewish – PM

Thursday
Dwivedi – AM
Dwivedi – Jewish – PM

Friday
Wayne – AM

Department of Surgery
University of Louisville School of Medicine

CONFERENCES

Mandatory conferences include Quality Improvement Conference, Grand Rounds, and Resident Teaching Conference on Fridays. Attendance at other conferences will be determined by individual rotations.

MONDAYS

GENERAL SURGERY

Surgical ICU Rounds ACB, JDR Memorial Library 7:00 am – 8:00 am	**Burn Rounds** ULH, Burn Unit ~ 5th Fl 8:00 am – 8:30 am
Interesting Case / M&M Conference Last Monday of the Month VA Hospital ~ Director's Conference Room 4:00 pm – 5:00 pm	**HAND SURGERY** **Kleinert Institute Hand Conference** 6:30 am – 7:30 am ***Virtual via Teams**

PLASTIC SURGERY

Plastic Surgery Research Conference ACB, JDR Memorial Library ~ 2nd Floor 1:00 pm – 1:30 pm	**Cosmetic, Craniofacial, & Hand Case Presentations** *Cosmetic – Third Monday of the Month ACB, JDR Memorial Library 1:30 pm – 2:00 pm
In-Service Board Review Course ACB, JDR Memorial Library ~ 2nd Floor 2:00 pm – 2:30 pm	**Indications Conference** ACB, JDR Memorial Library ~ 2nd Floor (2nd & 4th Monday) 2:30 pm – 3:30 pm
Workshops As Needed ACB, JDRichardson Memorial Library ~ 2nd Floor 3:30 pm – 4:30 pm	**Hand Conference** ACB, JDR Memorial Library ~ 2nd Floor 3:30 pm – 4:30 pm
Cosmetic Clinic *Third Monday of the Month 7th Floor HCOC, Suite 790 3:30 pm – 5:30 pm	**Anatomy Dissections** *Quarterly, Fourth Monday of the Month Fresh Tissue Laboratory 4:30 pm – 5:30 pm

Journal Club Meeting
*Quarterly
Location / TBA
6:30 pm

SURGICAL ONCOLOGY

Gastrointestinal Multidisciplinary Conference
12:00 pm – 1:00 pm
***For location details, please refer to the Surgical Oncology Surgery Calendar**

COLON / RECTAL SURGERY **Colon and Rectal Surgery Conference** ACB, Polk Conference Room ~ 2nd Fl 7:00 am – 8:00 am	**PEDIATRIC SURGERY** **Pediatric Surgery M&M Conference** Norton Children's Hospital ~ Varies 7:00 am

HAND SURGERY
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
***Virtual via Teams**

VASCULAR
Kosair Charities Board Room; 15th Floor Frazier Rehab Institute
6:30 am – 7:30 am

TUESDAYS

GENERAL SURGERY
Teaching Rounds
VA Hospital, SICU ~ 4th Fl
8:00 am – 9:00 am

HAND SURGERY
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
***Virtual via Teams**

PEDIATRIC SURGERY

Pediatric Surgery Residents' Conference-SCORE Topics Norton Children's Hospital ~ Varies 1:00 pm – 2:00 pm	**Radiology Conference** *First Tuesday of the Month (Pediatric Surgery Faculty & Radiology Staff) Norton Children's Hospital ~ Varies 12:00 pm – 1:00 pm
Pediatric Device/Other Presentations/Extra Time 3rd Tuesday of the Month Norton Children's Hospital ~ Varies 1:00 pm – 2:00 pm	**Pediatric Surgery Tumor Conference** *Fourth Tuesday of the Month Norton Hospital ~ Varies 12:00 pm – 1:00 pm
Pediatric Surgery Grand Rounds *Fourth Tuesday of the Month Norton Children's Hospital ~ Varies 1:00 pm – 2:00 pm	**Norton Children's– Tumor Conference** *Second Tuesday of the Month Norton Hospital Auditorium 12:00 pm – 1:00 pm
Pediatric Ethics/Resident's Conference Division Retreat 5th Tuesday of the Month Norton Children's Hospital 12:00 pm – 1:00 pm+	

THORACIC & CARDIOVASCULAR SURGERY

Case Presentations *First Tuesday of the Month UofL Health Heart Hospital CTS Conference Room ~ 12th Fl 5:00 pm – 6:00 pm	**Journal Club** *Second Tuesday of the Month UofL Health Heart Hospital CTS Conference Room ~ 12th Fl 5:00 pm – 6:00 pm

M & M Conference *Third Tuesday of the Month UofL Health Heart Hospital CTS Conference Room ~ 12th Fl 5:00 pm – 6:00 pm	**Scholarly Activity / Grand Rounds** *Fourth Tuesday of the Month UofL Health Heart Hospital CTS Conference Room ~ 12th Fl 5:00 pm – 6:00 pm
COLON / RECTAL SURGERY **Colon and Rectal Surgery Tumor Board Conference** *First and Third Tuesday of the Month Brown Cancer Center – 4th Fl Conference Room 7:00 am – 8:00 am	**COLON / RECTAL SURGERY** **Interesting Cases** Second Tuesday of the Month ACB, Polk Conference Room – 2nd Fl 7:00 am – 8:00 am
COLON / RECTAL SURGERY **Division QI** Fourth Tuesday Every Other Month (Alternates months with Faculty Mtg) ACB, Polk Conference Room – 2nd Fl 7:00 am – 8:00 pm	
SURGICAL ONCOLOGY **Melanoma Conference** 12:30-1:30 pm ***For location details, please refer to the Surgical Oncology Surgery Calendar**	

WEDNESDAYS

PLASTIC SURGERY	
Plastic Surgery Grand Rounds *1st, 2nd and 4th Wednesday of the Month ACB, JDR Memorial Library 7:00 am – 8:00 am	**Plastic Surgery Conference** ACB, JDR Memorial Library 8:00 am – 9:00 am *1st Week – Journal Review / 2nd Week - Quality* *4th Week – Indications / 5th Week – Division Mtg*
Facial Trauma Conference *Third Wednesday of the Month ACB Auditorium ~ 7:00 am – 8:00 am	**Plastic Surgery Grand Rounds** *Third Wednesday of the Month ACB, J David Richardson, MD Memorial Library 8:00 am – 9:00 am
THORACIC & CARDIOVASCULAR SURGERY **Pediatric Lecture: Fetal Heart Board** 2nd Wednesday of the Month Scheen Conf Cntr, Room 3, Norton Children's Hospital 4:00 pm – 5:00 pm	
SURGICAL ONCOLOGY **General/UGI Tumor Board** 7:00 am – 8:00 am ***For location details, please refer to the Surgical Oncology Surgery Calendar** **HPB Grand Rounds Videoconference Series** *Monthly ~ 5:00 pm- 6:00 pm ***For location details, please refer to the Surgical Oncology Surgery Calendar**	
CGSO National Videoconference *Quarterly 6:00 pm- 7:00 pm ***For location details, please refer to the Surgical Oncology Surgery Calendar**	
TRUAMA/CRITICAL CARE **Trauma Multi-Disciplinary Conference** ACB ~ Glassroom (Basement) *Third Wednesday of the Month 7:00 am – 8:00 am	

HAND SURGERY
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
***Virtual via Teams**

THURSDAYS

SURGICAL ONCOLOGY

Breast Multidisciplinary Conference 8:00 am – 9:00 am ***For location details, please refer to the Surgical Oncology Surgery Calendar**	**Sarcoma Conference** *Quarterly ***For location details, please refer to the Surgical Oncology Surgery Calendar**

Surgical Oncology Residence Conference
4:00 pm – 5:00 pm
***For location details, please refer to the Surgical Oncology Surgery Calendar**

HAND SURGERY
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
***Virtual via Teams**

SURGICAL CRITICAL CARE

Critical Care & Basic Science Surgical Conference *Second & Fourth Thursday of the Month ACB ~ JDR Memorial Library ~7:00 am – 8:00 am	**Trauma Quality Improvement Conference** *First Thursday of the Month ACB ~ Glassroom (Basement) ~7:00 am – 8:00 am

FRIDAYS

GENERAL SURGERY

Surgical Grand Rounds ACB ~ Auditorium (Basement) 7:00 am – 8:00 am ****Mandatory for All General Surgery Residents**	**Quality Improvement Conference** ACB ~ Room 1 (Basement) 8:00 am – 9:00 am ****Mandatory for All General Surgery Residents**

Resident Teaching Conference
ACB ~ Auditorium (Basement)
9:00 am – 10:00 am
****Mandatory for All General Surgery Residents**

THORACIC & CARDIOVASCULAR SURGERY
Wet Labs
Topics: CABG, Aortic Valve, Mitral Valve, Aortic Root
Cardiovascular Innovation Institute, 4th Floor Lab
3:00 pm – 4:00 pm

HAND SURGERY
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
***Virtual via Teams**

Department of Surgery
University of Louisville School of Medicine

Average of Cases
2018-2022

	2017-2018 U of L Averages	*2018-2019 U of L Averages*	*2019-2020 U of L Averages*	*2020-2021 U of L Averages*	*Total Average*	**ACGME Targets**
Skin and Soft Tissue/Breast	**102**	**78**	**67**	**87**	**83**	**25/40**
Head and Neck	**109**	**86**	**83**	**82**	**90**	**25**
Alimentary Tract	**316**	**318**	**321**	**348**	**325**	**180**
Abdomen	**373**	**310**	**324**	**351**	**339**	**250**
Liver	**28**	**16**	**17**	**16**	**22**	**5**
Pancreas	**17**	**15**	**10**	**12**	**19**	**5**
Vascular	**243**	**168**	**198**	**156**	**191**	**50**
Endocrine	**38**	**42**	**37**	**40**	**39**	**15**
Trauma (Operative)	**77**	**60**	**54**	**67**	**64**	**10**
Trauma (Non-Operative)	**49**	**48**	**52**	**51**	**50**	**40**
Thoracic	**58**	**40**	**38**	**34**	**42**	**20**
Pediatrics	**65**	**62**	**53**	**54**	**58**	**20**
Plastics	**44**	**42**	**39**	**33**	**39**	**10**
Laparoscopic Basic	**180**	**162**	**167**	**195**	**176**	**100**
Endoscopy	**179**	**133**	**139**	**140**	**147**	**85**
Laparoscopic Complex	**123**	**131**	**155**	**162**	**142**	**75**
Case						
Surgeon Chief	**211**	**194**	**249**	**316**	**242**	**200**
Teaching Assistant	**53**	**32**	**54**	**48**	**46**	**25**
Total Major Cases	**1,376**	**1,169**	**1,206**	**1,216**	**1,241**	**850**

Opportunities to Pursue Advanced Degrees

Collaborative programs within the basic science departments allow both specific research study and more formal instruction leading to a Master of Science or Doctor of Philosophy degree, which can be integrated with the usual flow of surgical training. Several surgical residents have earned a Ph.D. in Physiology over the last 2 decades. Such arrangements are best made at least 12 months in advance.

The Center for Epidemiology and Clinical Investigation Sciences at the University of Louisville offers a Clinical Research, Epidemiology and Statistics Training Program (CREST) that is supported by a Clinical Research Curriculum Award (K30) from the National Institutes of Health. This 3-tiered degree program consists of a graduate certification in the Clinical Investigation Sciences, an M.S.P.H. that can be done jointly with the M.D. degree and a Ph.D. in Epidemiology-Clinical Investigation Sciences.

New programs in Public Health and Business Administration also offer classes and programs that should be of interest to some surgeons in training, some leading to advanced degrees. Residents are encouraged to enroll, and will be allowed appropriate time off clinical duties to complete these courses.

Further information can be obtained at the website *www.instituteforbioethics.com,* or call 852-4980.

KY Division of the American Cancer Society

Ph: (502) 584-6782

The following is a list of service organizations affiliated with the American Cancer Society-Louisville and Jefferson County Unit. For detailed information, call 584-6782.

- ***Reach to Recovery:*** A physician referral organization serving mastectomy patients by mastectomy patients.

- ***Lost Cord Club:*** A visitation program for laryngectomy patients pre- and postoperatively.

- ***Surgical Dressings Program:*** A service providing surgical dressings for indigent cancer patients.

- ***Cancer Support Group:*** Educational programs for cancer patients and their families which give assistance in coping with cancer.

KY Organ Donor Affiliates

Ph: 1-800-525-3456

In July, 1987, the organ donor programs at the University of Louisville and the University of Kentucky merged to form a separate, non-profit corporation. KODA is a federally certified organ procurement agency with primary responsibility for organ and tissue recovery throughout the Commonwealth of Kentucky.

Because state and federal laws require hospitals to notify KODA of potential organ donors, all physicians must be familiar with basic donor criteria and KODA's role in the donor process.

Donor Criteria: Specific donor criteria vary depending on the organs and tissues donated. As a general rule, anyone under the age of 81 is a potential donor. Questions about the acceptability of specific donors are strongly encouraged and should be referred to the KODA coordinator on call. (Ph: 1-800-525-3456 or 581-9511).

All vascularized organs (i.e., heart, kidneys, pancreas, liver, lungs) must be obtained from previously healthy individuals who have sustained a massive injury to the brain, which results in brain death. Potential donors must be artificially maintained until the recovery process is complete. There is a donation after cardiac death protocol in place at the ULH, which requires KODA notification prior to withdrawing care.

Tissue donors (i.e., corneas, skin, bone, heart valves) need not be artificially maintained. In fact, tissue recovery can occur up to 8 hours after cardiac standstill.

KODA's Role: KODA provides 24-hour consultation and coordination of the organ donor process. Trained coordinators are available to assist in the evaluation of potential donors, counsel the donor's family and obtain consent, and arrange for the recovery and disposition of donated organs and tissues. Through its affiliation with the National Organ Procurement and Transplantation Network, KODA can identify potential recipients throughout the United States.

Physician's Responsibility: Physicians are responsible for identifying terminally ill patients and/or making the official pronouncement of death.

Once a potential organ/tissue donor has been identified, the organ procurement agency should be notified in a timely fashion. Only after KODA has been notified, and it has been determined that organ or tissue donation is a viable option for that family, should the family be approached regarding the option of donation. The option of donation will be provided to the family by the KODA coordinator. The decision should be made in an environment that supports and respects the wishes of the deceased and his/her family. In any case, a KODA coordinator is always available to counsel with the family, and it is strongly encouraged to get their involvement early in the potential donor process.

Department of Surgery
Faculty Listing

	Office	Fax
Chair, Ben A. Reid, Sr. Professor of Surgery		
Kelly M. McMasters, M.D., Ph.D.	852-5447	852-1704
Robert Wood Johnson Medical School	583-8303	
mcmasters@louisville.edu		
Contact Person: Pam Schmidt	852-5447	
Professor and Vice-Chair of Academic Affairs		
Chair of Surgery, University of Louisville Hospital		
Hiram C. Polk, Jr., M.D. Endowed Chair in Surgery		
Chief of Trauma		
Brian G. Harbrecht, M.D.	852-5452	852-8915
University of Louisville		
briang.harbrecht@louisville.edu		
Contact Person: Sharlene Dillander	852-5452	

Colorectal Surgery

PROFESSORS:

Kelli Bullard Dunn, M.D.	681-1359	852-8915
Harvard University		
kbdunn01@louisville.edu		
Contact Person: Lynn Daugherty	681-1359	
Price Endowed Professorship in Surgery		
Chief, Colorectal Surgery		
Program Director – Colorectal Surgery		
Director – Price Institute of Surgical Research		
Susan Galandiuk, M.D.	852-4568	852-8915
Universitat Wurzburg, Germany	583-8303	
s0gala01@louisville.edu		
Contact Person: Julie Watkins	852-4568	

ASSOCIATE PROFESSORS:

Russell Farmer, M.D.	852-1897	852-8915
University of Texas-Houston	583-8303	
Russell.w.farmer@gmail.com		
Contact Person: Debbie Davenport	852-1897	
Jeffrey R. Jorden, M.D.	852-1897	852-8915
University of South Florida	583-8303	
jeffrey.jorden@louisville.edu		
Contact Person: Debbie Davenport	852-1897	

	Office	Fax
ASSISTANT PROFESSORS:		
Associate Program Director – Colorectal Surgery		
Sandra L. Kavalukas, M.D.	852-1897	852-8915
Pennsylvania State University	583-8303	
sandra.kavalukas@louisville.edu		
Contact Person: Debbie Davenport	852-1897	
Hillary Simon, D.O.	852-1897	852-8915
Edward Via College of Osteopathic Medicine		
Virginia Campus	583-8303	
hillary.simon@louisville.edu		
Contact Person: Debbie Davenport	852-1897	

General Surgery

PROFESSORS:		
William G. Cheadle, M.D.	852-5675	852-8915
University of California – Irvine	583-8303	
wgchea01@louisville.edu		
Contact Person: Brenda Dawson	852-5676	
Surgical Services - VAMC		
Earl Gaar, M.D.	287-6847	287-6825
University of Louisville	583-8303	
earl.gaar@med.va.gov		
Contact Person: Kelli Peters	287-6804	
Berel L. Abrams, M.D. Endowed Chair in Surgery		
Chief of Division of General Surgery		
Associate Program Director – Trauma and Critical Care Surgery		
Chief Medical Officer University of Louisville Health		
Jason Smith, M.D, PhD, MBA	562-5619	852-8915
The Ohio State University	583-8303	
j0smit19@louisville.edu		
Contact Person: Tiffany Gantt	562-5619	
ASSISTANT PROFESSORS:		
Mason B. Holbrook, M.D.	852-1897	852-8915
University of Louisville	583-8303	
mbholb01@louisville.edu		
Contact Person: Laura 852-		
Samuel Pera, M.D.	852-1897	852-8915
Rush University	583-8303	
Samuel.pera@louisville.edu		
Contact Person: Debbie Davenport	852-1897	

	Office	Fax

Institute for Cellular Therapeutics

Jewish Hospital Distinguished Chair in Transplantation Research
Professor and Program Director

Suzanne T. Ildstad, M.D. 852-2080 852-2079
Mayo Medical School
suzanne.ildstad@louisville.edu
Contact Person: Kim Nicholas 905-0239

Minimally Invasive Surgery

PROFESSORS:

Associate Program Director – General Surgery Residency

Farid Kehdy, M.D. 852-4140 852-8915
American University of Beirut
fjkehd01@louisville.edu
Contact Person: Laura Lukat 852-

ASSISTANT PROFESSORS:

Elizabeth H. Bruenderman, M.D. 852- 852-8915
University of Louisville 583-8303
ehbrue01@louisville.edu
Contact Person: Laura Lukat 852-

Pediatric Surgery

PROFESSORS:

Sheldon Bond, M.D. 629-8630 583-9735
Medical College of Wisconsin 583-7337
sjbond01@louisville.edu
Contact Person: Lisa Pantoja 629-8630

Hirikati S. Nagaraj MD Endowed Chair for Pediatric Surgery
Program Director - Pediatric Surgery
Chief, Pediatric Surgery

Cynthia Downard, M.D. 629-8630 583-9735
Vanderbilt University
c0down01@louisville.edu
Contact Person: Lisa Pantoja 629-8630

Mary E. Fallat, M.D. 629-8638 583-9735
Health Science Center – Syracuse 583-7337
mefall01@louisville.edu
Contact Person: Becky Parr 629-8638

David S. Foley, M.D. 629-8632 583-9735
State University of New York – Buffalo 583-7337
dsfole01@louisville.edu
Contact Person: Lisa Pantoja 629-8630

	Office	Fax
ASSOCIATE PROFESSOR:		
Associate Program Director – Pediatric Surgery		
Tiffany N. Wright, M.D.	629-8630	583-9735
University of Kentucky		
tnwrig02@louisville.edu		
Contact Person: Lisa Pantoja	629-8630	583-9735
ASSISTANT PROFESSORS:		
Christie L. Buonpane, M.D.	629-8632	583-9735
Rutgers New Jersey Medical School		
Clbuon01@louisville.edu		
Contact Person:		
Stewart R. Carter, M.D.	629-8632	583-9735
University of Louisville		
stewart.carter@louisville.edu		
Contact Person: Lauren Wiley	629-8632	583-9735

Plastic and Reconstructive Surgery

PROFESSORS:		
Gordon R. Tobin, M.D.	852-6880	852-8915
University of California – San Francisco	583-8303	
gordon.tobin@louisville.edu		
Contact Person: Amory Alvey	852-6880	
Leonard J. Weiner Professorship in Plastic and Reconstructive Surgery		
Chief Plastic Surgery		
Program Director – Plastic and Reconstructive Surgery		
Bradon J. Wilhelmi, M.D.	852-6880	852-8915
Rush Medical College		
bjwilh01@louisville.edu		
Contact Person: Amory Alvey	852-6880	
ASSOCIATE PROFESSORS:		
Associate Program Director – Plastic and Reconstructive Surgery		
Joshua Choo, M.D.	852-6880	852-8915
Baylor College of Medicine		
jhchoo01@louisville.edu		
Contact Person: Amory Alvey	852-6880	
Terry McCurry, M.D.	852-6880	852-8915
University of Louisville		
Tmmccu01@louisville.edu		
Contact Person: Amory Alvey	852-6880	
ASSISTANT PROFESSOR:		
Ryan L. Shapiro, MD	852-6880	852-8915
Wright State University	583-8303	
Rlshap01@louisville.edu		
Contact Person: Amory Alvey	852-6880	

	Office	Fax

Surgical Oncology

PROFESSORS:

Sam and Lolita Weakley Endowed Chair in Surgical Oncology
Chief, Surgical Oncology

Robert C.G. Martin, II, M.D., Ph.D. 629-3355 629-3030
University of Louisville 583-8303
robert.martin@louisville.edu
Contact Person: Tracy Miller 629-3355

Chair, Ben A. Reid, Sr. Professor of Surgery

Kelly M. McMasters, M.D., Ph.D. 582-5447 852-1704
Robert Wood Johnson Medical School 583-8303
mcmasters@louisville.edu
Contact Person: Pam Schmidt 852-5447

Vice Chair, Surgery for Operations and Finance

Charles R. Scoggins, M.D., M.B.A. 629-6950 629-3183
University of Texas
crscog01@louisville.edu
Contact Person: Rachel Wietecha 629-6950

Gary C. Vitale, M.D. 629-2278 629-7421
Yale University 583-8303
garyvitale@gmail.com
Contact Person: Judy Slaughter 629-2278

ASSOCIATE PROFESSORS:

Nicolas Ajkay, M.D. 629-3355 629-3030
Rosario University
nicholas.ajkay@louisville.edu
Contact Person: Tracy Miller 629-3355

Michael Egger, MD 629-6950 629-3183
Emory University
michael.egger@louisville.edu
Contact Person: Rachel Wietecha 629-6950

Kenneth F. Von Roenn, MD Family Endowed Chair in Surgical Endocrinology in the Department of Surgery
Associate Program Director – General Surgery Residency

Mahsa Javid, M.D. 629-6950 629-3030
University of Cambridge Clinical School – England
mahsa.javid@louisville.edu
Contact Person: Tracy Miller 629-3355

Program Director – Surgical Oncology

Prejesh Philips, M.D. 629-6950 629-3183
Maulana Azad Medical College
p0phil02@louisville.edu
Contact Person: Rachel Wietecha 629-6950

	Office	Fax

Transplant Surgery

PROFESSORS:

Dr. Hiram C. Polk, Jr and Mrs. Lily Banerjee Endowed Chair in Surgery
Chief, Division of Hepatobiliary and Transplantation
Program Director – Hepatobiliary and Transplant Surgery

Christopher Jones, M.D.	852-8017	852-8915
Georgetown University		
christopher.jones.1@louisville.edu		
Contact Person: Lois Inlow	852-8017	

ASSOCIATE PROFESSORS:

Surgical Director of Kidney Transplantation, Division of Transplantation

Mary Eng, M.D.	852-8017	852-8915
Rush Medical College		
mary.eng@louisville.edu		
Contact Person: Lois Inlow	852-8017	

ASSISTANT PROFESSOR:

Surgical Director of the Living Donor Program
Director, Liver Transplantation

Dylan Adamson, M.D.	852-8017	852-8915
Tulane University		
dylan.adamson@louisville.edu		
Contact Person: Lois Inlow	852-8017	

Trauma and Critical Care Surgery

PROFESSORS:

Glen A. Franklin, M.D.	852-6191	852-8915
University of Louisville	583-8303	
glen.franklin@louisville.edu		
Contact Person: Laura Lukat	852-6191	

Vice-Chair of Academic Affairs
Chair of Surgery, University of Louisville Hospital
Hiram C. Polk, Jr., M.D. Endowed Chair in Surgery
Chief of Trauma

Brian G. Harbrecht, M.D.	852-5452	852-8915
University of Louisville		
brian.harbrecht@louisville.edu		
Contact Person: Sharlene Dillander	852-5452	

ASSOCIATE PROFESSOR:

Program Director – General Surgery Residency

Matthew Benns, M.D.	852-	852-8915
Indiana University	583-8303	
m0benn02@louisville.edu		
Contact Person: Laura Lukat	852-	

	Office	Fax
Matthew Bozeman, M.D.	852-	852-8915
Texas Tech University	583-8303	
Mcboze01@louisville.edu		
Contact Person: Laura Lukat	852-	
Jamie Coleman, M.D.	852-	852-8915
University of Tennessee College of Medicine	583-8303	
Jjcole03@louisville.edu		
Contact Person: Laura Lukat	852-	

Associate Program Director – General Surgery Residency

Keith Miller, M.D.	852-	852-8915
Indiana University	583-8303	
krmill01@louisville.edu		
Contact Person: Laura Lukat	852-	

Program Director – Surgical Critical Care

Nick Nash, M.D.	852-	852-8915
University of Louisville	583-8303	
Nanash01@louisville.edu		
Contact Person: Laura Lukat	852-	

ASSISTANT PROFESSORS:

George Ryne Marshall, M.D.	852-	852-8915
Indiana University	583-8303	
grmars01@louisville.edu		
Contact Person: Laura Lukat	852-	

Vascular Surgery and Endovascular

PROFESSORS:

Montgomery Endowed Professorship in Vascular Surgery
Chief of Vascular Surgery and Endovascular Therapeutics
Program Director – Vascular Surgery

Amit Dwivedi, M.D.	852-0864	852-8915
Mumbai University		
amit.dwivedi@louisville.edu		
Contact Person: Monica Sivori	852-0864	

ASSOCIATE PROFESSOR:

Abindra Sigdel, M.D.	852-0864	852-8915
B.P. Koirala Institute of Health Science		
amsidg01@louisville.edu		
Contact Person: Monica Sivori	852-0864	

ASSISTANT PROFESSORS:

Gerald "Jack" Cheadle, M.D.	852-0864	852-8915
University of Louisville		
gerald.cheadle@louisville.edu		
Contact Person: Monica Sivori	852-0864	

	Office	Fax
Nancy Clark, M.D., J.D.	852-0864	852-8915
University of Kentucky		
nancy.clark@louisville.edu		
Contact Person: Monica Sivori	852-0864	

Associate Program Director – Vascular Surgery

Erik Wayne, M.D.	852-0864	852-8915
University of Iowa		
eric.wayne@louisville.edu		
Contact Person: Monica Sivori	852-0864	

Clinical Surgical Faculty Listing

A

Allen, Jeffrey W., M.D. *(General Surgery)*	(502) 899-6405

B

Bhandari, Panambur, M.D. *(General Surgery)*	(502) 562-0312
Blandford, Jr., Joseph M., M.D. *(General Surgery)*	(502) 366-1090
Boodry, Courtney I, M.D. (*General Surgery*)	(502) 637-3311
Brown, Carter M., M.D. (*General Surgery*)	(502) 637-3311
Burke, Charity S., M.D. (Plastic Surgery)	(502) 629-4263

C

Calobrace, M. Bradley, M.D. *(Plastic & Reconstructive)*	(502) 899-9979
Campbell, Michael, M.D. *(General Surgery)*	(270) 843-7557
Carson, Samuel W., M.D. (*General Surgery*)	(270) 683-3720
Chapman, Darren C., M.D. *(General Surgery)*	(270) 326-4780
Chariker, Mark, M.D. *(Plastic & Reconstructive)*	(502) 568-4800
Citak, Michael S., M.D. *(General Surgery)*	(606) 451-0300
Cornell, Roy B (*General Surgery*)	(270) 683-3720

D

Darnell, Robert E., M.D. (*General Surgery*)	(502) 637-3311
Davis, Kathryn L., M.D. (*Vascular Surgery*)	(270) 769-2568
Decker, Philip A., M.D. *(General Surgery)*	(270) 683-3720
Derr, John W. Jr., M.D. *(Plastic & Reconstructive)*	(502) 589-6000
Digenis, Alexander G., M.D. *(Plastic & Reconstructive)*	(502) 589-5544

E F

Falcone, John L., M.D. *(General Surgery)*	(270) 683-3720

G

Galvis Leon, Elkin J., M.D. *(Hand Surgery)*	(502) 561-4263
Garmon, Joel, M.D. *(General Surgery)*	(502) 366-1090
George, Salem M. Jr., M.D. *(General Surgery)*	(502) 897-0635
Gerard, Robert R., M.D. (*General Surgery*)	(502) 637-3311
Glaser, Christopher C., M.D. *(General Surgery)*	(270) 683-3720

H

Hamman, Jack L., M.D. (*General Surgery)*	(270) 326-3800

I J

Jiao, Haiqiao (*Hand Surgery)*	(502) 561-4263
Juhl, Gregory, M.D. *(General Surgery)*	(502) 899-6150

K

Kasdan, Morton L., M.D. *(Plastic & Reconstructive)*	(502) 852-6880

L

Larson, Gerald, M.D. *(General Surgery)*	(502) 629-4242
Lusco, Vincent C. III, M.D. *(General Surgery)*	(502) 366-1090

M

Maki, Alexandra, M.D. *(General Surgery)*	(502) 637-3311
Maldonado, Alberto R., M.D. *(Plastic & Reconstructive)*	(502) 627-1112
Mays, Chet, M.D. *(Plastic & Reconstructive)*	(502) 899-9979
McMillin, Rodney, M.D. *(General Surgery)*	(502) 366-1090
Moreno, Rodrigo, M.D. *(Hand Surgery)*	(502) 561-4263
Moseley, Marcus D., D.O. (*General Surgery*)	(270) 683-3720
Mullins, Alan P., M.D. (*General Surgery*)	(270) 683-3720
Muradov, Johongir, M.D. (*General Surgery*)	(270) 377-2440
Muresan, Claudiu, M.D. *(Hand Surgery & Plastic)*	(502) 562-2880

N

Napolitano, Margaret, M.D. *(Hand Surgery)*	(502) 561-4263
Nebel, Thomas C., D.O. *(General Surgery)*	(270) 683-3720
Noel, R. Thomas, M.D. *(Plastic & Reconstructive)*	(502) 895-5466

O P

O'Daniel, T. Gerald, M.D. *(Plastic & Reconstructive)*	(502) 584-1109
Olsofka, John, M.D. *(General Surgery)*	(502) 366-1090
Ozyurekoglu, Tuna, M.D. *(Hand Surgery)*	(502) 561-4623
Palazzo, Michelle, M.D. *(Hand Surgery)*	(502) 561-4263
Pecache, Monica, M.D. (*Hand Surgery*)	(502) 561-4239
Polk, Jr., Hiram C., M.D. *(General Surgery)*	(502) 852-1897

Q R

Quillo, Amy R., M.D. (*General Surgery*)	(502) 815-7830
Rao, Mohan, M.D. *(General Surgery)*	(270) 825-7324
Raque, Jessica L, M.D. (*General Surgery*)	(270) 683-3720
Reid, Benjamin A. Jr., M.D. *(General Surgery)*	(502) 361-6070
Romines, Robert B., M.D. *(General Surgery)*	(502) 465-2821
Rosenbloom, Philip, Ph.D. *(General Surgery)*	(502) 636-0574

S

Salzman, Marc J., M.D. *(Plastic & Reconstructive)*	(502) 894-9900
Scheker, Luis R., M.D. *(Hand Surgery & Plast Reconst)*	(502) 561-4263
Schory, Thomas J., M.D. *(General Surgery)*	(502) 350-5492
Stewart, Robert, M.D. *(General Surgery)*	(502) 366-1090
Strothman, Gregory B., M.D. *(General Surgery)*	(502) 899-6470

T U V

Theuer, Christopher, M.D. *(General Surgery)*	(502) 633-6062
Thirklannad, Sunil, M.D. *(Hand Surgery)*	(502) 561-4233
Tsai, Tsu-Min, M.D. *(Hand Surgery)*	(502) 561-4263
Tuckson, Wayne, M.D. *(General Surgery)*	(502) 583-8005
Verbist, Daniel E., M.D. (*Plastic Surgery*)	((502)882-6500

W

Webster, Kristen L., M.D. *(General Surgery)*	(502) 895-5466
Wermeling, F. Ryan, M.D. *(Plastic Surgery)*	(270) 683-3720
Williams, Russell A., M.D. *(General Surgery)*	(502) 583-5948

X Y Z

Emeritus Surgical Faculty List

Barbara M. Baker, Ph.D.
David R. Cunningham, Ph.D.
Michael B. Flynn, M.D.
R. Neal Garrison, M.D.
Diller B. Groff, M.D.
Morton L. Kasdan, M.D.
Gerald M. Larson, M.D.
Serge A. Martinez, M.D.
Michael H. McCafferty, M.D.
Hirikati S. Nagaraj, M.D.
Hiram C. Polk, Jr., M.D.
Eugene H. Shively, M.D.
John S. Spratt, Jr., M.D.,M.S.P.H.
Leonard J. Weiner, M.D.
Heshan Sam Zhou, M.D.

Chairs

Jewish Hospital Distinguished Chair in Transplantation Research:
Jewish Hospital Foundation established this chair along with a gift matched by the state's Research Challenge Trust Fund.
*~ The chair is held by **Suzanne T. Ildstad, M.D.***

Hiram C. Polk, Jr., M.D. and Mrs. Lily Banerjee Chair in Surgery:
Established through contributions from more than 80 alumni and friends of Dr. Timir Banerjee.
*~ The chair is held by **Christopher M. Jones, M.D.***

Ben A. Reid, Sr., Professor of Surgery:
Established through contributions from more than 90 friends, alumni and principle benefactor, Ben A. Reid, Sr.
*~ The first occupant of the professorship is **Hiram C. Polk, Jr., M.D.***
*~ The chair is held by **Kelly McMasters, M.D., Ph.D.***

Kenneth F. Von Roenn, M.D. Family Chair in Surgical Endocrinology
This chair was created through the estate of Dr. Kenneth F. Von Roenn.
*~ The chair is held by **Masha Javid, M.D.***

Sam and Lolita S. Weakley Endowed Chair in Surgical Oncology:
Drs. Sam and Lolita Weakley endowed this chair to provide resources to attract a world-class cancer surgeon to the University of Louisville.
*~ The chair is held by **Robert C.G. Martin, II, M.D., Ph.D.***

Leonard J. Weiner Endowed Professor and Chair in Plastic and Reconstructive Surgery:
This endowment was provided by the contributions from Plastic and Reconstructive Surgery alumni and a matching gift from Jewish Hospital Foundation.
*~ The chair is held by **Bradon Wilhelmi, M.D.***

Hirikati S. Nagaraj, M.D. Professor in Surgery
This gift was provided by contributions from the Children's Hospital Foundation and Norton Healthcare, Inc.
*~The chair is held by **Cynthia Downard, M.D.***

Berel L. Abrams, M.D. Chair in Surgery
This endowment was established through contributions by Kenny Abrams, the Hiram C. Polk, Jr., M.D. Department of Surgery and the University of Louisville.
*~The chair is held by **Jason Smith, M.D., Ph.D.***

Hiram C. Polk Jr., M.D Chair in Surgery
This endowment was established by the Oxley Foundation in consideration of the importance of Hiram C. Polk, M.D. to the growth and success of the Department of Surgery.
*~The chair is held by **Brian Harbrecht, M.D.***

Departmental Awards & Recipients

JOHN W. PRICE and WILLIAM L. BROHM MEMORIAL AWARD: A surgeon in Louisville for many years, the late John W. Price, Jr. was particularly interested in surgical education and, with his wife Barbara Thruston Atwood Price, endowed the Price Institute of Surgical Research. After Dr. Price's death, friends made gifts in his memory to the Department. Each year a resident of the Department is selected for excellence in undergraduate instruction by vote of the surgical students.

Recipients:

2016 Nathan Ludwig, M.D.
2017 Mark Nicolas, M.D.
2018 Mark Nicolas, M.D.
2019 Joseph Sweeney, M.D.
2020 Gianna Karsaros, M.D.
2021 Seth Hall, M.D. & Mason Holbrook, M.D.
2022 Mohammed Ranavaya, M.D.

GERALD M. LARSON, M.D. AWARD (formerly)WILLIAM L. BROHM AWARD: An award in memory of William L. Brohm, M.D., a graduate of the University of Louisville in 1926, is given to the outstanding resident in general surgery. The recipient is selected from those in the final year of general surgical residency by three senior members of the Department of Surgery.

Recipients:

2016 Valerie Emaukhabon, M.D.
2017 Charles Kimbrough, M.D.
2018 Andrea "Annie" Nagengast, M.D. & Johangir Muradov, M.D.
2019 Emily Bond, M.D.
2020 Mark Nicolas, M.D.
2021 Neal Bhutiani, M.D.
2022 Elizabeth Bruenderman, M.D.

HIRAM C. POLK, JR., M.D., SCHOLARSHIP AWARD: Established by the 1985-86 Chief surgical residents of all the specialties, in appreciation of Dr. Polk's total commitment to surgical education.

Recipients:

2016 Michael McCafferty, M.D.
2017 Nicolas Ajkay, M.D.
2018 Kelly M. McMasters, M.D.
2019 Russell W. Farmer, M.D.
2020 Keith R. Miller, M.D.
2021 Michael Egger, M.D.

J. DAVID RICHARDSON AWARD FOR CLINICAL EXCELLENCE: This award is given to the person selected by the graduating Chief Residents and presented to the third year resident who best exemplifies those qualities of clinical expertise as portrayed by Dr. Richardson.

Recipients:

2016 Andrea "Annie" Nagengast, M.D.
2017 Erin Schumer, M.D.
2018 Jonathan Vacek, M.D.
2019 Tim Dawson, M.D.
2020 Amelia Rogers, M.D.
2021 Anthony Grzeda, M.D.
2022 William Risinger, M.D.

EDELEN-HAGAN PUBLICATION AWARD: A member of the clinical faculty for several decades, Charles M. Edelen endeavored to promote scholarly writing by residents in surgery. The best paper of the year by a surgical resident merits the award. To be eligible, the paper must be submitted for publication by May. A committee of three surgical faculty members judges the papers.

Recipients:

2016 Neal Bhutiani, M.D. & Charles Kimbrough, M.D.
2017 Neal Bhutiani, M.D., Natalia Paez, M.D., Erin Schumer, M.D. & Jessica Weaver, M.D.
2018 Neal Bhutiani, M.D., Natalia Paez, M.D. & Jessica Weaver, M.D.
2019 Natalia Paez, M.D.
2020 Matt Woeste, M.D. & Jessica Schucht, M.D.
2021 Elizabeth Bruenderman, M.D. & Aaron Marshall, M.D.
2022 Michael Carr, M.D. & Amelia (Rogers) Collings, M.D.

PEDIATRIC SURGERY AWARD: The Division of Pediatric Service presents this award to the outstanding resident rotating on the Pediatric Surgery Service each year.

Recipients:

2016 Garrett Mortensen, M.D. & Karen Parks, M.D.
2017 Jessica Raque, M.D.
2018 Lindsay Arnold, M.D. & Lela Posey, M.D.
2019 Alexis Nickols, M.D.
2020 Timothy Dawson, M.D.
2021 Elizabeth Bruenderman, M.D.

HUGH CARTLEDGE WILLIAMS TRAVEL SCHOLARSHIP: Established by Mrs. Frances Luckett (the former Mrs. Hugh C. Williams) in memory of Hugh Cartledge Williams, M.D., for his outstanding contribution to the Department of Surgery and the School of Medicine. Presented annually, this award is given to a deserving scholar who plans to take a year of special training in another institution of excellence. The candidate is nominated by the Chair of the Department of Surgery and approved by vote of the faculty.

Recipients:

2016 Neal Bhutiani, M.D. & Micah Whited, M.D.
2017 Jessica Schucht, M.D.,
2018 No Recipients
2019 Michael Carr, M.D., Andrew Tumen, M.D. & Jonathan Vacek, M.D.
2020 Michael Carr, M.D., Brittany Hegde, M.D., Amelia Rogers, M.D., Ansley Smith, M.D., Joseph Sweeney, M.D., Andrew Tumen, M.D.
Jonathan Vacek, M.D. & Matthew Woeste, M.D.
2021 Matthew Acton, M.D., Logan Bond, M.D., Nicholas Caminiti, M.D., Brittany Hegde, M.D., Amelia Rogers, M.D. & Matthew Woeste, M.D.
2022 Nicholas Caminiti, M.D., Brittany Hegde, M.D., David Keeven, M.D., William Risinger, M.D. & Chinweotuto Uma, M.D.

MORGAN WILLIAMS AWARD: The Department of Surgery presents an annual award in memory of Morgan Williams to the junior student who demonstrates the best overall performance in surgery.

Recipients:

2017 Courtney Lattimore
2018 Lauren R. Moore
2019 Seth Hall
2020 Victoria Hammond
2021 Katherine Whitehouse

WATERMAN/ABRAMS FELLOWSHIP AWARD: Presented by Martha McCoy, M.D., in recognition of compassionate patient care.

Recipients:

2016 Lindsay Arnold, M.D. & Andrea "Annie" Nagengast, M.D.
2017 Jessica Schucht, M.D. & Sam Carson, M.D.
2018 Joshua Clapp, M.D. & Lindsay Arnold, M.D.
2019 Brittany Hegde, M.D. & Christopher Murter, M.D.
2020 Elizabeth Bruenderman, M.D. & Christopher Murter, M.D.
2021 Amy Wise, M.D. & Jessica Masch, M.D.
2022 Amy Wise, M.D. & Alyssa Simpson, M.D.

Frank B. Miller, M.D. Excellence in Teaching Award: Given in recognition of Excellence in Undergraduate Instruction as Voted by Senior Students. This award was chosen from list of PGY-4and 5 Surgical Residents

Recipients:

2016 Tathyana Fensterer, M.D.
2017 Jessica Raque, M.D.
2018 Nathan Ludwig, M.D.
2019 Nathan Ludwig, M.D.
2020 Alexis Nickols, M.D.
2021 Gerald "Jack" Cheadle, M.D.
2022 Jonathan Vacek, M.D.

VASCULAR SURGERY AWARD: Given in Recognition for Leadership to one Senior Resident and one Junior Resident on the Vascular Surgery Service.

Recipients:

2016 Karen Parks, M.D. & Lindsay Arnold, M.D.
2017 Johongir Muradov, M.D., Christopher Murter, M.D. & Eric Anderson, M.D.
2018 Jordan Bond, M.D. & Christopher Murter, M.D.
2019 Christopher Murter, M.D., Beau Bush, M.D. & Adam Hicks, M.D.
2020 Gerald "Jack" Cheadle, M.D. & David Keeven, M.D.
2021 Gerald "Jack" Cheadle, M.D. Anthony Grzeda, M.D. & Logan Bond, M.D.
2022 Anthony Grzeda, M.D. & Kelsey Cage, M.D.

2022-2023 Publications

Faculty names are **bolded** and residents/fellows are underlined.

A

Abdullah F, Salazar JH, Gause CD, Gadepalli S, Biester TW, Azarow KS, Brandt ML, Chung DH, Lund DP, Rescorla FJ, Waldhausen JH, Tracy TF, **Fallat ME**, Klein MD, Lewis FR, Hirschl RB. Understanding the Operative Experience of the Practicing Pediatric Surgeon: Implications for Training and Maintaining Competency. JAMA Surg. 2016 Aug 1;151(8):735-41. doi: 10.1001/jamasurg.2016.0261. PMID: 27027471.

Anteby R, Verdugo FL, Aaron DG, **Polk HC Jr**, Qadan M. Perioperative Pharmacologic Prophylaxis of Venous Thromboembolism: A Professional Liability Analysis. J Surg Res. 2022 Jun;274:77-84. doi: 10.1016/j.jss.2021.11.019. Epub 2022 Feb 3. PMID: 35124464.

B

Baird R, Puligandla P, Lopushinsky S, Blackmore C, Krishnaswami S, Nwomeh B, **Downard C**, Ponsky T, Ghani MO, Lovvorn HN 3rd. Virtual curriculum delivery in the COVID-19 era: the pediatric surgery boot camp v2.0. Pediatr Surg Int. 2022 Oct;38(10):1385-1390. doi: 10.1007/s00383-022-05156-5. Epub 2022 Jul 9. PMID: 35809106; PMCID: PMC9455938.

Barrow BE, Alur AA, Kasdan ML, **Wilhelmi BJ**. Wine, Honey, and Boiling Oil: A Modern Understanding of Ancient Wound Care Practices. Am Surg. 2022 Mar 1:31348221078981. doi: 10.1177/00031348221078981. Epub ahead of print. PMID: 35232246.

Barrow BE, Kachare MD, Simpson AM, West NJ, Corey SL, **Wilhelmi BJ**. Breast Implants Save Lives: Gunshot Wound to a Silicone Gel Implant. Eplasty. 2023 Jan 30;23:QA4. PMID: 36846083; PMCID: PMC9949879.

Berman L, Renaud E, Pace D, **Downard CD**, Nwomeh BC, Huang EY, Weatherall YZ, Gadepalli SK, Mollen KP, Mak GZ, Newman E; APSTPD DEI Committee. Inclusion and representation in the pediatric surgery workforce: Strategies to mitigate bias in the fellowship application process. J Pediatr Surg. 2022 Nov;57(11):592-597. doi: 10.1016/j.jpedsurg.2021.12.023. Epub 2022 Jan 8. PMID: 35065807.

Bhutiani N, Bruenderman E, Davidyuk V, Mortensen GF, O'Brien S, **Martin RCG**, **Vitale GC**. Is More Anesthesia Care Better in Endoscopy? Comparing the Safety and Cost of Conscious Sedation and Anesthesia Provider-Based Care. J Gastrointest Surg. 2022 Feb;26(2):483-485. doi: 10.1007/s11605-021-05120-z. Epub 2021 Sep 10. PMID: 34506018.

Bowder AN, Bence CM, Rymeski BA, Gadepalli SK, Sato TT, Szabo A, Arendonk KV, Minneci PC, **Downard CD**, Hirschl RB, Markel T, Courtney CM, Deans KJ, **Fallat ME**, Fraser JD, Grabowski JE, Helmrath MA, Kabre RD, Kohler JE, Landman MP, Lawrence AE, Leys CM, Mak G, Port E, Saito J, Silverberg J, Slidell MB, St Peter SD, Troutt M, **Wright TN**, Lal DR; Midwest Pediatric Consortium. Acid suppression duration does not alter anastomotic stricture rates after esophageal atresia with distal tracheoesophageal fistula repair: A prospective multi-institutional cohort study. J Pediatr Surg. 2022 Jun;57(6):975-980. doi: 10.1016/j.jpedsurg.2022.02.004. Epub 2022 Feb 14. PMID: 35304025.

Bozeman MC, Schott LL, Desai AM, Miranowski MK, Baumer DL, Lowen CC, Cao Z, Araujo Torres K. Healthcare Resource Utilization and Cost Comparisons of High-Protein Enteral Nutrition Formulas Used in Critically Ill Patients. J Health Econ Outcomes Res. 2022 Jul 1;9(2):1-10. doi: 10.36469/001c.36287. PMID: 35854856; PMCID: PMC9249438.

Byerly S, Nahmias J, Stein DM, Haut ER, **Smith JW**, Gelbard R, Ziesmann M, Boltz M, Zarzaur BL, Bala M, Bernard A, Brakenridge S, Brohi K, Collier B, Burlew CC, Cripps M, Crookes B, Diaz JJ, Duchesne J, Harvin JA, Inaba K, Ivatury R, Kasten K, Kerby JD, Lauerman M, Loftus T, Miller PR, Scalea T, Yeh DD. A core outcome set for damage control laparotomy via modified Delphi method. Trauma Surg Acute Care Open. 2022 Jan 4;7(1):e000821. doi: 10.1136/tsaco-2021-000821. PMID: 35047673; PMCID: PMC8728413

C

Callcut RA, Dixon R, **Smith JW**, Zarzaur B; EAST Research-Scholarship Committee. Growing the next generation of trauma surgeon-scientists: Reflections on 20 years of research investment. J Trauma Acute Care Surg. 2022 Sep 1;93(3):340-346. doi: 10.1097/TA.0000000000003714. Epub 2022 Jun 1. PMID: 35653510.

Campwala I, Guyette FX, Brown JB, Yazer MH, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Eastridge B, Nirula R, Vercruysse GA, O'Keeffe T, Joseph B, Neal MD, Zuckerbraun BS, Sperry JL. Evaluation of critical care burden following traumatic injury from two randomized controlled trials. Sci Rep. 2023 Jan 20;13(1):1106. doi: 10.1038/s41598-023-28422-5. PMID: 36670216; PMCID: PMC9860020.

Carroll D, **Kavalukas S**. Evaluation and Management of Supralevator Abscess. Dis Colon Rectum. 2023 May 1;66(5):626-628. doi: 10.1097/DCR.0000000000002789. Epub 2023 Feb 24. PMID: 36825962.

Chandran S, Mohiuddin A, Cash E, Albert C, **Kehdy F**. The Inclusion of Voice Assessments to Aid Diagnostic and Surgical Decision Making for Patients With Laryngopharyngeal Reflux. J Voice. 2022 May 7:S0892-1997(22)00082-0. doi: 10.1016/j.jvoice.2022.03.016. Epub ahead of print. PMID: 35537976.

Chesney J, Lewis KD, Kluger H, Hamid O, Whitman E, Thomas S, Wermke M, Cusnir M, Domingo-Musibay E, Phan GQ, Kirkwood JM, Hassel JC, Orloff M, Larkin J, Weber J, Furness AJS, Khushalani NI, Medina T, **Egger ME**, Graf Finckenstein F, Jagasia M, Hari P, Sulur G, Shi W, Wu X, Sarnaik A. Efficacy and safety of lifileucel, a one-time autologous tumor-infiltrating lymphocyte (TIL) cell therapy, in patients with advanced melanoma after progression on immune checkpoint inhibitors and targeted therapies: pooled analysis of consecutive cohorts of the C-144-01 study. J Immunother Cancer. 2022 Dec;10(12):e005755. doi: 10.1136/jitc-2022-005755. PMID: 36600653; PMCID: PMC9748991.

Clapp JH, Gaskins JT, **Kehdy FJ**. [S156] Comparing outcomes of per-oral pyloromyotomy and robotic pyloroplasty for the treatment of gastroparesis. Surg Endosc. 2022 Jul 28. doi: 10.1007/s00464-022-09437-x. Epub ahead of print. PMID: 35902402.

Clapp JH, Gaskins JT, **Kehdy FJ**. [S156] Comparing outcomes of per-oral pyloromyotomy and robotic pyloroplasty for the treatment of gastroparesis. Surg Endosc. 2023 Mar;37(3):2247-2252. doi: 10.1007/s00464-022-09437-x. Epub 2022 Jul 28. PMID: 35902402.

Collings AT, Farazi M, Van Arendonk K, **Fallat ME**, Minneci PC, Sato TT, Speck KE, Deans KJ, Falcone RA, **Foley DS**, Fraser JD, Keller MS, Kotagal M, Landman MP, Leys CM, Markel T, Rubalcava N, St Peter SD, Flynn-O'Brien KT; Midwest Pediatric Surgery Consortium. Impact of "Stay-at-Home" orders on non-accidental trauma: A multi-institutional study. J Pediatr Surg. 2022 Jun;57(6):1062-1066. doi: 10.1016/j.jpedsurg.2022.01.056. Epub 2022 Feb 14. PMID: 35292165; PMCID: PMC8842346.

Collings AT, Farazi M, Van Arendonk KJ, **Fallat ME**, Minneci PC, Sato TT, Speck KE, Deans KJ, Falcone RA Jr, **Foley DS**, Fraser JD, Gadepalli SK, Keller MS, Kotagal M, Landman MP, Leys CM, Markel TA, Rubalcava N, St Peter SD, Flynn-O'Brien KT; Midwest Pediatric Surgery Consortium. The COVID-19 pandemic and associated rise in pediatric firearm injuries: A multi-institutional study. J Pediatr Surg. 2022 Jul;57(7):1370-1376. doi: 10.1016/j.jpedsurg.2022.03.034. Epub 2022 Apr 12. PMID: 35501165; PMCID: PMC9001175.

Cotter G, Beal EW, Poultsides GA, Idrees K, Fields RC, Weber SM, **Scoggins CR**, Shen P, Wolfgang C, Maithel SK, Pawlik TM. Using machine learning to preoperatively stratify prognosis among patients with gallbladder cancer: a multi-institutional analysis. HPB (Oxford). 2022 Nov;24(11):1980-1988. doi: 10.1016/j.hpb.2022.06.008. Epub 2022 Jun 20. PMID: 35798655.

D

Deeb AP, Lu L, Guyette FX, Peitzman AB, Daley BJ, Miller RS, **Harbrecht BG**, Phelan HA, Sperry JL, Brown JB. Optimal Prehospital Crystalloid Resuscitation Volume in Trauma Patients at Risk for Hemorrhagic Shock. J Am Coll Surg. 2023 Mar 28. doi: 10.1097/XCS.0000000000000695. Epub ahead of print. PMID: 36975122.

Deeb AP, Guyette FX, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Eastridge BJ, Joseph B, Nirula R, Vercruysse GA, Sperry JL, Brown JB. Time to early resuscitative intervention association with mortality in trauma patients at risk for hemorrhage. J Trauma Acute Care Surg. 2023 Apr 1;94(4):504-512. doi: 10.1097/TA.0000000000003820. Epub 2023 Jan 11. PMID: 36728324; PMCID: PMC10038862.

Dekonenko C, Fraser JD, Deans K, **Fallat ME**, Helmrath M, Kabre R, Leys CM, Burns RC, Corkum K, Dillon PA, **Downard C**, **Wright TN**, Gadepalli SK, Grabowski J, Hernandez E, Hirschl R, Johnson KN, Kohler J, Landman MP, Landisch RM, Lawrence AE, Mak GZ, Minneci P, Rymeski B, Sato TT, Slater BJ, Peter SSD. Does Use of a Feeding Protocol Change Outcomes in Gastroschisis? A Report from the Midwest Pediatric Surgery Consortium. Eur J Pediatr Surg. 2022 Apr;32(2):153-159. doi: 10.1055/s-0040-1721074. Epub 2020 Dec 27. PMID: 33368085.

Ding C, Shrestha R, Zhu X, Geller AE, Wu S, Woeste MR, Li W, Wang H, Yuan F, Xu R, Chariker JH, Hu X, Li H, Tieri D, Zhang H, Rouchka ED, Mitchell R, Siskind LJ, Zhang X, Xu XG, **McMasters KM**, Yu Y, Yan J. Inducing trained immunity in pro-metastatic macrophages to control tumor metastasis. Nature Immunology. 2023 Feb;24(2):239-254. doi: 10.1038/s41590-022-01388-8. Epub 2023 Jan 5. PMID: 36604547.

Doud A, Bond L, **Downard C**, **Vitale G**, **Fallat M**, **Foley D**, **Wright T**, **Bond S**. Management of complicated biliary disease in the pediatric population. Surgery. 2022 Mar;171(3):736-740. doi: 10.1016/j.surg.2021.09.041. Epub 2021 Nov 27. PMID: 34844759.

E

Egger ME. Incremental Improvements in the Ability to Distinguish High-Risk Intraductal Papillary Mucinous Neoplasms. Ann Surg Oncol. 2023 Feb 3. doi: 10.1245/s10434-023-13202-2. Epub ahead of print. PMID: 36735083.

Engwall-Gill AJ, Chan SS, Boyd KP, Saito JM, **Fallat ME**, St Peter SD, Bolger-Theut S, Crotty EJ, Green JR, Hulett Bowling RL, Kumbhar SS, Rattan MS, Young CM, Canner JK, Deans KJ, Gadepalli SK, Helmrath MA, Hirschl RB, Kabre R, Lal DR, Landman MP, Leys CM, Mak GZ, Minneci PC, **Wright TN**, Kunisaki SM; Midwest Pediatric Surgery Consortium. Accuracy of Chest Computed Tomography in Distinguishing Cystic Pleuropulmonary Blastoma From Benign Congenital Lung Malformations in Children. JAMA Netw Open. 2022 Jun 1;5(6):e2219814. doi: 10.1001/jamanetworkopen.2022.19814. PMID: 35771571; PMCID: PMC9247735.

Eruchalu CN, Etheridge JC, Hammaker AC, Kader S, Abelson JS, Harvey J, Farr D, Stopenski SJ, Nahmias JT, Elsaadi A, Campbell SJ, Foote DC, Ivascu FA, Montgomery KB, Zmijewski P, Byrd SE, Kimbrough MK, Smith S, Postlewait LM, Dodwad SM, Adams SD, Markesbery KC, Meister KM, Woeste MR, **Martin RCG 2nd**, Callahan ZM, Marks JA, Patel P, Anstadt MJ, Nasim BW, Willis RE, Patel JA, Newcomb MR, Stahl CC, Yafi MA, Sutton JM, George BC, Quillin RC 3rd, Cho NL, Cortez AR. Racial and Ethnic Disparities in Operative Experience Among General Surgery Residents: A Multi-Institutional Study from the US ROPE Consortium. Ann Surg. 2023 Mar 17. doi: 10.1097/SLA.0000000000005848. Epub ahead of print. PMID: 36928294.

Ettinger NA, Hill VL, Russ CM, Rakoczy KJ, **Fallat ME**, **Wright TN**, Choong K, Agus MSD, Hsu B; SECTION ON CRITICAL CARE, COMMITTEE ON HOSPITAL CARE, SECTION ON SURGERY, Mack E, Day S, Lowrie L, Siegel L, Srinivasan V, Gadepalli S, Hirshberg EL, Kissoon N, October T, Tamburro RF, Rotta A, Tellez S, Rauch DA, Ernst K, Vinocur C, Lam VT, Romito B, Hanson N, Gigli KH, Mauro M, Leonard MS, Alexander SN, Davidoff A, Besner GE, Browne M, **Downard CD**, Gow KW, Islam S, Saunders Walsh D, Williams RF, Thorne V. Guidance for Structuring a Pediatric Intermediate Care Unit. Pediatrics. 2022 May 1;149(5):e2022057009. doi: 10.1542/peds.2022-057009. PMID: 35490284.

F

Fallat ME, Treager C, Humphrey S, Gumer L, Jawad K, Butler E, Rogers FB, Rivara FP, Collings AT. A Novel Approach to Assessment of US Pediatric Trauma System Development. JAMA Surg. 2022 Nov 1;157(11):1042-1049. doi: 10.1001/jamasurg.2022.4303. PMID: 36129715; PMCID: PMC9494270.

Fallat ME. Contemporary Advice for Medical Providers Caring for Pilonidal Disease in Women. Dis Colon Rectum. 2022 Sep 1;65(9):1075-1076. doi: 10.1097/DCR.0000000000002463. Epub 2022 Mar 23. PMID: 35333795.

Filson A, Gaskins JT, **Martin RCG**. A meta-analysis and systematic review of intraoperative bile cultures association with postoperative complications in pancreaticoduodenectomy. Surgery. 2023 May;173(5):1231-1239. doi: 10.1016/j.surg.2022.12.012. Epub 2023 Jan 25. PMID: 36707272.

Flint L, **Smith JW**. A Tribute to J.D. Richardson, MD, FACS. J Trauma Acute Care Surg. 2022 Feb 1;92(2):241. doi: 10.1097/TA.0000000000003458. Erratum in: J Trauma Acute Care Surg. 2022 Apr 1;92(4):765. PMID: 34738998.

Flynn-O'Brien KT, Collings AT, Farazi M, **Fallat ME**, Minneci PC, Speck KE, Van Arendonk K, Deans KJ, Falcone RA Jr, **Foley DS**, Fraser JD, Gadepalli S, Keller MS, Kotagal M, Landman MP, Leys CM, Markel TA, Rubalcava N, St Peter SD, Sato TT; Midwest Pediatric Surgery Consortium. Pediatric Injury Transfer Patterns During the COVID-19 Pandemic: An Interrupted time Series Analysis. J Surg Res. 2022 Aug 30;281:130-142. doi: 10.1016/j.jss.2022.08.029. Epub ahead of print. PMID: 36155270; PMCID: PMC9424522.

Flynn-O'Brien KT, Collings AT, Farazi M, **Fallat ME**, Minneci PC, Speck KE, Van Arendonk K, Deans KJ, Falcone RA Jr, **Foley DS**, Fraser JD, Gadepalli S, Keller MS, Kotagal M, Landman MP, Leys CM, Markel TA, Rubalcava N, St Peter SD, Sato TT; Midwest Pediatric Surgery Consortium. Pediatric injury trends and relationships with social vulnerability during the COVID-19 pandemic: A multi-institutional analysis. J Trauma Acute Care Surg. 2023 Jan 1;94(1):133-140. doi: 10.1097/TA.0000000000003687. Epub 2022 May 20. PMID: 35995783; PMCID: PMC9812296.

Fraser JA, Deans KJ, **Fallat ME**, Helmrath M, Kabre R, Leys CM, Markel TA, Dillon PA, **Downard C**, **Wright TN**, Gadepalli SK, Grabowski JE, Hirschl R, Johnson KN, Kohler JE, Landman MP, Mak GZ, Minneci PC, Rymeski B, Sato TT, Slater BJ, Peter SDS, Fraser JD; Midwest Pediatric Surgery Consortium. Evaluating the risk of peri-umbilical hernia after sutured or sutureless gastroschisis closure. J Pediatr Surg. 2022 Mar 26:S0022-3468(22)00250-0. doi: 10.1016/j.jpedsurg.2022.03.019. Epub ahead of print. PMID: 35450699.

Fraser JD, Duran YK, Deans KJ, **Downard CD**, **Fallat ME**, Gadepalli SK, Hirschl RB, Lal DR, Landman MP, Leys CM, Mak GZ, Markel TA, Minneci PC, Sato TT, St Peter SD; Midwest Pediatric Surgery Consortium. Natural history and consequence of patent processus vaginalis: An interim analysis from a multi-institutional prospective observational study. J Pediatr Surg. 2022 Oct 3:S0022-3468(22)00603-0. doi: 10.1016/j.jpedsurg.2022.09.012. Epub ahead of print. PMID: 36307301.

Fromer MW, **Scoggins CR**, **Egger ME**, **Philips P**, **McMasters KM**, **Martin II RCG**. Preventing Futile Liver Resection: A Risk-Based Approach to Surgical Selection in Major Hepatectomy for Colorectal Cancer. Ann Surg Oncol. 2022 Feb;29(2):905-912. doi: 10.1245/s10434-021-10761-0. Epub 2021 Sep 14. PMID: 34522997; PMCID: PMC8439367.

Fromer MW, Wilson KD, **Philips P**, **Egger ME**, **Scoggins CR**, **McMasters KM**, **Martin RCG**. Locally advanced pancreatic cancer: a reliable contraindication to resection in the modern era? HPB (Oxford). 2022 Oct;24(10):1789-1795. doi: 10.1016/j.hpb.2021.09.002. Epub 2021 Sep 24. PMID: 35491339.

Fromer MW, **Scoggins CR**, **Egger ME**, **Philips P**, **McMasters KM**, **Martin RCG**. Authors' reply to preventing futile liver resection: biology should be central in patients' selection. Ann Surg Oncol 2022;29:5859-5860.

Furmanek S, Salunkhe V, Pahwa S, Samanapally H, Nathala P, Xu Q, Ali T, Deepti F, Glynn A, McGuffin T, Titus D, Farah I, **Jones CM**, Ramirez JA, Clifford SP, Arnold FW, Kong M, Roser L, Huang J; Center of Excellence for Research in Infectious Diseases Coronavirus Study Group on behalf of the COVID-19 CardioVascular Research Group. Correlations of Before and After Event Echocardiographic Parameters with Troponin and BNP in Hospitalized COVID-19 Patients With Cardiovascular Events. J Cardiothorac Vasc Anesth. 2022 Sep 2;36(12):4553–5. doi: 10.1053/j.jvca.2022.08.024. Epub ahead of print. PMID: 36184474; PMCID: PMC9436869.

G

Galandiuk S. Sixty-Five Years Since the First Issue of Diseases of the Colon & Rectum! Dis Colon Rectum. 2023 Jan 1;66(1):1-2. doi: 10.1097/DCR.0000000000002658. Epub 2022 Oct 26. PMID: 36515508.

Gelbard RB, Nahmias J, Byerly S, Ziesmann M, Stein D, Haut ER, **Smith JW**, Boltz M, Zarzaur B, Callum J, Cotton BA, Cripps M, Gunter OL, Holcomb JB, Kerby J, Kornblith LZ, Moore EE, Riojas CM, Schreiber M, Sperry JL, Yeh DD. Establishing a Core Outcomes Set for Massive Transfusion: an EAST Modified Delphi Method Consensus Study. J Trauma Acute Care Surg. 2023 Jan 23. doi: 10.1097/TA.0000000000003884. Epub ahead of print. PMID: 36727810.

Geller AE, Shrestha R, Woeste MR, Guo H, Hu X, Ding C, Andreeva K, Chariker JH, Zhou M, Tieri D, Watson CT, Mitchell RA, Zhang HG, Li Y, **Martin II RCG**, Rouchka EC, Yan J. The induction of peripheral trained immunity in the pancreas incites anti-tumor activity to control pancreatic cancer progression. Nat Commun. 2022 Feb 9;13(1):759. doi: 10.1038/s41467-022-28407-4. PMID: 35140221; PMCID: PMC8828725.

Georgeades CM, Collings AT, Farazi M, **Fallat ME**, Minneci PC, Sato TT, Speck KE, Van Arendonk K, Deans KJ, Falcone RA, **Foley DS**, Fraser J, Gadepalli S, Keller MS, Kotagal M, Landman MP, Leys CM, Markel TA, Rubalcava N, St Peter SD, Flynn-O'Brien KT. A multi-institutional study evaluating pediatric burn injuries during the COVID-19 pandemic. J Burn Care Res. 2022 Aug 19:irac118. doi: 10.1093/jbcr/irac118. Epub ahead of print. PMID: 35985296; PMCID: PMC9452075.

Gil LA, Lutz CM, Dillon PA, **Downard CD**, Ehrlich PF, **Fallat ME**, Fraser JD, Grabowski JE, Helmrath MA, Hertweck SP, Hirschl RB, Kabre R, Lal DR, Landman MP, Lawrence AE, Leys CM, Mak GZ, Markel TA, Raiji MT, Rymeski B, Saito JM, Sato TT, St Peter SD, Stafford LMC, Deans KJ, Minneci PC, Hewitt GD, Aldrink JH; Midwest Pediatric Surgery Consortium. Use and Accuracy of Intraoperative Frozen Section Analysis for Ovarian Masses in Children and Adolescents. J Pediatr Adolesc Gynecol. 2022 Oct 7:S1083-3188(22)00295-9. doi: 10.1016/j.jpag.2022.10.001. Epub ahead of print. PMID: 36209999.

Grzeda AL, Hicks AC, Cheadle GA, Sangroula D, **Wayne EJ**, **Dwivedi AJ**, **Sigdel A**. Endovascular Repair of Transected Axillary Artery via Snare Assisted Through and Through Femoral to Brachial Artery Access. Am Surg. 2022 Jul;88(7):1543-1545. doi: 10.1177/00031348221083936. Epub 2022 Mar 25. PMID: 35337191.

Gupta S, Grier Arthur L, Chandler N, Danielson P, **Downard C**, Ehrlich P, Gaines B, Gray B, Javid P, Lallier M, Nwomeh B, Tagge E, Weiss R, Tsao K, Garrison AP, Mak G. Is the changing landscape of fellowship recruitment during COVID-19 here to stay? J Pediatr Surg. 2022 Oct;57(10):445-450. doi: 10.1016/j.jpedsurg.2021.10.024. Epub 2021 Oct 29. PMID: 34857373; PMCID: PMC8628613.

Gupta S, Jackson JE, Shindorf ML, Arthur LG, Chandler N, Danielson P, **Downard C**, Ehrlich P, Gaines B, Gray B, Javid P, Lallier M, Nwomeh B, Tagge E, Weiss R, Mak G, Garrison AP. Success in pediatric surgery: An updated survey of Program Directors 2020. J Pediatr Surg. 2022 Oct;57(10):438-444. doi: 10.1016/j.jpedsurg.2021.10.055. Epub 2021 Nov 6. PMID: 34865831.

H

Hammaker AC, Dodwad SM, Salyer CE, Adams SD, Foote DC, Ivascu FA, Kader S, Abelson JS, Al Yafi M, Sutton JM, Smith S, Postlewait LM, Stopenski SJ, Nahmias JT, Harvey J, Farr D, Callahan ZM, Marks JA, Elsaadi A, Campbell SJ, Stahl CC, Hanseman DJ, Patel P, Woeste MR, **Martin RCG**, Patel JA, Newcomb MR, Greenwell K, Meister KM, Etheridge JC, Cho NL, Thrush CR, Kimbrough MK, Nasim BW, Willis RE, George BC, Quillin RC 3rd, Cortez AR. A multi-institutional study from the US ROPE Consortium examining factors associated with directly entering practice upon residency graduation. Surgery. 2022 Sep;172(3):906-912. doi: 10.1016/j.surg.2022.05.033. Epub 2022 Jul 1. PMID: 35788283.

Hicks AC, Sangroula D, **Dwivedi AJ**, **Wayne EJ**, **Sigdel A**. Inferior vena cava perforation during percutaneous filter removal. Vascular. 2022 Oct 21:17085381221135268. doi: 10.1177/17085381221135268. Epub ahead of print. PMID: 36269323.

Hicks A, Grzeda A, Schucht J, Bond J, Bush C, **Dwivedi A**, **Sigdel A**. Comparing Patency Rates of Arteriovenous Dialysis Access following Percutaneous Thrombectomy Using Various Catheter Directed Therapies. Ann Vasc Surg. 2023 Jan 7:S0890-5096(22)00898-6. doi: 10.1016/j.avsg.2022.12.067. Epub ahead of print. PMID: 36623720.

IJK

Ising MS, Smith SA, Trivedi JR, **Martin RC**, **Phillips P**, **Van Berkel V**, **Fox MP**. Minimally Invasive Esophagectomy Is Associated with Superior Survival Compared to Open Surgery. Am Surg. 2022 Mar 23:31348221078962. doi: 10.1177/00031348221078962. Epub ahead of print. PMID: 35317621.

Kachare MD, Barrow BE, Corey S, Elfanagely O, Rossi AJ, Simpson AM, Kachare SD, **Choo J**, **Wilhelmi BJ**. Prevention of Implant Malposition in Latissimus Dorsi Myocutaneous Flap Breast Reconstruction Using an Acellular Dermal Matrix With Pectoralis Muscle Following Mastectomy for Breast Cancer: A Clinical Review. Eplasty. 2022 Sep 6;22:e39. PMID: 36160664; PMCID: PMC9490880.

Kachare MD, Kachare SD, Vivace BJ, Elfanagely O, Barrow B, O'Toole A, Simpson AM, Safeek R, **Choo JH**, **McCurry TM**, **Wilhelmi BJ**. Restoring Breast Volume in High BMI Patients: A Single-Center Review of Breast Reconstruction Using Hyperinflated Saline Implants. Eplasty. 2022 Jul 21;22:e30. PMID: 36000008; PMCID: PMC9361388.

Kachare MD, Elfanagely O, Safeek RH, Barrow B, Simpson AM, O'Toole A, Hsiao EC, Kachare SD, Engineer N, Quintero J, **Wilhelmi BJ**. Complete Penile Amputation: An Anatomical Reference and Surgical Pearls to Ensure a Successful Replantation. Eplasty. 2022 Aug 16;22:ic12. PMID: 36160661; PMCID: PMC9490876.

Kachare SD, Kachare MD, Vivace BJ, Barrow BE, Ablavsky M, Abell S, **Choo JH**, **Wilhelmi BJ**. The 5 D's to Dunk the Dog: A Retrospective Clinical Review to Prevent Dog-Ear Contour Abnormalities in Vertical Breast Reductions and Breast Lifts. Eplasty. 2023 Feb 27;23:e13. PMID: 36919153; PMCID: PMC10008304.

Kaikaus J, Moseley MD, **Dwivedi AJ**, **Sigdel A**. A Large True Brachial Artery Aneurysm in an Infant. Am Surg. 2022 Aug;88(8):1938-1939. doi: 10.1177/00031348221087903. Epub 2022 Apr 28. PMID: 35484636.

Kavalukas SL, Scheurlen KM, **Galandiuk S**. State-of-the-art surgery for Crohn's disease: Part I-small intestine/ileal disease. Langenbecks Arch Surg. 2022 May;407(3):885-895. doi: 10.1007/s00423-021-02324-4. Epub 2021 Nov 4. PMID: 34738167.

Kavalukas S, McClave SA. Immunonutrition vs standard nutrition for patients with cancer. Nutr Clin Pract. 2023 Feb 14. doi: 10.1002/ncp.10963. Epub ahead of print. PMID: 36788760.

Kaylor DM, Caminiti N, **Harbrecht B**, McPheeters C, Scherrer LA. Safety of De-Escalating Empiric Antimicrobial Agents in Trauma Patients with Indigenous Oral Flora Ventilator-Associated Pneumonia. Surg Infect (Larchmt). 2022 Aug;23(6):597-603. doi: 10.1089/sur.2022.126. PMID: 35917387.

Kelly KN, Macedo FI, Seaton M, Wilson G, Hammill C, **Martin RC**, et al. Intraoperative pancreatic neck margin assessment during pancreaticoduodenectomy for pancreatic adenocarcinoma in the era of neoadjuvant therapy: a multi-institutional analysis from the central pancreatic consortium. Ann Surg Oncol 2022;29:6004-6012.

Knaus ME, Onwuka AJ, Bowder A, Courtney C, Deans KJ, **Downard CD**, Duran YK, **Fallat ME**, Fraser JD, Gadepalli SK, Kabre R, Kalbfell EL, Kohler J, Lal DR, Landman MP, Lawrence AE, Leys CM, Lu P, Mak GZ, Markel TA, Merchant N, Nguyen T, Pilkington M, Port E, Rymeski B, Saito J, Sato TT, St Peter SD, **Wright T**, Minneci PC, Grabowski JE; Midwest Pediatric Surgery Consortium. Disparities in the Management of Pediatric Breast Masses. J Surg Res. 2022 Nov;279:648-656. doi: 10.1016/j.jss.2022.06.049. Epub 2022 Aug 3. PMID: 35932719.

Knaus ME, Onwuka AJ, Afrazi A, Breech L, Corkum KS, Dillon PA, Ehrlich PF, **Fallat ME**, Fraser JD, Gadepalli SK, Grabowski JE, Hertweck SP, Kabre R, Lal DR, Landman MP, Lawrence AE, Leys CM, Mak GZ, Markel TA, Merchant N, Elliott Overman R, Rademacher BL, Raiji MT, Rymeski B, Sato TT, Scannell M, Schikler AG, Sujka JA, **Wright T**, Aldrink JH, Hewitt GD, Minneci PC, Deans KJ; Midwest Pediatric Surgery Consortium. Laparoscopy versus laparotomy for pediatric ovarian dermoids. J Pediatr Surg. 2022 Jun;57(6):1008-1012. doi: 10.1016/j.jpedsurg.2022.01.053. Epub 2022 Feb 12. PMID: 35292164.

Knaus ME, Onwuka AJ, Afrazi A, Breech L, Corkum KS, Dillon PA, Ehrlich PF, **Fallat ME**, Fraser JD, Gadepalli SK, Grabowski JE, Hertweck SP, Kabre R, Lal DR, Landman MP, Lawrence AE, Leys CM, Mak GZ, Markel TA, Merchan N, Overman RE, Rademacher BL, Raiji MT, Rymeski B, Sato TT, Scannel M, Schikler AG, Sujka JA, **Wright T**, Aldrink JH, Hewitt GD, Minneci PC, Deans KJ; Midwest Pediatric Surgery Consortium. Multi-Institutional Review of the Preoperative Diagnostic Accuracy for Pediatric Ovarian Mature Cystic Teratomas. J Pediatr Adolesc Gynecol. 2022 Aug;35(4):478-485. doi: 10.1016/j.jpag.2022.01.009. Epub 2022 Feb 4. PMID: 35124214.

Kunisaki SM, Saito JM, **Fallat ME**, Peter SDS, Lal DR, Karmakar M, Deans KJ, Gadepalli SK, Hirschl RB, Minneci PC, Helmrath MA; Midwest Pediatric Surgery Consortium. Fetal Risk Stratification and Outcomes in Children with Prenatally Diagnosed Lung Malformations: Results from a Multi-Institutional Research Collaborative. Ann Surg. 2022 Nov 1;276(5):e622-e630. doi: 10.1097/SLA.0000000000004566. Epub 2020 Nov 17. PMID: 33214447.

L

Lee SA, Hata JL, Thompson MP, **Fallat ME**, Riggle KM, Bickel SG. Atypical pulmonary carcinoid tumor encapsulated by a Staphylococcus aureus infection. Pediatr Pulmonol. 2023 Jan;58(1):353-355. 2022 Oct 4. doi: 10.1002/ppul.26175. Epub ahead of print. PMID: 36193652.

Lewis RE, Muluk SL, Reitz KM, Guyette FX, Brown JB, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Yazer MH, Heidel RE, Rowe AS, Sperry JL, Daley BJ; PAMPer Study Group. Prehospital plasma is associated with survival principally in patients transferred from the scene of injury: A secondary analysis of the PAMPer trial. Surgery. 2022 Oct;172(4):1278-1284. doi: 10.1016/j.surg.2022.04.039. Epub 2022 Jul 19. PMID: 35864051; PMCID: PMC9999176.

Li Y, Lam SSK, Shi XJ, Tan M, **Martin RC**. Thermal ablation enhances immotherapeutic effect of IP-001 on orthotopic liver cancer in a rat model [abstract A7]. Ann Surg Oncol 2022;29:508.

Li Y, Hong YK, Wang X, Pandit H, Zheng Q, Yu Y, Shi X, Chen Y, Tan M, Pulliam Z, Bhutiani N, Lin A, Badach J, Zhang P, **Martin RC**. Epigenetic modulation enhances immunotherapy for pancreatic ductal adenocarcinoma. Clin Transl Immunology. 2022 Nov 28;11(12):e1430. doi: 10.1002/cti2.1430. PMID: 36452477; PMCID: PMC9705274.

Lupton JR, Davis-O'Reilly C, Jungbauer RM, Newgard CD, **Fallat ME**, Brown JB, Mann NC, Jurkovich GJ, Bulger E, Gestring ML, Lerner EB, Chou R, Totten AM. Mechanism of injury and special considerations as predictive of serious injury: A systematic review. Acad Emerg Med. 2022 Sep;29(9):1106-1117. doi: 10.1111/acem.14489. Epub 2022 Apr 22. PMID: 35319149; PMCID: PMC9545392.

Lupton JR, Davis-O'Reilly C, Jungbauer RM, Newgard CD, **Fallat ME**, Brown JB, Mann NC, Jurkovich GJ, Bulger E, Gestring ML, Lerner EB, Chou R, Totten AM. Under-Triage and Over-Triage Using the Field Triage Guidelines for Injured Patients: A Systematic Review. Prehosp Emerg Care. 2022 Mar 4:1-8. doi: 10.1080/10903127.2022.2043963. Epub ahead of print. PMID: 35191799.

M

Macleod A, **Kavalukas SL**, Scheurlen KM, **Galandiuk S**. State-of-the-art surgery for Crohn's disease: Part II-colonic Crohn's disease and associated neoplasms. Langenbecks Arch Surg. 2022 Nov;407(7):2595-2605. doi: 10.1007/s00423-022-02572-y. Epub 2022 Jun 22. PMID: 35729401.

Marquart JP, Bowder AN, Bence CM, St Peter SD, Gadepalli SK, Sato TT, Szabo A, Minneci PC, Hirschl RB, Rymeski BA, **Downard CD**, Markel TA, Deans KJ, **Fallat ME**, Fraser JD, Grabowski JE, Helmrath MA, Kabre RD, Kohler JE, Landman MP, Lawrence AE, Leys CM, Mak GZ, Port E, Saito J, Silverberg J, Slidell MB, **Wright TN**, Lal DR; Midwest Pediatric Surgery Consortium. Thoracoscopy versus thoracotomy for esophageal atresia and tracheoesophageal fistula: Outcomes from the Midwest Pediatric Surgery Consortium. J Pediatr Surg. 2022 Sep 24:S0022-3468(22)00607-8. doi: 10.1016/j.jpedsurg.2022.09.015. Epub ahead of print. PMID: 36283849.

Martin RCG 2nd, Simo KA, Hansen P, Rocha F, **Philips P**, **McMasters KM**, Tatum CM, Kelly LR, Driscoll M, Sharma VR, Crocenzi TS, **Scoggins CR**. ASO *Visual Abstract:* Drug-Eluting Beads with Irinotecan Therapy of Unresectable Intrahepatic Cholangiocarcinoma (DELTIC) with Concomitant Systemic Gemcitabine and Cisplatin. Ann Surg Oncol. 2022 Sep;29(9):5474-5475. doi: 10.1245/s10434-022-12022-0. Epub 2022 Jul 12. PMID: 35829798.

Martin RCG, Simo KA, Hansen OP, Rocha F, **Philips P**, **McMasters KM**, Tatum CM, Kelly LR, Driscoll M, Sharma VR, Crocenzi TS, **Scoggins CR**. Drug-eluting bead, irinotecan therapy of unresectable intrahepatic cholangiocarcinoma (DELTIC) with conconmitant systemic gemcitabine and cisplatin. Ann Surg Oncol 2022;29:5462-5473.

Martin RCG 2nd, Woeste M, **Egger ME**, **Scoggins CR**, **McMasters KM**, **Philips P**. Patient Selection and Outcomes of Laparoscopic Microwave Ablation of Hepatocellular Carcinoma. Cancers (Basel). 2023 Mar 25;15(7):1965. doi: 10.3390/cancers15071965. PMID: 37046625.

Martin RCG 2nd, Schoen EC, **Philips P**, **Egger ME**, **McMasters KM**, **Scoggins CR**. Impact of margin accentuation with intraoperative irreversible electroporation on local recurrence in resected pancreatic cancer. Surgery. 2023 Mar;173(3):581-589. doi: 10.1016/j.surg.2022.07.033. Epub 2022 Oct 8. PMID: 36216618; PMCID: PMC9918678.

Miller KR, **Egger ME**, Pike A, Burden J, **Bozeman MC**, **Franklin GA**, **Nash NA**, **Smith JW**, **Harbrecht BG**, **Benns MV**. The limitations of hospital and law enforcement databases in characterizing the epidemiology of firearm injury. J Trauma Acute Care Surg. 2022 Jan 1;92(1):82-87. doi: 10.1097/TA.0000000000003367. PMID: 34284466.

Miller KR. Invited Commentary: The Necessity of Sub-Typing Firearm Injury to Facilitate an Overdue Public Health Approach to "Gun Violence". J Am Coll Surg. 2023 Jan 1;236(1):45-46. doi: 10.1097/XCS.0000000000000437. Epub 2022 Dec 15. PMID: 36519908.

Minneci PC, Hade EM, Gil LA, Metzger GA, Saito JM, Mak GZ, Hirschl RB, Gadepalli S, Helmrath MA, Leys CM, Sato TT, Lal DR, Landman MP, Kabre R, **Fallat ME**, Cooper JN, Deans KJ; Midwest Pediatric Surgery Consortium. Demographic and Clinical Characteristics Associated With the Failure of Nonoperative Management of Uncomplicated Appendicitis in Children: Secondary Analysis of a Nonrandomized Clinical Trial. JAMA Netw Open. 2022 May 2;5(5):e229712. doi: 10.1001/jamanetworkopen.2022.9712. PMID: 35499827; PMCID: PMC9062687.

Mirzaei A, **Carter SR**, Patanwala AE, Schneider CR. Missing data in surveys: Key concepts, approaches, and applications. Res Social Adm Pharm. 2022 Feb;18(2):2308-2316. doi: 10.1016/j.sapharm.2021.03.009. Epub 2021 Mar 19. PMID: 33775556.Mouw TJ, **Scoggins CR**. Radiographic features and behaviors of neuroendocrine tumors: can we judge a book by its cover? Hepatobiliary Surg Nutri 2021;10:573-574.

Mouw TJ, Foster J, Senders Z, **McMasters KM**, **Philips P**, **Egger ME**, **Scoggins CR**, **Martin RC**. Disparate survival for colorectal cancer iin rural vs urbanpopulatins is not explained by lack of receipt of guideline-concordant therapy [abstract 65]. Ann Surg Oncol 2022;29:362.

Mouw TJ, Senders Z, **Philips P**, **Scoggins CR**, **Egger ME**, Al-Kasspooles MF, **McMasters KM**, **Martin RCG 2nd**. Continuous manual agitation significantly improves temperature distribution during closed hyperthermic intraperitoneal chemotherapy: Results of a porcine model. Surgery. 2022 Oct 12:S0039-6060(22)00691-2. doi: 10.1016/j.surg.2022.08.036. Epub ahead of print. PMID: 36243569.

Mullinax JE, **Egger ME**, McCarter M, Monk BJ, Toloza EM, Brousseau S, Jagasia M, Sarnaik A. Surgical Considerations for Tumor Tissue Procurement to Obtain Tumor-Infiltrating Lymphocytes for Adoptive Cell Therapy. Cancer J. 2022 Jul-Aug 01;28(4):285-293. doi: 10.1097/PPO.0000000000000608. PMID: 35880938; PMCID: PMC9335895.

Multicenter Selective Lymphadenectomy Trials Study Group, Crystal JS, Thompson JF, Hyngstrom J, Caracò C, Zager JS, Jahkola T, Bowles TL, Pennacchioli E, Beitsch PD, Hoekstra HJ, Moncrieff M, Ingvar C, van Akkooi A, Sabel MS, Levine EA, Agnese D, Henderson M, Dummer R, Neves RI, Rossi CR, Kane JM 3rd, Trocha S, Wright F, Byrd DR, Matter M, Hsueh EC, MacKenzie-Ross A, Kelley M, Terheyden P, Huston TL, Wayne JD, Neuman H, Smithers BM, Ariyan CE, Desai D, Gershenwald JE, Schneebaum S, Gesierich A, Jacobs LK, Lewis JM, **McMasters KM**, O'Donoghue C, van der Westhuizen A, Sardi A, Barth R, Barone R, McKinnon JG, Slingluff CL, Farma JM, Schultz E, Scheri RP, Vidal-Sicart S, Molina M, Testori AAE, Foshag LJ, Van Kreuningen L, Wang HJ, Sim MS, Scolyer RA, Elashoff DE, Cochran AJ, Faries MB. Therapeutic Value of Sentinel Lymph Node Biopsy in Patients With Melanoma: A Randomized Clinical Trial. JAMA Surg. 2022 Sep 1;157(9):835-842. doi: 10.1001/jamasurg.2022.2055. PMID: 35921122; PMCID: PMC9475390.

Musick JR, Gaskins JT, **Martin RCG**. A meta-analysis and systematic review of the comparison of laparoscopic ablation to percutaneous ablation for hepatic malignancies. Int J Clin Oncol. 2023 Apr;28(4):565-575. doi: 10.1007/s10147-023-02304-2. Epub 2023 Feb 6. PMID: 36745265.

Musick JR, **Philips P**, **Scoggins CR**, **Egger ME**, **McMasters KM**, **Martin RC 2nd**. Laparoscopic microwave ablation versus percutaneous microwave ablation of hepatic malignancies: Efficacy and recurrence-free survival outcomes in patients. Surgery. 2023 Mar;173(3):598-602. doi: 10.1016/j.surg.2022.06.054. Epub 2022 Oct 19. PMID: 36270823.

N

Nahmias J, Byerly S, Stein D, Haut ER, **Smith JW**, Gelbard R, Ziesmann M, Boltz M, Zarzaur B, Biffl WL, Brenner M, DuBose J, Fox C, Galante J, Martin M, Moore EE, Moore L, Morrison J, Norii T, Scalea T, Yeh DD. A core outcome set for resuscitative endovascular balloon occlusion of the aorta: A consensus based approach using a modified Delphi method. J Trauma Acute Care Surg. 2022 Jan 1;92(1):144-151. doi: 10.1097/TA.0000000000003405. PMID: 34554137.

Newgard CD, Fischer PE, Gestring M, Michaels HN, Jurkovich GJ, Lerner EB, **Fallat ME**, Delbridge TR, Brown JB, Bulger EM; Writing Group for the 2021 National Expert Panel on Field Triage. National guideline for the field triage of injured patients: Recommendations of the National Expert Panel on Field Triage, 2021. J Trauma Acute Care Surg. 2022 Aug 1;93(2):e49-e60. doi: 10.1097/TA.0000000000003627. Epub 2022 Apr 27. PMID: 35475939; PMCID: PMC9323557.

Newgard CD, Babcock SR, Song X, Remick KE, Gausche-Hill M, Lin A, Malveau S, Mann NC, Nathens AB, Cook JNB, Jenkins PC, Burd RS, Hewes HA, Glass NE, Jensen AR, **Fallat ME**, Ames SG, Salvi A, McConnell KJ, Ford R, Auerbach M, Bailey J, Riddick TA, Xin H, Kuppermann N; Pediatric Readiness Study Group. Emergency Department Pediatric Readiness Among US Trauma Centers: A Machine Learning Analysis of Components Associated with Survival. Ann Surg. 2022 Nov 1. doi: 10.1097/SLA.0000000000005741. Epub ahead of print. PMID: 36538639.

Nicolas CT, **Carter SR**, Martin CA. Impact of maternal factors, environmental factors, and race on necrotizing enterocolitis. Semin Perinatol. 2023 Feb;47(1):151688. doi: 10.1016/j.semperi.2022.151688. Epub 2022 Dec 21. PMID: 36572622.

OP

O'Brien SJ, Scheurlen K, Rochet A, Fiechter C, Paas M, Pan J, Rai SN, **Galandiuk S**. Increased Expression of Long Non-coding RNA H19 is Associated With Colon Cancer Recurrence. J Surg Res. 2022 Jan;269:59-68. doi: 10.1016/j.jss.2021.08.004. Epub 2021 Sep 11. PMID: 34520983.

O'Brien SJ, Bhutiani N, Young JI, **Phillips P**, Weaver KH, Kline D, **Vitale GC**. Impact of myopenia and myosteatosis in patients undergoing abdominal surgery for chronic pancreatitis. Surgery. 2022 Jul;172(1):310-318. doi: 10.1016/j.surg.2022.01.021. Epub 2022 Mar 1. PMID: 35246331.

O'brien SJ, Gaskins JT, **Ellis CT**, Martin BA, Mcdowell J, Gondim DD, **Galandiuk S**. Temporal increase in the incidence of anal squamous cell carcinoma in Kentucky and factors associated with adverse outcomes. Cancer Med. 2023 Mar 29. doi: 10.1002/cam4.5865. Epub ahead of print. PMID: 36991580.

O'Neill CH, Tan M, Yan J, Li Y, **Martin RCG**. Perioperative systemic immunophenotype following irreversible electroporation (IRE) predicts recurrence. Am J Cancer Res. 2022 Jan 15;12(1):165-175. PMID: 35141011; PMCID: PMC8822285.

Pawlik TM, **McMasters KM**. Practice-Changing Evidence in Surgical Oncology: An Annals of Surgical Oncology Series. Ann Surg Oncol. 2023 Apr;30(4):1930-1931. doi: 10.1245/s10434-023-13135-w. Epub 2023 Jan 21. PMID: 36681735.

Pera SJ, Schucht J, **Smith JW**. Direct Peritoneal Resuscitation for Trauma. Adv Surg. 2022 Sep;56(1):229-245. doi: 10.1016/j.yasu.2022.03.003. Epub 2022 Jul 20. PMID: 36096569.

QR

Reshko LB, Pan J, Rai SN, **Ajkay N**, Dragun A, Roberts TL, Riley EC, Quillo AR, **Scoggins CR**, **McMasters KM**, Eldredge-Hindy H. Final Analysis of a Phase 2 Trial of Once Weekly Hypofractionated Whole Breast Irradiation for Early-Stage Breast Cancer. Int J Radiat Oncol Biol Phys. 2022 Jan 1;112(1):56-65. doi: 10.1016/j.ijrobp.2021.06.026. Epub 2021 Oct 25. PMID: 34710520.

Risinger WB, **Pera SJ**, Bhutiani N, Ruther M, **Harbrecht BG**, **Smith JW**, **Benns MV**, **Miller KR**. A new pandemic and an old epidemic: The impact of COVID-19 and gun violence as measured by years of potential life lost in a US city. Surgery. 2022 Nov;172(5):1555-1562. doi: 10.1016/j.surg.2022.06.040. Epub 2022 Jul 15. PMID: 36055817; PMCID: PMC9283608.

S

Safeek RH, Vavra J, Kachare MD, **Wilhelmi BJ**, **Choo J**. Functional Disability Associated With Proximal Clavicle Resection and Pectoralis Flap Transposition for Sternoclavicular Joint Infections. Eplasty. 2022 Aug 18;22:e34. PMID: 36160665; PMCID: PMC9490884.

Safeek RH, O'Toole A, Furtado WR, **Wilhemi BJ**, **Choo JH**. Isolated Ulnar Artery Injury: Indications for and Timing of Operative Intervention. Eplasty. 2022 Aug 24;22:e37. PMID: 36160666; PMCID: PMC9490881.

Sangroula D, Maggard B, Abdelhaleem A, Furmanek S, Clemons V, Marsili B, Stikes R, Hill M, **Sigdel A**, Clifford SP, Huang J, Akca O, Logsdon MC. Hemodynamic changes associated with neuraxial anesthesia in pregnant women with covid 19 disease: a retrospective case-control study. BMC Anesthesiol. 2022 Jun 9;22(1):179. doi: 10.1186/s12871-022-01719-0. PMID: 35681119; PMCID: PMC9178224.

Scheurlen KM, Snook DL, Walter MN, Cook CN, Fiechter CR, Pan J, Beal RJ, **Galandiuk S**. Itaconate and leptin affecting PPARγ in M2 macrophages: A potential link to early-onset colorectal cancer. Surgery. 2022 Mar;171(3):650-656. doi: 10.1016/j.surg.2021.10.054. Epub 2021 Dec 6. PMID: 34876290; PMCID: PMC8885843.

Scheurlen KM, Chariker JH, Kanaan Z, Littlefield AB, George JB, Seraphine C, Rochet A, Rouchka EC, **Galandiuk S**. The NOTCH4-GATA4-IRG1 axis as a novel target in early-onset colorectal cancer. Cytokine Growth Factor Rev. 2022 Oct;67:25-34. doi: 10.1016/j.cytogfr.2022.06.002. Epub 2022 Jun 30. PMID: 35941043.

Scheurlen KM, MacLeod A, **Kavalukas SL**, **Galandiuk S**. State-of-the-art surgery for Crohn's disease: part III-perianal Crohn's disease. Langenbecks Arch Surg. 2023 Mar 30;408(1):132. doi: 10.1007/s00423-023-02856-x. PMID: 36995518.

Scheurlen KM, Snook DL, Alfieri T, Littlefield AB, George JB, Seraphine C, Cook CN, Rochet A, Gaskins JT, **Galandiuk S**. Obesity hormones and itaconate mediating inflammation in human colon cancer cells - Another lead to early-onset colon cancer? Heliyon. 2023 Jan 21;9(2):e13132. doi: 10.1016/j.heliyon.2023.e13132. PMID: 36825172; PMCID: PMC9941943.

Scoggins CR, **Egger ME**. Improved Access to Healthcare is Good for Everyone. Ann Surg Oncol. 2022 Jan;29(1):17-19. doi: 10.1245/s10434-021-10793-6. Epub 2021 Sep 17. PMID: 34533677.

Senders ZJ, **Martin RCG 2nd**. Intratumoral Immunotherapy and Tumor Ablation: A Local Approach with Broad Potential. Cancers (Basel). 2022 Mar 30;14(7):1754. doi: 10.3390/cancers14071754. PMID: 35406525; PMCID: PMC8996835.

Senders ZJ, Bartlett E, Mouw TJ, **McMasters KM**, **Egger ME**. Stage migration as a consequence of omitting completion lymph node dissection for melanoma [abstract 52]. Ann Surg Oncol 2022;29:355.

Senders ZJ, Bartlett EK, Mouw TJ, **McMasters KM**, **Egger ME**. ASO Visual Abstract: Does Stage Migration Occur as a Consequence of Omitting Completion Lymph Node Dissection for Melanoma? Ann Surg Oncol. 2023 Apr 12. doi: 10.1245/s10434-023-13439-x. Epub ahead of print. PMID: 37043035.

Senders ZJ, Bartlett EK, Mouw TJ, **McMasters KM**, **Egger ME**. Does Stage Migration Occur as a Consequence of Omitting Completion Lymph Node Dissection for Melanoma? Ann Surg Oncol. 2023 Mar 19. doi: 10.1245/s10434-023-13342-5. Epub ahead of print. PMID: 36934378.

Simpson AM, Barrow BE, Corey SL, Kachare MD, **Choo JH**, **Wilhelmi BJ**. Red Breast Syndrome: Complete Resolution Following Replacement of Acellular Dermal Matrices With Acellular Collagen Matrices. Eplasty. 2022 Sep 6;22:QA1. PMID: 36330504; PMCID: PMC9615911.

Smith JW, Schucht JE, **Harbrecht BG**, Bond LM, Matheson PJ. Effect of Plasma Resuscitation with Adjunctive Peritoneal Resuscitation on Hepatic Blood Flow and End-Organ Damage after Hemorrhagic Shock. J Am Coll Surg. 2022 Oct 1;235(4):643-653. doi: 10.1097/XCS.0000000000000284. Epub 2022 Sep 15. PMID: 36106867.

TUV

Tran BV, Moris D, Markovic D, Zaribafzadeh H, Henao R, Lai Q, Florman SS, Tabrizian P, Haydel B, Ruiz RM, Klintmalm GB, Lee DD, Taner CB, Hoteit M, Levine MH, Cillo U, Vitale A, Verna EC, Halazun KJ, Tevar AD, Humar A, Chapman WC, Vachharajani N, Aucejo F, Lerut J, Ciccarelli O, Nguyen MH, Melcher ML, Viveiros A, Schaefer B, Hoppe-Lotichius M, Mittler J, Nydam TL, Markmann JF, Rossi M, Mobley C, Ghobrial M, Langnas AN, Carney CA, Berumen J, Schnickel GT, Sudan DL, Hong JC, Rana A, **Jones CM**, Fishbein TM, Busuttil RW, Barbas AS, Agopian VG. Development and validation of a REcurrent Liver cAncer Prediction ScorE (RELAPSE) following liver transplantation in patients with hepatocellular carcinoma: analysis of the us multicenter hcc transplant consortium. Liver Transpl. 2023 Apr 10. doi: 10.1097/LVT.0000000000000145. Epub ahead of print. PMID: 37029083.

Vavra JM, Kachare SD, Vivace BJ, **Choo JH**, **Wilhelmi BJ**. Centralizing the Umbilicus in Abdominoplasty: Eccentric versus Concentric Fascial Plication in Addition to Medializing at the Skin. Plast Reconstr Surg. 2023 Mar 1;151(3):526-531. doi: 10.1097/PRS.0000000000009910. Epub 2022 Nov 21. PMID: 36730529.

Verna EC, Phipps MM, Halazun KJ, Markovic D, Florman SS, Haydel BM, Ruiz R, Klintmalm G, Lee DD, Taner B, Hoteit MA, Tevar AD, Humar A, Chapman WC, Vachharajani N, Aucejo FN, Melcher ML, Nguyen MH, Nydam TL, Markmann JF, Mobley C, Ghobrial RM, Langnas AN, Carney C, Berumen J, Schnickel GT, Sudan D, Hong JC, Rana A, **Jones CM**, Fishbein TM, Busuttil RW, Agopian V; US Multicenter HCC Transplant Consortium. Outcomes in liver transplant recipients with nonalcoholic fatty liver disease-related HCC: results from the US multicenter HCC transplant consortium. Liver Transpl. 2023 Jan 1;29(1):34-47. doi: 10.1097/LVT.0000000000000007. Epub 2022 Dec 23. PMID: 36630156.

Vivace BJ, Kachare SD, Meredith LT, Kachare MD, Kapsalis CN, Muresan C, **Choo JH**, Kasdan ML, **Wilhelmi BJ**. Posterior Interosseous Nerve Graft: Utilizing External Landmarks and Anthropometric Ratios to Predict Available Length for Digital Nerve Reconstruction in a Cadaveric Study. Plast Surg (Oakv). 2022 May;30(2):130-135. doi: 10.1177/2292550321995731. Epub 2021 May 12. PMID: 35572081; PMCID: PMC9096857.

W

Werner NL, Cralley A, Lawless R, Platnick KB, Cohen MJ, **Coleman JJ**, Hoehn M, Campion E, Pieracci FM, Burlew CC. Time to Look for Another Infectious Source? White Blood Cell Trends during Ventilator-Associated Pneumonia. Surg Infect (Larchmt). 2022 Sep;23(7):656-660. doi: 10.1089/sur.2022.094. Epub 2022 Aug 5. PMID: 35930247.

Winer LK, Kader S, Abelson JS, Hammaker AC, Eruchalu CN, Etheridge JC, Cho NL, Foote DC, Ivascu FA, Smith S, Postlewait LM, Greenwell K, Meister KM, Montgomery KB, Zmijewski P, Byrd SE, Kimbrough MK, Stopenski SJ, Nahmias JT, Harvey J, Farr D, Callahan ZM, Marks JA, Stahl CC, Al Yafi M, Sutton JM, Elsaadi A, Campbell SJ, Dodwad SM, Adams SD, Woeste MR, **Martin RCG**, Patel P, Anstadt MJ, Nasim BW, Willis RE, Patel JA, Newcomb MR, George BC, Quillin RC 3rd, Cortez AR. Disparities in the Operative Experience Between Female and Male General Surgery Residents: A Multi-Institutional Study from the US ROPE Consortium. Ann Surg. 2023 Mar 30. doi: 10.1097/SLA.0000000000005847. Epub ahead of print. PMID: 36994704.

Wise AK, Bhutiani N, Werthmann N, **Kavalukas SL**, **Galandiuk S**, **Farmer RW**. Early experience with focused telemedicine implementation in an academic colorectal surgery practice. Surgery. 2022 Jul;172(1):83-88. doi: 10.1016/j.surg.2022.01.033. Epub 2022 Mar 2. PMID: 35248363.

Wise AK, Hicks AC, **Sigdel A**. Vagal Nerve Stimulator Placement by a Vascular Surgeon. Am Surg. 2022 Mar;88(3):525-527. doi: 10.1177/0003134820943553. Epub 2020 Oct 7. PMID: 33026229.

Woeste MR, Salyer CE, Hammaker AC, Dodwad SJ, Foote DC, Nahmias JT, Callahan ZM, Quillin RC 3rd, Cortez AR; US Resident OPerative Experience (ROPE) Consortium. Do General Surgery Residents Begin Specializing Before Fellowship? A Multi-Institutional Study from the US ROPE Consortium. J Am Coll Surg. 2022 Nov 1;235(5):799-808. doi: 10.1097/XCS.0000000000000311. Epub 2022 Oct 17. PMID: 36102575.

Woeste MR, Wilson KD, Kruse EJ, Weiss MJ, Christein JD, White RR, **Martin RCG 2nd**. Optimizing Patient Selection for Irreversible Electroporation of Locally Advanced Pancreatic Cancer: Analyses of Survival. Front Oncol. 2022 Jan 13;11:817220. doi: 10.3389/fonc.2021.817220. PMID: 35096621; PMCID: PMC8793779.

Woeste MR, Strothman P, Jacob K, **Egger ME**, **Philips P**, **McMasters KM**, **Martin RCG**, **Scoggins CR**. Hepatopancreatobiliary readmission score out performs administrative LACE+ index as a predictive tool of readmission. Am J Surg. 2022 May;223(5):933-938. doi: 10.1016/j.amjsurg.2021.09.037. Epub 2021 Oct 1. PMID: 34625205.

Woeste MR, Jacob K, Duff MB, Donaldson M, Sanders MAG, **McMasters KM**, **Ajkay N**. Impact of routine expert breast pathology consultation and factors predicting discordant diagnosis. Surg Oncol. 2022 Oct 5;45:101860. doi: 10.1016/j.suronc.2022.101860. Epub ahead of print. PMID: 36242980.

Wu J, Moheimani H, Li S, Kar UK, Bonaroti J, Miller RS, Daley BJ, **Harbrecht BG**, Claridge JA, Gruen DS, Phelan HA, Guyette FX, Neal MD, Das J, Sperry JL, Billiar TR. High Dimensional Multiomics Reveals Unique Characteristics of Early Plasma Administration in Polytrauma Patients With TBI. Ann Surg. 2022 Oct 1;276(4):673-683. doi: 10.1097/SLA.0000000000005610. Epub 2022 Jul 19. PMID: 35861072; PMCID: PMC9463104.

Wu J, Cyr A, Gruen DS, Lovelace TC, Benos PV, Das J, Kar UK, Chen T, Guyette FX, Yazer MH, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Zuckerbraun BS, Neal MD, Johansson PI, Stensballe J, Namas RA, Vodovotz Y, Sperry JL, Billiar TR; PAMPer study group. Lipidomic signatures align with inflammatory patterns and outcomes in critical illness. Nat Commun. 2022 Nov 10;13(1):6789. doi: 10.1038/s41467-022-34420-4. PMID: 36357394.

XYZ

Yaddanapudi K, Stamp BF, Subrahmanyam PB, Smolenkov A, Waigel SJ, Gosain R, **Egger ME**, **Martin RCG**, Buscaglia R, Maecker HT, **McMasters KM**, Chesney JA. Single-Cell Immune Mapping of Melanoma Sentinel Lymph Nodes Reveals an Actionable Immunotolerant Microenvironment. Clin Cancer Res. 2022;28:2069-2081.

Zemmar A, Sinofsky A, Sheng Z, **Pera S**, **Harbrecht B**, Neimat J. Ogilvie's syndrome after paddle spinal cord stimulator implantation: An experience report. Pain Pract. 2023 Mar 28. doi: 10.1111/papr.13225. Epub ahead of print. PMID: 36975778.

Research Facilities

Cardiovascular Innovation Institute:
The Cardiovascular Innovation Institute (CII) consists of research labs, fabrication facilities, operating rooms, recovery rooms, diagnostic equipment, training facilities, mock circulation labs, administrative offices, conference rooms, storage areas, sterile supply rooms, necropsy rooms and medical imaging areas. Led by Dr. Stuart Williams, a team of researchers at Louisville's CII have recently been awarded a grant from the National Institutes of Health (NIH) for more than $1.25 million to study new ways of fighting diabetes and cardiovascular disease.

Interior of the Cardiovascular Institute

Price Institute of Surgical Research Laboratories:
Founded in 1957 by John W. Price, Jr., MD, the Institute strives to enhance the care of patients through advances in surgical techniques and technology and through basic and clinical research. Each of our 12 laboratories focuses on a specific field of surgical research, including digestive disease, cardiovascular biomechanics and circulatory support, reconstructive hand surgery, and traumatic injury.

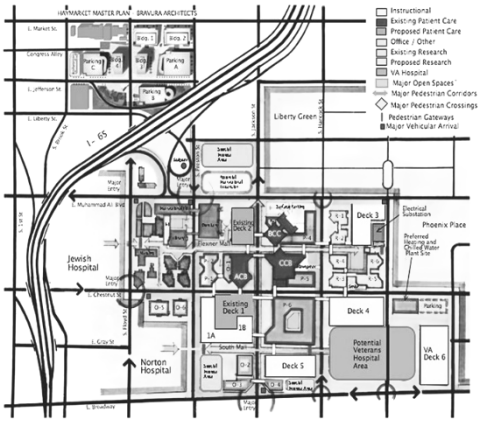
Reconstructive Surgery Research Laboratories:
The Reconstructive Surgery Research Laboratories team consists of clinical and basic science faculty, research fellows, and medical students from diverse educational and training backgrounds who work together to identify clinical problems, design experimental protocols, develop animal models, perform experiments, collect/organize/evaluate and interpret data. The specific research focuses on facial and hand transplantation, ischemia/reperfusion Injury, dynamic myoplasty and microcirculation.

The Institute of Cellular Therapeutics:
Several research core facilities have been established to enhance collaborative efforts between academic programs and limit the necessity for duplication of laboratory resources, including instrumentation, personnel and research space. To date, these core facilities include: flow cytometry, specimen repository, clinical data management, and informatics. The Institute occupies the 4th floor of the Donald E. Baxter Biomedical Research Building at the University of Louisville's Health Sciences Center campus.

Baxter Research Buildings & U of L Research Tower

Christine M. Kleinert Institute of Hand Surgery:
The Christine M. Kleinert Institute's fellowship program is affiliated with Kleinert, Kutz, and Associates Hand Care Center. Fellows are encouraged to participate in research opportunities, which may be developed independently or with the assistance and supervision of faculty members and the research department.

Louisville Veterans Affairs Medical Center:
Dr. Smith maintains extensive research laboratories at the Louisville VAMC. There are full-time investigators, fellows, and students who assist with various surgical research projects.



The "20-Year Master Plan" for the University of Louisville's Health Sciences Campus (above) includes new research space and buildings for patient care.

Websites

University of Louisville:	**www.louisville.edu**
Department of Surgery:	**www.louisvillesurgery.com**

Website contains links to:
Colon & Rectal Surgery, ERCP, Pediatric Surgery, Plastic & Reconstructive Surgery, Surgical Critical Care, Surgical Oncology & Price Institute of Surgical Research.

UofL, Department of Surgery Alumni:	**www.facebook.com**
ACGME:	**www.acgme.org**
MedHub:	**www.louisville.medhub.com**
Clinical Trials Information:	**www.AboutMelanoma.com** **www.AboutBreastHealth.com** **www.AboutLiverTumors.com**
University of Louisville Social Media	**louisvillesurgery.com/residGen.html**

University of Louisville & Affiliated Hospitals

University of Louisville Hospital:	**(502) 562-3000**	OR:	(502) 562-3504
VA Medical Center:	**(502) 287-4000**	OR:	(502) 287-6808
Norton Hospital:	**(502) 629-8000**	OR:	(502) 629-7100
Norton Audubon	**(502) 636-7111**		
Norton Children's Hospital:	**(502) 629-6000**	OR:	(502) 629-4800
Norton Women's & Children Hospital:	**(502) 893-1000**	OR:	(502) 893-1010
UofL Health - Jewish Hospital:	**(502) 587-4011**	OR:	(502) 587-4234
Baptist Health Madisonville	**(270) 825-5100**	OR:	(270) 825-5115
Owensboro Health Regional Hospital	**(270) 417-2000**	OR:	(270) 417-5500
UofL Health Mary & Elizabeth Hospital	**(502) 361-6000**		