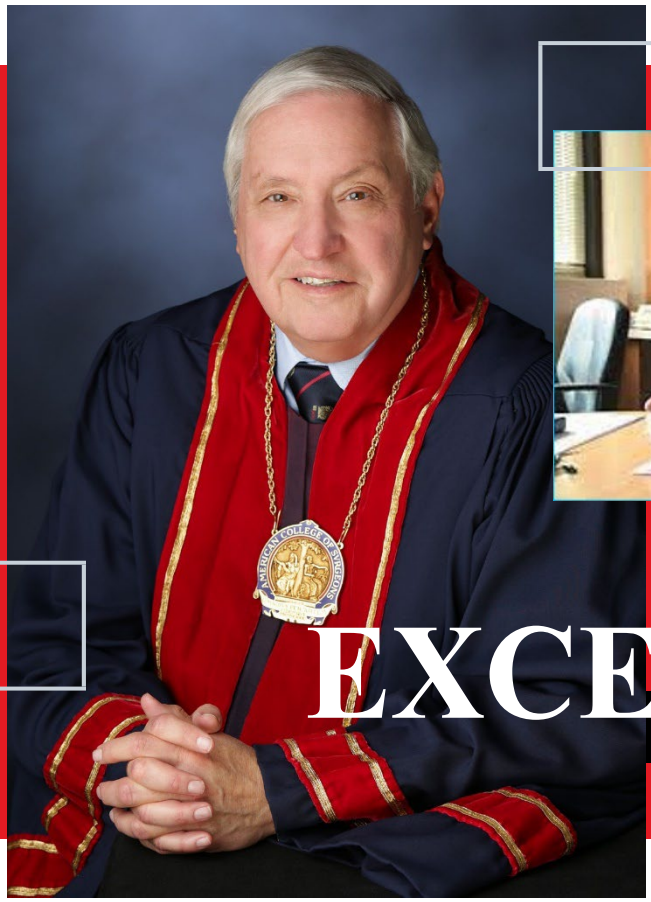
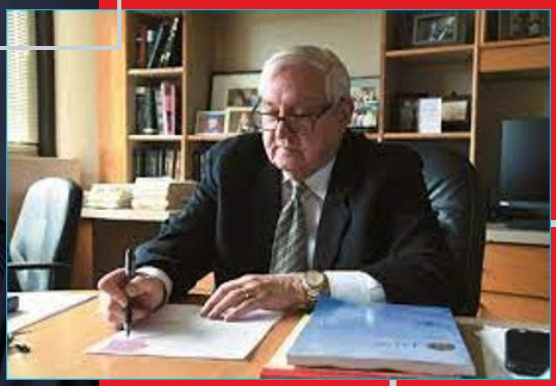




EXCELLENCE

"to whom much is given, much is expected"

In loving memory of Dr. J. David Richardson

2022-2023

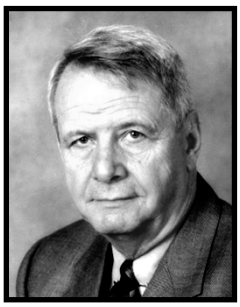
University of Louisville
The Hiram C. Polk, Jr., MD Department of Surgery
Surgical Resident Manual

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.

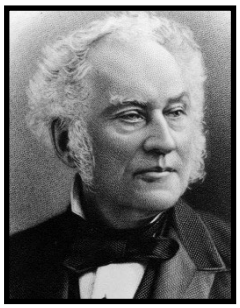
Chair, 1938-1952

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.)**

2022-2023 Surgical Resident & Fellow Directory

GENERAL SURGERY RESIDENTS

	Postgraduate Year V:	Pager	Medical School
	**William Bishop** william.bishop.2@louisville.edu	464-7018	West Virginia University
	**Dylan Carroll** dylan.carroll@louisville.edu	455-0945	West Virginia University
	**Anthony Clark** anthony.clark.3@louisville.edu	478-2945	University of South Florida
	**Caitlin Griffin** caitlin.griffin@louisville.edu	478-1457	Wake Forest
	**Anthony Grzeda** anthony.grzeda@louisville.edu	478-0737	St. Louis University
	**Ahmed Hassan** Ahmed.hassan.1@louisville.edu	209-1566	Assuit University
	**Mason Holbrook** mason.holbrook@louisville.edu	455-1620	University of Louisville
	**Jessica Masch** jessica.masch@louisville.edu	478-0482	University of Cincinnati
	***Jessica Schucht** jessica.schucht@louisville.edu	478-0114	Wright State University
	**Jonathan Vacek** jonathan.vacek@louisville.edu	209-1666	St. George's University

**Administrative Chief Resident*

Postgraduate Year IV:	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** michael.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

	Postgraduate Year III:	Pager	Medical School
	**Matthew Acton** matthew.acton@louisville.edu	209-1307	Indiana University
	**William Allen** **william.allen.4@louisville.edu**	209-1448	University of South Florida
	**Sellers Boudreau** **sellers.boudreau@louisville.edu**	209-1503	University of Alabama
	**Hiley Cammock** **hiley.cammock@louisville.edu**	209-1504	University of Cincinnati
	**Nicolas Cassata** **nicolas.cassata@louisville.edu**	209-1548	University of Texas – Houston
	**Samuel Dacus** **samuel.dacus@louisville.edu**	209-1567	University of South Carolina
	**Walter Donica** **walter.donica@louisville.edu**	209-1641	University of Cincinnati
	**Seth Hall** **seth.hall@louisville.edu**	209-1643	University of Louisville
	**Alexandra Jones** **alexandra.jones.1@louisville.edu**	209-1644	University of Oklahoma
	**Matthew Woeste** matthew.woeste@louisville.edu	209-1366	University of Louisville

	Postgraduate Year II:	Pager	Medical School
	**Pooja Avula** pooja.avula@louisville.edu	209-1269	Western Michigan
	**Toyokazu Endo** toyokazu.endo@louisville.edu	209-1320	University of Nevada
	**Victoria Hammond** victoria.hammond@louisville.edu	209-1339	University of Louisville
	**Mohammed Ranavaya** mohammed.ranavaya@louisville.edu	209-1424	Marshall University
	**Brandon Ryvkin** brandon.ryvkin@louisville.edu	209-1551	St. Louis University
	**Brittany Sims** brittany.sims@louisville.edu	209-1573	University of Louisville
	**Kyle Stephens** kyle.stephens@louisville.edu	209-1585	University of New Mexico
	**Alan Sumski** alan.sumski@louisville.edu	209-1662	Ohio State University

Postgraduate Year I:	Pager	Medical School
 **Akhila Ankem** akhila.ankem@louisville.edu	209-1255	University of Louisville
 **Joshua Crane** joshua.crane@louisville.edu	209-1262	Georgetown University
 **Maggie Durci** maggie.durci@louisville.edu	209-1263	LSU – Shreveport
 **Zach Hier** zach.hier@louisville.edu	209-1265	University of Pittsburgh
 **Kevin Jacob** kevin.jacob@louisville.edu	209-1284	University of Louisville
 Donya Jahandar donya.jahandar@louisville.edu	209-1282	U of Missouri – Kansas City
 **Joel Kramer** joel.kramer@louisville.edu	209-1285	University of Washington
 **Grace Osagie** grace.osagie@louisville.edu	209-1286	UNC – Chapel Hill
 **Matthew Peters** matthew.peters@louisville.edu	209-1287	University of Louisville
 **Thomas Touma** thomas.touma@louisville.edu	209-1300	USC - Columbia
 **Noah Whited** noah.whited@louisville.edu	209-1301	Texas Tech

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

Lois Inlow, Program Coordinator Sr.
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-8017 ~ Email: lois.inlow@louisville.edu

SURGICAL RESEARCH RESIDENTS

	Research Residents	Pager	Medical School	Research Years(s)
	**Nicholas Caminiti – PGY-2** nicholas.caminiti@louisville.edu	209-1563	University of Connecticut	2021-2023
	**Brittany Hegde – PGY3** Brittany.wiseman@lousiville.edu		University of Tennessee	2020-2023
	**William Risinger – PGY-3** william.risinger@louisville.edu	209-1457	University of Louisville	2022-2024
	**Chinweotuto Uma – PGY-2** **vanessa.uma@louisville.edu**	209-1672	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

Lois Inlow, Program Coordinator Sr.
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-8017 ~ Email: lois.inlow@louisville.edu

COLON & RECTAL SURGERY FELLOW

		Pager	Medical School	Fellowship Year(s)
	**Hillary Simon** Hillary.simon@louisville.edu	485-5078	Edward Via	2022-2023

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)
Evan Kelly, MD evan.kelly@louisville.edu	Wayne State University	2022-2023

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

HAND SURGERY

Christopher Bobbitt
cbobbitt@KleinertKutz.com
Julian Justino
jjustino@KleinertKutz,com
Alexander Neusener
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Rosa Park
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Christina Beckum, Education Coordinator, Fellowship Assistant
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PEDIATRIC SURGERY FELLOWS

Fellow	Pager	Medical School	Fellowship Year(s)
 **Heron Baumgarten** heron.baumgarten@louisville.edu	421-4350	University of Washington	2021-2023

Lindsey Gumer, Pediatric Surgery Fellowship Coordinator
Norton Healthcare Pavilion – 315 E. Broadway, Suite # 565
Phone: 629-8630 ~ Email: lhjone03@louisville.edu

PLASTIC & RECONSTRUCTIVE SURGERY FELLOWS

Independent Plastic Surgery:

Fellow Chief Year:		Pager	Medical School
	**Milind Kachare** milind.kachare@louisville.edu	478-2838	SUNY at Buffalo
	**Alexander Nixon** alexander.nixon@louisville.edu	478-0531	Chicago Medical School

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

Integrated Plastic Surgery:

Resident Second 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 First 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

Amory Alvey, Plastic and Reconstructive Surgery Residency Coordinator
Department of Surgery – Ambulatory Care Building, 2nd Floor
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SURGICAL CRITICAL CARE/TRAUMA FELLOWS

	Fellow	Pager	Medical School	Year(s)
	**Erin Fuller** erin.fuller@louisville.edu	209-1305	Tufts University	2022-2023
	**David Keeven** david.keeven@louisville.edu	209-1455	U of Kentucky	2022-2023
	**Tyler Van De Voort** tyler.vandevoort@louisville.edu	209-1309	U of Wisconsin	2022-2023

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SURGICAL ONCOLOGY FELLOWS

	Fellow	Pager	Medical School	Year(s)
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	**Mackenzie Shindorf** Mackenzie.shindorf@louisville.edu		U of Toledo	2022-2024

Cathy Buckley, Surgical Oncology Fellow Coordinator
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Phone: 629-6950 ~ Email: cathy.buckley@louisville.edu

VASCULAR SURGERY FELLOWS

	Fellow	Pager	Medical School	Year(s)
	**Jack Cheadle** gerald.cheadle@louisville.edu	478-6023	University of Louisville	2021-2023

Vascular Surgery Program
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-0864

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 2022-2023

University of Louisville Hospital	July 2022	August	September	October	November	December
Trauma I	Schucht Boudreau Avula Peters Laungani (OMFS)	Schucht Boudreau Avula Jacob Duffy (ENT)	Masch Donica Endo Durci Crane	Hassan Cammock Stephens Osagie Williamson (Ortho	Holbrook Cassata Sumski Whited Way (OMFS)	Vacek Woeste Endo Graham (PRS) Hurn (Ortho)
Trauma II	Grzeda Acton Ranavaya Ankem Zhu (ENT)	Grzeda Acton Ranavaya Wells (ER) Gellert (ER) Harrison (Uro)	Carroll Jones Ryvkin Duff (ENT) Stults (ER)	Bishop Hall Hammond Paul (PRS) Aiello (ER)	Clark Dacus Sims Durci (1-15) Osagie (16-30) Sudebaker (ER)	Griffin Allen Avula Kramer Loche (ER)
Trauma ICU Day Float	Sims Hill-Norby (ER)	Ryvkin Salven (ER)	Peake Nelson (ER)	Ranavaya Lehnig (ER)	Endo McMurray (ER)	Stephens Bishop (ER)
University General Surgery	Masch Jones Jahandar	Holbrook Hall Hier	Clark Woeste Touma (16-30)	Carroll (1-15) Holbrook (16-31) Donica	Schucht Jones	Grzeda Acton
Veterans Hospital						
VAMC Surgery	Hassan Cammock Hammond Graham (PRS)	Kaikaus Cassata Nguyen Ankem	Bishop (1-15) Smith (1-15) Schafer (16-30) Hall (1-15) Hammond (1-15) Avula (16-30) Sims (16-30) Osagie	Masch (1-15) Bond (16-31) Boudreau (1-15) Jones (16-31) Sumski Jacob	Carr Acton (1-15) Peake (16-30) Stephens Pail (1-15) Crane (16-30)	Clark (1-15) Cage (16-31) Donica (1-15) Nguyen (16-31) Ranavaya Touma

Norton Hospital / Jewish Hospital General Surgery	July 2022	August	September	October	November	December
Acute Care Surgery (NH, JH)	Carroll Hall Ryvkin	Masch Donica	Grzeda Boudreau	Clark Cassata	Griffin Woeste	Bishop Dacus
***Norton Float Chief**	Howard(1-15)**	Bishop*				Carroll*
Minimally Invasive Surgery NH, Kehdy	Bond	Carroll	Schucht	Vacek	Bishop	Holbrook
Robotic	Endo		Avula (1-15)			Sumski (1-15)
Williams Service (JH, Jewish East)	Collings	Smith	Simpson	Tumen	Kaikaus	Sweeney
Norton Hospital Interns	Touma Crane Uma, Caminiti, Risinger	Jahandar Durci Paul (PRS) Uma, Caminiti, Risinger	Peters Whited	Ankem (1-15) Hier (16-31) Kramer (1-15) Midenberg (16-31)	Graham (PRS) Harrison (1-15) Jacob (16-30)	Osagie Paul (PRS)
Jewish Hospital Interns	Whited Duff (ENT) Jacob Uma, Caminiti, Risinger	Kramer Peters Zhu (ENT) Uma, Caminiti, Risinger	Jahandar (1-15) Graham (16-30) Duffy (ENT)	Graham (PRS) Peters (1-15) Whited (16-31)	Kramer Ankem	Hier Durci
Norton Children's Hospital						
Norton Children's Hospital	Schafer Sumski Duffy (ENT) Williamson (Ortho)	Bond Hammond Duff (ENT) Pamplin (Ortho)	Vacek* (1-15) Collings Ranavaya Kramer Zhu (ENT)	Smith Avula Touma Hurn (Ortho)	Cage Nguyen Jahandar Stoltz (Ortho)	Collings Peake Crane Midenberg (Uro)

Jewish Hospital Specialty Services						
Transplant	Griffin Peake	Cage Endo	Hassan Stephens	Kaikaus (1-15) Carr (16-31) Nguyen	Schafer	Simpson Sims
Thoracic	Allen	Cammock	Acton	Endo (1-15) Woeste (16-31)	Ranavaya (1-15) Hammond (16-30)	Ryvkin
Cardiac		Sweeney	Vacek (16-30)	Schucht (1-15) Collings (16-31)		

Elective Services	July 2022	August	September	October	November	December
Surgical Oncology ****Case Float**	Bishop Kaikaus Cassata Stephens Durci Osagie	Vacek Carr Woeste Sims Crane Whited **Sumski (1-15)	Holbrook Tumen Allen Sumski Hier Ankem	Griffin Schafer Dacus Peake Jahandar	Masch Collings Donica Ryvkin Touma **Allen (1-15)	Schucht Bond Jones Hammond Peters Jacob **Cassata (1-15)
Colorectal Surgery	Vacek Dacus Kramer	Hassan Allen Touma	Carr Cammock (1-15) Hammond (16-30) Jacob	Simpson Ryvkin (1-15) Sims (16-31) Crane	Sweeney (1-15) Tumen (16-30) Hall Hier	Kaikaus Boudreau Whited
Vascular	Clark Donica Hier Midenberg (Uro)	Tumen Jones Osagie Williamson (Ortho)	Kaikaus Cassata Harrison (Uro) Pamplin (Ortho)	Grzeda* Sweeney Acton Durci	Bond Boudreau Peters	Smith Hall Jahandar Ankem
Plastics	Simpson Nguyen Paul	Peake Graham	Nguyen Paul		Simpson (1-15) Peake (1-15)	Nguyen (1-15)
Bariatrics (Allen)	Tumen	Simpson	Bond	Cage	Carroll	Masch
NH Audubon	Sweeney	Schafer			Smith	Hassan

Mary and Elizabeth	Holbrook Endo (1-15)	Clark Sumski (16-31)	Griffin (16-30) Dacus (1-156) Sims (1-15)		Vacek (1-15) Avula (1-15)	Cammock
GYN/Onc (Parker)	Carr					
Endoscopy					Grzeda (1-15)	
Rural General Surgery **Madisonville** **Owensboro*** **Africa**** **Missouri*****	Woeste Cage*	Dacus Collings*	Cage	Allen	Cammock	Tumen Carr** Schafer***
Vacation		Stephens (1-15)	Griffin (1-15) Schafer (1-15) Touma (1-15) Graham (1-15) Bishop (16-30) Smith (16-30) Cammock (16-30) Dacus (16-30) Hall (16-30) Jahandar (16-30)	Holbrook (1-15) Bond (1-15) Carr (1-15) Woeste (1-15) Sims (1-15) Hier (1-15) Whited (1-15) Midenberg (1-15) Carroll (16-31) Masch (16-31) Schucht (16-31) Kaikaus (16-31) Boudreau (16-31) Endo (16-31) Ryvkin (16-31) Kramer (16-31) Peters (16-31) Ankem (16-31)	Tumen (1-15) Hammond (1-15) Crane (1-15) Osagie (1-15) Jacob (1-15) Grzeda (16-30) Vacek (16-30) Simpson (16-30) Sweeney (16-30) Acton (16-30) Allen (16-30) Avula (16-30) Ranavaya (16-30) Durci (16-30) Paul (16-30) Harrison (16-30)	Cage (1-15) Clark (16-31) Cassata (16-31) Donica (16-31) Sumski (16-31)

General Surgery Master Schedule 2022-2023

University of Louisville Hospital	January 2023	February	March	April	May	June
Trauma I	Vacek Hall Sims Touma Hier	Griffin Donica Ryvkin Jahandar Ankem	Grzeda Woeste Stephens Launguani Soderstom (Ortho)	Carroll Hall Hammond Jahandar Kramer	Bishop Acton Ranavaya Hier Stoltz (Ortho)	Masch Jones Hammond Way Pamplin (Ortho)
Trauma II	Masch Dacus Sumski Jacob Huttner (ER)	Hassan Cassata Endo Crane Beard (ER)	Clark Allen Sims Whited Daniel (ER)	Schucht Cassata Ryvkin Peters Kushner (ER)	Holbrook Boudreau Sumski Touma Roberts (ER)	Vacek Cammock Stephens Midenberg (Uro) Ganshirt (ER)
Trauma ICU Day Float	Nguyen Edwards	Sumski Stucker	Hammond Martinez	Avula Alia	Stephens (1-15) Sims (16-31) Baird-Ferko	Ryvkin (1-15) Sumski (16-30) Boland
University General Surgery	Hassan Cassata	Bishop Cammock	Schucht Boudreau	Vacek Allen	Griffin Dacus	Carroll Hall
Veterans Hospital						
VAMC Surgery	Cage (1-15) Griffin (16-31) Woeste (1-15) Ranavaya (16-31) Peake Kramer	Simpson Allen Dacus Whited	Smith (1-15) Kaikaus (16-31) Ryvkin Avula Jahandar	Holbrook Collings (1-15) Acton (1-15) Dacus (16-30) Sims Hier (1-15) Ankem (16-30)	Grzeda (1-15) Clark (16-31) Endo (1-15) Ryvkin (1-15) Peters (1-15) Cassata (16-31) Allen (16-31) Osagie (16-31)	Tumen Woeste Endo Paul (1-15) Durci (16-30)

Norton Hospital / Jewish Hospital General/Acute Care Surgery	January 2023	February	March	April	May	June
Acute Care Surgery (NH, JH) ***Norton Float Chief**	Holbrook Allen *Bond	Schucht Acton	Vacek (1-15) Griffin (16-31) Jones (1-15) Hall (16-31)	Hassan Jones	Carroll Cammock	Bishop Dacus
Minimally Invasive Surgery NH, Kehdy **Robotic**	Schucht Hammond (16-31)	Grzeda Sims (15-28)	Carroll (1-15) Holbrook (16-31)	Tumen	Collings	Smith
Williams Service (JH, Jewish East)	Griffin (1-15) Cage (16-31)	Bond	**Schafer**	Kaikaus	Carr	Cage
Norton Hospital Interns	Durci Crane	Hier Peters	Osagie Ankem	Durci Whited	Ankem Kramer	Touma Jacob
Jewish Hospital Interns	Osagie Ankem	Touma Harrison (Uro)	Kramer (1-15) Graham (16-31) Midenberg (Uro)	Crane Jacob	Jahandar Paul (PRS)	Hier Osagie
Norton Children's Hospital						
Norton Children's Hospital	Tumen Ryvkin Harrison (Uro) Soderstom (Ortho)	Carr Avula Jacob Durci	Bond Endo Hier Peters	Simpson Stephens Osagie Paul (PRS)	Kaikaus Hammons (1-15) Peake (16-31) Graham (PRS) Whited	Sweeney Sims Snkem Crane (1-15) Whited (16-30)

Jewish Hospital Specialty Services						
Transplant	Collings Avula	Clark Hammond	Tumen Ranavaya	Smith Sumski	Bond (1-15) Schafer (16-31)	Hassan Durci)1-15) Ryvkin (16-30)
Thoracic	Bishop Ranavaya (1-15) Stephens (16-31)	Vacek Peake	Sweeney Graham (1-15) Touma (16-31)	Masch Endo	Smith Jacob (1-15) Stephen (16-31)	Griffin Nguyen
Cardiac	Kaikaus		Masch (1-15)			

Elective Services	January 2023	February	March	April	May	June
Surgical Oncology ****Cade Float**	Grzeda Sweeney Donica Endo Paul (PRS) Jahandar (16-31) **Boudreau	Carroll Smith Woeste Ranavaya Kramer **Stephens	Hassan Cage Acton Sumski Crane **Cammock	Carr Schafer Cammock Nguyen Graham (PRS)	Vacek Simpson Hall Peake (1-15) Nguyen (16-31) Durci	Schucht Collings Boudreau Avula Peters **Donica (1-15)
Colorectal Surgery	Carroll Acton Peters	Holbrook Jones Osagie	Collings Donica Durci (1-15) Paul (16-31)	Bishop Woeste Midenberg (Uro)	Masch Nguyen (1-15) Avula (16-31) Harrison (Uro)	Clark Cassata Jahandar
Vascular	Clark Cammock Whited Hum (Ortho)	Masch Collings Boudreau Graham (1-14) Stoltz (Ortho)	Simpson Dacus Jacob Paul (1-15)	Griffin Donica Touma	Cage Woeste Crane	Carr Schafer Allen Kramer Soderstom (Ortho)
Plastics	Graham	Nguyen Paul	Nguyen Peake	Peake		Peake Graham
Bariatrics (Allen)	Smith	Sweeney	Bishop (1-15) Carr (16-31)	Clark	Jones	Holbrook
NH Audobon	Simpson	Kaikaus		Cage (1-15)	Tumen (1-15)	Bond

Mary and Elizabeth	Schafer Hammond (1-15)	Tumen Sims (1-14) Stephens (14-28)		Sweeney		Simpson (16-30) Ranavaya
Ortho		Cage				
Hepatobillary					Sweeney (1-15)	Grzeda
Endoscopy					Schucht (1-15)	
Rural General Surgery **Madisonville** **Owensboro*** **Africa****	Jones Carr**	Hall Schafer*	Cassata	Boudreau Bond*	Donica	Acton Kaikaus*
Vacation	Stephens (1-15) Jahandar (1-15) Boudreau (16-31) Woeste (16-31)	Graham (15-28)	Griffin (1-15) Holbrook (1-15) Carr (1-15) Kaikaus (1-15) Cammock (1-15) Hall (1-15) Touma (1-15) Bishop (16-31) Carroll (16-31) Masch (16-31) Vacek (16-31) Smith (16-31) Jones (16-31) Kramer (16-31) Durci (16-31)	Dacus (1-15) Ankem (1-15) Collings (16-30) Acton (16-30) Ranavaya (16-30) Hier (16-30)	Clark (1-15) Hassan (1-31) Schafer (1-15) Cassata (1-15) Allen (1-15) Avula (1-15) Sims (1-15) Osagie (1-15) Grzeda (16-31) Schucht (16-31) Bond (16-31) Sweeney (16-31) Tumen (16-31) Endo (16-31) Hammond (16-31) Ryvkin (16-31) Peters (16-31) Jacob (16-31)	Simpson (1-15) Sumski (1-15) Whited (16-30) Donica (16-30) Crane (16-30) Paul (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 2020-2021

	University	Hand	Recon	Recon II	VAMC	Head & Neck	Electives	Electives
July 2022	MacDavid (F) Simpson (GSR) Paul (R)	Nixon (F)	Kachare (F)	Nguyen (R)	Azzolini (F)	Westrick (F)	Katsnelson (F) *Ortho*	
August 2022	Westrick (F) Graham (R)	Kachare (F)	Nixon (F)	Peake (R)	Katsnelson (F)	MacDavid (F)	Azzolini (F) *Ortho*	
September 2022	MacDavid (F)	Westrick (F)	Katsnelson (F)	Nguyen (R)	Paul (R)	Azzolini (F)	Kachare (F) *Derm*	Nixon (F) *Anesth*
October 2022	Westrick (F)	MacDavid (F)	Azzolini (F)	Nixon (F)	Kachare (F)	Katsnelson (F)		
November 2022	Nixon (F) Peake (R) (1-15) Simpson (GSR)	Azzolini (F)	Westrick (F)	Kachare (F)	Katsnelson (F)	MacDavid (F)		
December 2022	Kachare (F) McManus (PR)	Nixon (F)	Katsnelson (F)	Nguyen (R) (1-15)	Azzolini (F)	Westrick (F)	MacDavid (F) *CMF*	
January 2023	MacDavid (F) Schultz (PR)	Kachare (F)	Azzolini (F)	Graham (R) (1-15)	Nixon (F)	Katsnelson (F)	Westrick (F) *CMF*	
February 2023	Westrick (F) Nguyen (R) Sweeney (PR)	Katsnelson (F)	Kachare (F)	Paul (R)	MacDavid (F)	Azzolini (F)	Nixon (F) *Derm*	
March 2023	Katsnelson (F)	Azzolini (F)	Westrick (F)	Peake (R)	Nguyen (R)	MacDavid (F)	Kachare (F) *Anesth*	Nixon (F) *Elective*
April 2023	Azzolini (F) Pritchett (PR)	Katsnelson (F)	MacDavid (F)	Nixon (F)	Peake (R)	Westrick (F)	Kachare (F) *Elective*	
May 2023	Katsnelson (F) Wireman (PR)	MacDavid (F)	Nixon (F)	Kachare (F)	Westrick (F)	Azzolini (F)		
June 2023	Azzolini (F) Hale (PR)	Westrick (F)	MacDavid (F)	Peake (R)	Graham (R)	Katsnelson (F)	Kachare (F) *Elective*	Nixon (F) *Elective*

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

ROBOTIC SURGERY (UNIVERSITY, NORTON, and JEWISH HOSPITALS)

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

COLORECTAL SURGERY AT NORTON, JEWISH AND UNIVERSITY HOSPITALS:
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.

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 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

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

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.

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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.

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Revision approved by GMEC: 3/21/01
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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.

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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.

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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

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

Resident Time Off

(maternity leave, paternity leave, job/fellowship interviewing, scientific meeting, etc.)

Time off, in addition to regularly scheduled days off and approved vacation time, may be granted at the digression of the Program Director or the Associate Program Directors for a variety of reasons. These reasons include, but are not limited to, maternity leave/ fraternity leave, job/fellowship interviewing, attendance at a scientific meeting, etc. In addition, there may be other extenuating reasons that a resident would request additional time off during the course of their training. The forms are mandatory and are available in the General Surgery Residency office (Machenize and Lois). All important elements of this form must be completed in order for a time off request to be approved.

It is the resident's responsibility to arrange coverage for their duties during their absences. It is mandatory to notify all faculty and the chief resident on the service of any and all coverage changes. The resident time off request form must be signed by the Program Director before the time off request is approved and valid. Completed forms will be maintained in the Residency Coordinator's office (Machenize and Lois) in the residents file as a permanent record of time off during the residency-training program.

Maternity leave:

Maternity leave shall be defined as leave following the birth or adoption of a child. A Resident Leave Request Form must be completed and signed by the Program Director and resident.

Maternity Leave may be paid, unpaid or a combination of paid and unpaid.

A resident may be paid during the maternity leave in utilizing any unused vacation days (up to 28 calendar days per year). Additionally, Program Directors may allow up to two additional weeks (14 calendar days) of paid leave per contract year (Program Director's Discretionary Time). By utilizing, the entire annual vacation leave and being granted two weeks of discretionary time by the Program Director the resident can achieve a six-week (42 calendar days) paid maternity leave.

Maternity leave extending beyond the available vacation days and the Program Director's Discretionary Time (if granted) will be unpaid leave, in accordance with the Graduate Medical Student Leave Policy. Residents should check with UofL Human Resources Department to determine the status of the health insurance benefits coverage.

Maternity leave may require additional training time to fulfill RRC and/or Board Certification Requirements. Program Directors are responsible for determining, in accordance with the RRC and Board requirements, the amount of time that must be made up. If residents are required to make up time missed, that time must be covered by a House Staff Agreement, with the resident being paid at the appropriate level.

Residents requiring additional leave due to complications of pregnancy or delivery should refer to the Sick Leave Policy. In case of extended sick leave (90 days or greater) residents should contact the resident disability insurance carrier.

Should this policy be in conflict with the respective ACGME or Board requirements, those requirements will take precedence.

Paternity Leave:
Paternity leave is available either from unused paid vacation leave and Program Director's discretionary personal/educational days or as unpaid leave as outlined in the "Graduate Medical Students Leave Policy."

Leaves of absence may require additional training time to fulfill RRC or board certification requirements.

All leave of absence must be authorized and taken in accordance with established policies mentioned above and with individual program policies. Should these policies be in conflict with ACGME or Board requirements, the ACGME or Board requirements will take precedence.

Career Interviews
Time off is typically granted for fellowship and job interviews, **but this must be approved and will be limited to 7-10 working days during the course of the year**. Additional time off for interviewing may require the use of the resident's allotted vacation time. Extended periods of leave time may also require approval by the Program Director and subsequent notification of the University's GME office depending on the length of time and nature of the request. Additional training time may be required by the American Board of Surgery.

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.

All of the University's leave policies and procedures can be found online.
http://louisville.edu/hr/benefits/leave

Revised: September 2018
Reviewed June 2019

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.

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

General Advice

- Always call for help if you feel in over your head. Residency represents a balance of service and education with the primary goal being providing the best possible care to patients. Your seniors/midlevel residents cannot help you with either of those if we do not know what is going on.
- For each operation/procedure, you are about to do, please read and know about the patient, disease process, and procedure itself before you do it.
- **Please be professional with everyone in the hospital**. This includes other physicians, NPs/PAs, CRNAs, nurses, PCAs, and, of course, patients and their families. Recognize that your relationships with each of these groups affects not only their relationship with you and our department, but also the quality of care we provide to patients.
- There are two things that the entire residency finds unacceptable: **dishonesty and laziness.**
    - Please never lie about anything. Saying "I don't know" is acceptable as long as you take the initiative to learn the answer. Use instances of not knowing as a way to recognize your weaknesses and address them.
    - Please work as a team and do not "dump" work on other residents. We all would like to leave the hospital after a long day, but sometimes, work remains to be done. Often times, addressing these outstanding issues as a team leads to things getting done more expeditiously and the nighttime resident being able to attend to new tasks. **Ultimately, working hard and working together results in excellent patient care.**
- When a nurse pages you about a patient, unless it is for an order clarification, please go see the patient. It takes relatively little time and allows you to make sure the patient has not had a concerning status change.
- Communicate events as they happen/status updates on tasks to your team so everybody is on the same page.
- Many services round in the afternoon/evening as a team (run through the list, see sick patients together). On those that do not, take the initiative to do so on your own to ensure everything is tidied up before signing out.
- In general, discuss blood transfusions with your chief resident before ordering.
- Please always be respectful of each other and faculty. When talking to patients, please refer to all residents and faculty as "Dr. XXXX." It is strongly recommended that you employ this practice at all times. Though you may hear chief/senior residents referring to attendings in a more familiar fashion, that derives from working with and knowing the faculty as residents/fellows when they were training here.
- Please try and remain calm during emergencies. That will enable you to think through the problem and make reasonable decisions. Also, recognize that there is always someone available to help, whether that be in the hospital or a short drive away. If you ever need help, again, please call.
- To access the EMR from home/other hospitals
    - Go to https://louisville.edu/medicine/departments/medicine/divisions/gimedicine/physician-resources/important-links
    - Click on the link for the EMR you would like to access.
    - Please make sure to have the DuoMobile app downloaded on your cell phone for two-factor authentication, which is required by all EMRs.
    - Note that accessing CPRS at the VA remotely requires purchasing a card reader and getting VPN access. Please talk to Kelli Peters at the VA if you are interested in getting this set up.
- **Parking**
    - U of L – 620 Parking Garage (next to the Clinical and Translational Research Building (CTRB) parking permit available for no charge to all residents.
    - U of L Health Jewish Hospital – Parking garage access available with your ID badge.

- Norton passes are only good for one month while on service at the Parking Office (corner of Floyd and Gray, blue sign) You can/should get a Norton pass while on Norton General/Surg Onc/Colorectal/Vascular/Pediatric Surgery.
- VA you can park in the parking lot or get a visitor pass from the Security Office.

Helpful Information

- **Replacing electrolytes**
  - 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 = 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. Sodium phos if Na<140, typically 15mmole phos 2.5-2.9, 30mmol 2.0-2.5 recheck/replace as needed. 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 hypoalbuminemia 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 does not matter) then recheck K after 1 hour. Get EKG. If patient is in renal failure, contact the nephrology service because they may just need dialysis. Nephrology team should be managing their electrolytes, but clarify who is doing what so you do not overdose/underdose the patient.
- **Daily Rounds/Service Work**
  - Evaluate wounds/drain/lines/tubes each day
  - For patients with NG tubes for decompression please ensure the NG tube is functioning each day. A document regarding troubleshooting NG tubes will be circulated among all residents early this academic year.
  - Every day, please be thinking about ways to advance the care of each patient. As their diet advances postop, you should be adding PO pain meds, decreasing IV pain meds, d/c'ing IV fluids. PT/OT should begin seeing patients on POD1. Assess the need for lines and tubes. Beginning thinking about social work consults for disposition planning in patients who may need home health or rehabilitation in early postop period. Assess home medications and when/if they should be restarted each day. Incentive spirometry and pulmonary toilet are mandatory for all patients for the duration of their hospital stay.
  - Talk to/consult social workers and case management on disposition plans. Frequently, patients require insurance precertifications (precerts) prior to being approved for rehabilitation/nursing homes/home health. It is best to get this process started early. The NPs on each service can help you with this.
  - Always check to see if VTE prophylaxis is prescribed/needs to be added. For most patients, SCDs/foot pumps should be on and working while they are in bed. The exceptions are vascular patients who have undergone extremity bypass and trauma patients with vascular injuries to their lower extremities. In those patients, avoid SCDs on the affected extremity. Chemoprophylaxis should be initiated when appropriate. Typically, this comprises Lovenox (30mg BID for trauma patients, 40mg daily for Neurosurgery patients and everyone else as long as they are not actively bleeding) or subQ heparin (5000u q8h). For patients with diminished GFR (either acute or chronic), please discuss with your chief/attending as well as pharmacy regarding the appropriateness of Lovenox.
  - Dressings should be taken down on POD2 unless otherwise instructed.
  - Please be judicious with fluid administration in all patients. Do not just bolus if low UOP but look at EBL from the operation, time since surgery, etc. Consider increasing the rate of fluids first. Remember, over-resuscitation can lead to its own set of problems, namely cardiopulmonary ones. The goal is euvolemia.

- **For all H&Ps/consults, please be sure to document a full 12-point review of systems with two elements in each system and a full 10-point physical exam with two elements for each component.** This allows for appropriate level billing for each H&P/consult.

- **Night Call**
  - In general, avoid advancing diets or removing urinary catheters unless explicitly instructed by a chief resident or attending. In general, a good rule of thumb is to not change too much for the services you are cross-covering unless absolutely necessary. You will get these phone calls. Do not get bullied into doing things you are not sure need to be done in the middle of the night.
  - In general, do not administer sleep aids (i.e. benzodiazepines, systemic Benadryl) and avoid administering large doses of narcotics (i.e. 2 mg IV Dilaudid) or anxiolytics (i.e. 2 mg Ativan).
  - If you get called for "anxiety" or "confusion," please go see the patient. Often "anxiety" is actually caused by hypoxia.
  - Perform a brief “Night of Surgery” check on every day of surgery patient and write a “Night of Surgery” note. Note vitals, UOP, pertinent exam findings, pain control, and the nature of any tubes/lines/drains. Your note can be brief, but documenting your assessment demonstrates that you saw and evaluated the patient.
  - If you are unsure about something, please call your supervisor in July and August or the chief resident on call.
  - **For all status changes or concerning issues for which you saw the patient, please document your response to these as well as your patient assessment and plan of action.**
- **Procedures**
  - During bedside procedures, (central lines, arterial lines, chest tubes, etc) review the steps of the procedure 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.
  - **Central lines**
    - If at Norton, ensure the attending on call has been contacted by the RN and approved the line.
    - Request that the RN draw coags (PT/INR, PTT) and obtain the ultrasound and central line kit. Politely ask the RN to call when he or she has collected all supplies and the coags have resulted. Attendings vary on placing lines in patients with underlying coagulopathies. Some will say place a groin line and some will say do not place a line. When in doubt, ask your chief or attending before placing it.
    - At Norton and Jewish, RN gets consent for you. At University, you obtain your own consent. Regardless, please 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 where you place central lines. Please avoid placing a subclavian line unless instructed. In general, the internal jugular vein is preferred unless coags are abnormal. In emergencies or if a patient is coagulopathic, the femoral vein is preferred.
      - The subclavian vein should 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.
    - Please obtain a CXR after IJ/subclavian line placement to confirm placement and check for a pneumothorax. Pneumothoraxes occur rarely but do happen. Many residents before and many residents after you will cause a pneumothorax during line placement. Please make sure the patient knows this risk before beginning the procedure.
    - 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. This ideally avoids the scenario where you cause bilateral pneumothoraxes 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 catheters as well).
        - For instructional videos on central line placement (including site-specific techniques), see below:
            - https://www.nejm.org/doi/full/10.1056/NEJMvcm055053
            - https://www.nejm.org/doi/full/10.1056/NEJMvcm0810156
            - https://www.nejm.org/doi/full/10.1056/NEJMvcm074357
            - https://www.nejm.org/doi/full/10.1056/NEJMvcm0801006
    - **Arterial lines**
        - Similar technique to central line placement (modified Seldinger technique)
        - USE AN ULTRASOUND WHENEVER POSSIBLE. This will allow you to perform the procedure more efficiently
        - Employ sterile technique
        - Avoid placement of brachial arterial lines. This can result in limb ischemia.
        - For instructional videos on arterial line placement, see below:
            - https://www.nejm.org/doi/full/10.1056/NEJMvcm044149
            - https://www.nejm.org/doi/full/10.1056/NEJMvcm1213181
    - **Chest tubes**
        - If at Norton/Jewish, call attending prior to placement. At ULH, call the PGY2/PGY3/chief/fellow.
        - Check coags if able.
        - Need: Chest tube, atrium, suction tubing, chest tube kit, suture, lidocaine and needles, prep (chlorhexidine or iodine), Vaseline gauze, 4x4, foam tape/Tegaderm
        - In non-trauma/non-emergent settings, please discuss the choice of tube with a chief resident/attending. Different pathologies and situations call for different types and sizes of tubes. In general, when placing a standard chest tube, you should not need larger than a 28F tube, as larger tubes will get pinched at the level of the intercostal space.
        - In a controlled situation, chest tube insertion should take 15-30 minutes. In a code/room 9 situation, it should take 30-60 seconds.
    - **Please enter a procedure note after completion of each procedure.**
- **Initial workup of basic things**
    - When getting calls on acute issues, go see the patient.
    - If during the day, see the patient and contact someone more senior with a plan.
    - If at night, see the patient, document your findings/plan in the chart, and contact the chief and attending on call if anything abnormal/concerning/you are not sure what to do.
    - **Tachycardia**
        - Common causes: hypovolemia, sepsis, anastomotic leak, pulmonary embolus, pain, lack of home medications (especially beta blockers)
        - Ask RN during initial call/look in chart: baseline HR, BP, O2 sats, UOP
        - Low UOP? Ask if they have a foley, can the foley be flushed, has the patient had a bladder scan. You do not want to bolus someone who just has urinary retention, as it makes patients very uncomfortable. Try fluid bolus if hypovolemia and reassess (be careful in renal failure, CHF, COPD)
        - Recent surgery with anastomosis? possible leak; abdominal exam
            - Consider starting with an acute abdominal series (flat/upright abdominal film + CXR).

- Shortness of breath/concern for PE? ABG, CXR, pulse ox, TALK TO SOMEONE FIRST but may need lower extremity duplex, CT PE protocol, heparin drip.
- Cardiac history? EKG, troponins, BMP/mag/phos
- New onset atrial fibrillation in a patient with a recent bowel resection? Think anastomotic leak.
- Atrial fibrillation 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 the chief/attending.
- If you are ordering an ABG on a patient on the floor, you should also be alerting your team and be considering ICU transfer. 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.

- **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. BiPAP can be a useful adjunct in some patients but should be avoided in patients with an aspiration risk or recent esophagogastric anastomosis.
    - 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. Check first: may need duplex low extremities, CT PE protocol, heparin drip.
    - Call your chief/attending before ordering heparin drip or CT PE.
  - Fluid overload? BNP, electrolytes, UOP, fluid balance.
    - May need diuresis (check first). Check the rate at which IV fluids are running.
- **Confusion**
  - Common causes: sun-downing, hypoxia, sepsis, EtOH withdrawal
  - Always be sure to rule out hypoxia first.
  - When RN calls: vitals, UOP, home meds, PMH (dementia)
  - Sepsis? cultures, 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 (sleep hygiene). 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 someone more senior. May need CIWA protocol (Ativan, etc.) and transfer to ICU.
- **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 do not want to miss a tension pneumothorax.
        - Call someone more senior, consider ICU transfer. Do not initiate vasopressors without informing/discussing with more senior members of your team. Consider placing a 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 crossmatch, fluid bolus, call someone
        - Sepsis/anastomotic leak? Abdominal exam, fluid bolus, CBC/ABG
        - Cardiac history? EKG, troponins, electrolytes
        - If a patient is receiving vasopressors, they should be going through a central line. Prolonged vasopressors through peripheral IVs can result in gangrenous extremities requiring amputations, so if they need vasopressors, think about placing a central line or requesting a PICC.
    - Indications for dialysis: AEIOU. Acidosis, electrolyte imbalance, intoxication, overload (fluid), uremia.

Trauma

- **Service setup**
    - Two teams (trauma I and II) that alternate call every other day
    - An elective team takes calls on Tuesday and Friday nights
    - Team composition: Fellow, PGY5 (chief), PGY3 (ER), PGY2 (ICU), interns, NPs (Trauma 1 – Karina Pentecost and Diana Blevins, Trauma 2 – Kim Broughton-Miller and Michelle Frisbie)
    - Trauma I attendings: Franklin, Smith
    - Trauma II attendings: Harbrecht
    - Attendings who switch: Benns, Bozeman, Miller, Nash, Wood
    - Other attendings who take trauma call: McMasters, Cheadle
    - Where you spend your time: trauma workroom on the second floor
    - Clinics are every Tuesday (teams alternate weeks) in the Ambulatory Care Building (ACB). You are expected to be there after morning rounds.
    - ORs: 2nd floor
    - Prior to starting on service, pick up your Trauma Activation (Level 1) pager in the Trauma Institute on the basement floor by the cafeteria.
    - 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. The 5th year oversees everything. People that are admitted from the ER will come to the floor. Your 3rd year 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 admissions. Sometimes final reads change from initial reads. At a 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. If you are having difficulty contacting them, please let your PGY3/chief/NPs know.
- When maintaining the list, please document all tubes/lines/drains/antibiotics and the time since their placement/initiation.
- When downsizing a trach, have someone more senior with experience doing this 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. This is a good time to see how code/trauma lines/tubes/intubations are done.
- Learn by watching then ask the PGY3 to take you through procedures **in less critical patients**
- Your primary responsibility, as with other services, is ensuring completion of floor work/documentation in a timely manner.

- 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.
- If possible, plan to scrub burn debridements and skin grafts. These procedures are best completed as expeditiously as possible to avoid hypothermia.
- Cross covering is difficult you will be essentially responsible for many 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.
- Watch out for older patients. They can get sick very quickly without much warning. They have little reserve.
- Go see new consults when you get called about them. Then present them to your PGY3 in a timely manner.
- For a look inside the mind of Dr. Harbrecht: https://www.ncbi.nlm.nih.gov/pubmed/?term=harbrecht+bg+%5Bauthor%5D
    - I strongly recommend being familiar with some of the position papers/large trials he has coauthored (as well as standard trauma/critical care information) as well as guidelines published by the IDSA regarding appropriateness of antibiotic duration.

VA

- **Service Setup**
    - Team composition: chief (PGY4/5), PGY3, PGY2, intern, NP (Jane Kittle)
    - Attendings: Gaar, Schory, Franklin, Carson (general surgery/coloproctology), Yancey (vascular), Wrightson (thoracic)
    - Operative days: M/W/F
    - Clinic days: T/Th (1st floor).
    - Where you spend your time: workroom on 4th floor beside ORs; call rooms are hidden on the 3rd floor (have a 2nd or 3rd year show you where). A call room key is available
    - ORs: 4th floor
- **Paperwork**
    - Contact Security about getting a parking pass.
    - Make sure your login and access codes/passwords work AT LEAST ONE MONTH prior to starting. Accounts lock after three months of inactivity. Getting your accounts reactivated is usually a slow process that requires contacting Kelli Peters as well as calling the IT help desk.
- **Access Codes**
    - MICU 123#
    - Locker rooms (on 4th floor, only way to get to lounge on weekends/early AM) 46808
    - ER 911*
    - Lounge 55363
- Call about/discuss all new consults with your chief. After that, call and discuss with the attending on call that day.
- 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 prepare patients for the OR before 0700. 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
- 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

- **Service Setup**
  - Team consists of PGY4/5 (chief), PGY3, two interns, NP (Stacy Block)
  - Attendings: Kehdy, Carson, Cheadle
  - Other attendings who operate at NH: Adamson (spines usually), Benns, Bozeman, Nash, Van Berkel, Fox, Miller.
  - Where you spend your time: the "Nerve" on the second floor in the service building
  - ORs: basement
  - ICUs: 4B, 4F, 5B, 5F, 5H
  - ER: lower level
  - Cafeteria: first floor; MD lounge (breakfast and lunch): 2nd floor
- You are expected to help pre-op patient and discharge the outpatients in addition to the floor duties.
- 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 codes and help provide airway/access/management as needed
- To reach Dr. Dwivedi, page him.
- 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 fundoplications, which are listed in the Nerve.
- Dr. Martin has specific instructions for all of his patients. Please be familiar with them. if you have questions regarding his patients, please discuss with the Surgical Oncology chief/fellow.
- There are several "dot phrase" notes already created for H&Ps, central lines, arterial lines, consults, etc. Ask senior residents to share these with you.

Jewish General

- **Service Setup**
  - Service composition: PGY4 (chief), PGY2/3, two interns
  - Attendings: Benns, Bozeman, Nash, Miller, Wood, Williams
  - Where you spend your time: OR lounge on 2nd floor; call rooms on 3rd floor by 3E
  - OR: 2nd floor
  - ER: 1st floor
  - Cafeteria: first floor; MD lounge: first floor (breakfast and lunch)
- **Access Codes**
  - MD elevator: 2424enter
  - Call rooms: 75337 (our rooms are 3rd on the left 1221 and third on the right 8477)
  - ER 1234*
  - Endoscopy 4080*
  - Dialysis 4688
- Dr. Williams has a busy operative day on Thursday with two rooms running virtually all day. You can help your chief and midlevel resident out significantly by ensuring that all of Dr. Williams' patients have consent, an H&P or H&P update, and appropriate preoperative orders entered in a timely fashion.
- **ONLY ATTENDING PHYSICIANS CAN MARK PATIENTS AT JEWISH.**
- Williams likes to round in the evenings, so if you are the night resident, be familiar with his patients in case he rounds after the chief and midlevel have left. 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 Hospital

- **Service Setup**
  - Team composition: fellow, chief, PGY2, two interns, NP (Barb Combs)
  - Attendings: Fallat, Bond, Foley, Downard, Wright

    - Where you spend your time: 8th floor OR lounge; call room on 5W (code 15)
    - Elevator code to 8th floor OR: 8621*
    - OR: 8th floor
    - ER: Lower level
- There is always an attending/chief/fellow in house.
- Present your consults to the attending as soon as you see the patient. Each attending prefers the presentation in a different way. Bond, Wright, and Foley are relatively laid back. Fallat will want to know a lot of the social history. Downard will want to know (in order) – patient's name, birthday, location, reason for consult, HPI, exam, imaging, plan.
- There are two lists: one on EPIC and an Excel spreadsheet on one of the computers in the OR lounge on the 8th floor. The team uses the Excel spreadsheet. Please keep this updated.
- ER Trauma training is required **each time** you rotate at Norton Children's Hospital.
- Be as patient as possible with the pediatric residents and nurses. If you start to get frustrated, just say "Thank you. I'll see the patient/address the issue/discuss with my chief/fellow/attending" and walk away.
- Do not put in orders on PICU/NICU patients. The ICUs are closed units. Instead, write recommendations in your notes and, if possible, discuss those recommendations with the PICU/NICU staff after rounds.
- IV fluid calculations are very important.
- Barb (NP) and Sharon (weekend NP) can both be quite helpful if you demonstrate a good work ethic and good communication skills.
- As with other services, please prepare patients for surgery and help with discharges.
- Make sure consulting services fill out a "line sheet" for central line requests
- For a variety of reasons, virtually all procedures, including abscess drainage and line placement, will be done in the OR. Please DO NOT do procedures out of the OR without your attending/chief/fellow present.
- Please read the handbook (provided at start of rotation) for specific Norton Children's Hospital information

Transplant

- **Service Setup**
    - Team composition: chief, intern
    - Attendings: Jones, Adamson, Eng
    - Where you spend your time: Jewish; OR lounge, call rooms on 3E
    - Hospital: Jewish
- There is a printed transplant manual available for you. Ask the nurse coordinator for a copy at the beginning of your rotation.
- All transplants get postop labs and an ultrasound within 4 hours of transplant; ALWAYS follow this up promptly and update chief and attending with results
- 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.
- Immunosuppression levels and adjustments are made by NP 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.

Surgical Oncology

- **Service Setup**

    - Team composition: Fellows (CGSO, Vitale), PGY 5/4/3/2/1, NP (Lisa Puffer)
    - Attendings: McMasters (breast/melanoma), Scoggins (upper GI/HPB/sarcoma), Martin (upper GI/HPB), Vitale (pancreatobiliary/ERCP/EUS), Quillo (endocrine), Philips (upper GI/HPB/melanoma/ERCP), Ajkay (breast), Egger (HPB/melanoma/endocrine)
    - Hospitals: University, Jewish, Norton
- Enhanced recovery (ERAS) order sets are available for many procedures (upper GI/HPB, breast). Please ask your team members and Lisa Puffer to share those order sets with you and be familiar with their components.
- Quillo: 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 her. There are thyroid and parathyroid instruction sheets that more senior members of your team can share with you.
- McMasters: always wear the headlight. Always hand tie knots. Do not put the collimator on the end of the gamma probe. Know the cut-off for taking nodes (blue, 10% of radiation signal of sentinel node). Know margins for melanoma.
- Scoggins: Do not suction Bovie smoke. He likes small bites on deep dermals. Do not palm the needle driver (leave fingers in the holes).
- Ajkay: know about breast cancer. 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 your chief/fellow/attending before making changes on these patients given their complexity.
- Lots of clinic, so have dress clothes in the call room/car.
- Check clinic schedule. Some are HCOC, some BCC
    - Martin Monday
    - Phillips Tuesday
    - Quillo Wednesday
    - Scoggins Thursday, Ajkay Thursday
    - McMasters Friday

Colorectal:

- **Service Setup**
    - Team composition: fellow, PGY4/5, PGY2, intern, NP (Janice Fiechter)
    - Attendings: Galandiuk, Farmer, Jorden, Ellis, Kavalukas
    - 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.
- Case conference Monday 0700, Polk Conference Room
- Clinics throughout the week in 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**
  - Team composition: Fellow, PGY4/5, PGY2, intern
  - Attendings: Dwivedi, Wayne, Sigdel, Clark
  - Hospitals: University, Norton, Jewish, Mary & Elizabeth
  - 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.
- When able, please help prepare patients for the OR and cath labs each day and help with discharges as able.
- You usually run the list in the cath lab at NH each morning. 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.
- **ONLY THE RESIDENT/ATTENDING DOING AN OPERATION CAN MARK PATIENTS AT NORTON HOSPITAL.**
- **ONLY THE ATTENDING CAN MARK PATIENTS AT JEWISH HOSPITAL.**
- All cath lab patients at Norton will need a Sedation Document note. Senior members of your team can share this with you.
- Sigdel clinic Tuesday mornings, Dwivedi clinic Wednesday and Thursday mornings, Wayne clinic Friday mornings, Clark clinic Monday mornings. All in HCOC 7th floor.

University of Louisville School of Medicine

Resident Stipend Rates
2021-2022

PG Level	Annual
PG Level **1**	$57,755.46
PG Level **2**	$59,913.83
PG Level **3**	$61,848.34
PG Level **4**	$64,642.39
PG Level **5**	$67,775.42
PG Level **6**	$70,834.52
PG Level **7**	$73,781.68
PG Level **8**	$77,703.51

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 Hagan 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
Hepatobiliary & Liver – AM/PM

Thursday
Kidney/Pancreas – PM

THORACIC CLINICS

Monday
van Berkel –AM
Black – PM

Wednesday
van Berkel –AM/PM
Fox – PM
Black – AM

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 (2nd Tuesday)
McMasters - AM

Thursday
Vitale –AM
Ajkay – AM/PM
Scoggins – AM/PM

Friday
Egger – AM/PM
Philips – PM (Alternating weeks)

COLORECTAL CLINICS

Monday
Jorden – PM (MCNE)

Tuesday
Galandiuk – AM/PM
Kavalukas – AM/PM

Wednesday

Thursday
Farmer – AM/PM
Galandiuk – AM
Jorden – AM/PM
Kavalukas – PM (MCE 2nd & 4th)

VASCULAR CLINICS

Monday
Clark – AM/PM

Tuesday
Sigdel – AM
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
ULH, 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, J David Richardson, MD
Memorial Library ~ 2nd Floor
1:00 pm – 1:30 pm

Cosmetic, Craniofacial, & Hand Case Presentations
*Cosmetic – Third Monday of the Month
ACB, J David Richardson, MD
Memorial Library
1:30 pm – 2:00 pm

In-Service Board Review Course
ACB, J David Richardson, MD
Memorial Library ~ 2nd Floor
2:00 pm – 2:30 pm

Indications Conference
ACB, J David Richardson, MD
Memorial Library ~ 2nd Floor
2:30 pm – 3:30 pm

Workshops
*First Monday of the Month
ACB, J David Richardson, MD
Memorial Library ~ 2nd Floor
3:30 pm – 4:30 pm

Hand Conference
ACB, J David Richardson, MD
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 ~ Conference Center Rm 1
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 ~ Conference Center Rm 4 1:00 pm – 2:00 pm	**Radiology Conference** *First Tuesday of the Month (Pediatric Surgery Faculty & Radiology Staff) Norton Children's Hospital ~ Conference Center Rm 4 12:00 pm – 1:00 pm
Pediatric Device/Other Presentations/Extra Time 3rd Tuesday of the Month Norton Children's Hospital ~ Conference Center Rm 4 1:00 pm – 2:00 pm	**Pediatric Surgery Tumor Conference** *Fourth Tuesday of the Month Norton Hospital ~ Dining Rooms A/B 12:00 pm – 1:00 pm
Pediatric Surgery Grand Rounds *Fourth Tuesday of the Month Norton Children's Hospital ~ Conference Center Rm 4 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 Rudd Heart & Lung Center, TCVS Conference Room ~ 12th Fl 5:00 pm – 6:00 pm	**Journal Club** *Second Tuesday of the Month Rudd Heart & Lung Center, TCVS Conference Room ~ 12th Fl 5:00 pm – 6:00 pm

M & M Conference *Third Tuesday of the Month Rudd Heart & Lung Center, TCV Conference Room ~ 12th Fl 5:00 pm – 6:00 pm	**Scholarly Activity / Grand Rounds** *Fourth Tuesday of the Month Rudd Heart & Lung Center, TCVS 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 ACB, Polk Conference Room ~ 2nd Fl 7:00 am – 8:00 am
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, J David Richardson, MD Memorial Library 7:00 am – 8:00 am	**Plastic Surgery Conference** Rudd Heart & Lung ~ 15th Fl, Conf Rm D 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	**HAND SURGERY** **Kleinert Institute Hand Conference** 6:30 am – 7:30 am ***Virtual via Teams**
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

<table>
<tr><td colspan="2"><u>SURGICAL ONCOLOGY</u></td></tr>
<tr><td>Breast Multidisciplinary Conference
8:00 am – 9:00 am
*For location details, please refer to the Surgical Oncology Surgery Calendar</td><td>Sarcoma Conference
*Quarterly
*For location details, please refer to the Surgical Oncology Surgery Calendar</td></tr>
<tr><td colspan="2">Surgical Oncology Residence Conference
4:00 pm – 5:00 pm
*For location details, please refer to the Surgical Oncology Surgery Calendar</td></tr>
<tr><td colspan="2"><u>HAND SURGERY</u>
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
*Virtual via Teams</td></tr>
<tr><td colspan="2"><u>SURGICAL CRITICAL CARE</u></td></tr>
<tr><td>Critical Care & Basic Science Surgical Conference
*Second & Fourth Thursday of the Month
ACB ~ JDR Memorial Library ~7:00 am – 8:00 am</td><td>Trauma Quality Improvement Conference
*First Thursday of the Month
ACB ~ Glassroom (Basement) ~7:00 am – 8:00 am</td></tr>
</table>

FRIDAYS

<table>
<tr><td colspan="2"><u>GENERAL SURGERY</u></td></tr>
<tr><td>Surgical Grand Rounds
ACB ~ Auditorium (Basement)
7:00 am – 8:00 am
*Mandatory for All General Surgery Residents</td><td>Quality Improvement Conference
ACB ~ Room 1 (Basement)
8:00 am – 9:00 am
*Mandatory for All General Surgery Residents</td></tr>
<tr><td colspan="2">Resident Teaching Conference
ACB ~ Auditorium (Basement)
9:00 am – 10:00 am
*Mandatory for All General Surgery Residents</td></tr>
<tr><td colspan="2"><u>THORACIC & CARDIOVASCULAR SURGERY</u>
Wet Labs
Topics: CABG, Aortic Valve, Mitral Valve, Aortic Root
Cardiovascular Innovation Institute, 4th Floor Lab
3:00 pm – 4:00 pm</td></tr>
<tr><td colspan="2"><u>HAND SURGERY</u>
Christine M. Kleinert Institute Hand Conference
6:30 am – 7:30 am
*Virtual via Teams</td></tr>
</table>

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. 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	

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		
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:	852-1897	
Jeffrey R. Jorden, M.D.	852-1897	852-8915
University of South Florida	583-8303	
jeffrey.jorden@louisville.edu		
Contact Person:	852-1897	

ASSISTANT PROFESSORS:

Sandra L. Kavalukas, M.D.	852-1897	852-8915
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Jewish Hospital Distinguished Chair in Transplantation Research
Professor and Director

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Minimally Invasive Surgery

PROFESSORS:

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Pediatric Surgery

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Plastic and Reconstructive Surgery

PROFESSORS:

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Leonard J. Weiner Professorship in Plastic and Reconstructive Surgery
Chair of Plastic Surgery, Program Director

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Surgical Oncology

PROFESSORS:

Sam and Lolita Weakley Chair in Surgical Oncology
Director of Surgical Oncology

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Chair of Surgery, University of Louisville Hospital
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Diller B. Groff, M.D.
Morton L. Kasdan, M.D.
Gerald M. Larson, M.D.
Michael H. McCafferty, M.D.
Hirikati S. Nagaraj, M.D.
Hiram C. Polk, Jr., M.D.
Eugene H. Shively, M.D.
Leonard J. Weiner, 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.

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.

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.

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.

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.

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.

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.

2020 Publications

Faculty names are **bolded** and residents/fellows are underlined.

A

Adeniji N, Arjunan V, Prabhakar V, Mannalithara A, Ghaziani T, Ahmed A, Kwo P, Nguyen M, Melcher ML, Busuttil RW, Florman SS, Haydel B, Ruiz RM, Klintmalm GB, Lee DD, Burcin Taner C, Hoteit MA, Verna EC, Halazun KJ, Tevar AD, Humar A, Chapman WC, Vachharajani N, Aucejo F, Nydam TL, Markmann JF, Mobley C, Ghobrial M, Langnas AN, Carney CA, Berumen J, Schnickel GT, Sudan DL, Hong JC, Rana A, **Jones CM**, Fishbein TM, Agopian V, Dhanasekaran R. Posttransplant Outcomes in Older Patients With Hepatocellular Carcinoma Are Driven by Non-Hepatocellular Carcinoma Factors. Liver Transpl. 2021 May;27(5):684-698. doi: 10.1002/lt.25974. Epub 2021 Mar 1. PMID: 33306254; PMCID: PMC8140549.

Al Dallal HA, Narayanan S, **Jones CM**, Lockhart SR, Snyder JW. First Case Report of an Unusual Fungus (*Sporopachydermia lactativora)* Associated with a Pulmonary Infection in a Drug Injection User. Clin Pathol. 2021 Jul 12;14:2632010X211029970. doi: 10.1177/2632010X211029970. PMID: 34345817; PMCID: PMC8280816.

Arias D, **Carter SR**, Chen TF, Moles RJ. Australian care givers' knowledge of and attitudes towards paediatric fever management. J Paediatr Child Health. 2022 Jan;58(1):54-62. doi: 10.1111/jpc.15625. Epub 2021 Jun 30. PMID: 34191367.

B

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.

Bence CM, Rymeski B, Gadepalli S, Sato TT, Minneci PC, **Downard C**, Hirschl RB, Amin RA, Burns RC, Cherney-Stafford L, Courtney CM, 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 JM, Silverberg J, Slidell MB, St Peter SD, Troutt M, Walker S, **Wright T**, Lal DR; Midwest Pediatric Surgery Consortium. Clinical outcomes following implementation of a management bundle for esophageal atresia with distal tracheoesophageal fistula. J Pediatr Surg. 2021 Jan;56(1):47-54. doi: 10.1016/j.jpedsurg.2020.09.049. Epub 2020 Oct 6. PMID: 33131776.

Bhade P, Parsons A, Smiley A, Shreffler J, **Nash N**, Baker J, **Harbrecht B**, Huecker M. Fall, Crush, Kick: Mechanisms and Outcomes in a Cohort of Equine-Related Injuries. Am Surg. 2021 Oct 13:31348211048836. doi: 10.1177/00031348211048836. Epub ahead of print. PMID: 34645327.

Bhutiani N, **Ajkay N**. ASO Author Reflections: The Broad Impact of the Margin Consensus Guidelines for Breast-Conserving Surgery in DCIS. Ann Surg Oncol. 2021 Nov;28(12):7439-7440. doi: 10.1245/s10434-021-10170-3. Epub 2021 May 26. PMID: 34041628.

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.

Bhutiani N, Bruenderman EH, Jones JM, Wehry JH, **Egger ME**, **Philips P**, **Scoggins CR**, **McMasters KM**, **Martin RCG**. A literature-based treatment algorithm for low-grade neuroendocrine liver metastases. HPB (Oxford). 2021 Jan;23(1):63-70. doi: 10.1016/j.hpb.2020.04.012. Epub 2020 May 21. PMID: 32448647.

Bhutiani N, Holland MM, Mercer MK, Donaldson M, Berry TS, **McMasters KM**, **Ajkay N**. Effect of the Ductal Carcinoma In Situ Margin Consensus Guideline Implementation on Re-Excision Rates, Satisfaction, and Cost. Ann Surg Oncol. 2021 Nov;28(12):7432-7438. doi: 10.1245/s10434-021-10120-z. Epub 2021 May 27. PMID: 34043091.

Bodily NE, Bruenderman EH, Bhutiani N, The S, Schucht JE, **Bozeman MC**. The Effect of Transfer on Outcomes in Burns. J Burn Care Res. 2021 Sep 30;42(5):841-846. doi: 10.1093/jbcr/irab092. PMID: 34086949.

Bruenderman EH, Bhutiani N, **Martin RCG**, Fox MP, van Berkel VH, Block SB, **Kehdy FJ**. Intraoperative Esophagogastroduodenoscopy During Heller Myotomy: Evaluating Guidelines. World J Surg. 2021 Mar;45(3):808-814. doi: 10.1007/s00268-020-05870-y. Epub 2020 Nov 23. PMID: 33230586.

Bruenderman EH, Block SB, **Kehdy FJ**, **Benns MV**, **Miller KR**, Motameni A, **Nash NA**, **Bozeman MC**, **Martin RCG**. An evaluation of emergency general surgery transfers and a call for standardization of practices. Surgery. 2021 Mar;169(3):567-572. doi: 10.1016/j.surg.2020.08.022. Epub 2020 Oct 1. PMID: 33012562; PMCID: PMC7528972.

C

Canton SP, Lutfi W, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Guyette FX, Sperry JL, Brown JB. Lactate as a mediator of prehospital plasma mortality reduction in hemorrhagic shock. J Trauma Acute Care Surg. 2021 Jul 1;91(1):186-191. doi: 10.1097/TA.0000000000003173. PMID: 33797485.

Carter TS, **Philips P**, **Egger M**, **Scoggins C**, **Martin RCG 2nd**. Outcomes of Esophageal Stent Therapy for the Management of Anastomotic Leaks. Ann Surg Oncol. 2021 Sep;28(9):4960-4966. doi: 10.1245/s10434-021-09669-6. Epub 2021 Mar 17. PMID: 33730227.

Cheadle GA, **Cheadle WG**. A Review of "Options in Management of Trauma to the Esophagus" (1982) "Submitted for the Literary Festschrift in Honor of J. David Richardson, MD". Am Surg. 2021 Feb;87(2):183-187. doi: 10.1177/0003134820988816. Epub 2021 Jan 30. PMID: 33522267.

D

Davidyuk V, Bhutiani N, Gold MK, Mortensen GF, Trestrail T, Brown AN, Vitale RJ, McClave SA, **Vitale GC**. Surgical Diagnoses of Pancreatic Adenocarcinoma Not Found on Previous Endoscopic Ultrasound: A Case Series and Review of the Literature. Am Surg. 2021 Nov 8:31348211054531. doi: 10.1177/00031348211054531. Epub ahead of print. PMID: 34743589.

Dawson TH, Bhutiani N, **Benns MV**, **Miller KR**, **Bozeman MC**, **Kehdy FJ**, Motameni AT. Comparing patterns of care and outcomes after operative management of complications after bariatric surgery at MBSAQIP accredited bariatric centers and non-bariatric facilities. Surg Endosc. 2021 Aug;35(8):4719-4724. doi: 10.1007/s00464-020-07942-5. Epub 2020 Sep 9. PMID: 32909202.

Dekonenko C, Fraser JD, Deans KJ, **Fallat ME**, Helmrath M, Kabre R, Leys CM, Burns RC, Corkumd K, Dillon PA, **Downard C**, **Wright TN**, Gadepalli SK, Grabowski JE, Hernandez E, Hirschl R, Johnson KN, Kohler JE, Landman MP, Landisch RM, Lawrence AE, Mak GZ, Minneci PC, Rymeski B, Sato TT, Slater BJ, St Peter SD. Outcomes in gastroschisis: expectations in the postnatal period for simple vs complex gastroschisis. J Perinatol. 2021 Jul;41(7):1755-1759. doi: 10.1038/s41372-021-01093-8. Epub 2021 May 25. PMID: 34035447.

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.

Dwivedi A, **Wayne E**, Sangroula D, **Sigdel A**. Endovascular Treatment of Giant Celiac Artery Aneurysm in Behcet's Disease. Vasc Endovascular Surg. 2021 May;55(4):398-401. doi: 10.1177/1538574420975906. Epub 2020 Nov 26. PMID: 33243094.

E

Egger ME. Prognosis in Thin Melanoma Patients: Is Slightly Less Than Excellent Still Okay? Ann Surg Oncol. 2021 Nov;28(12):6911-6914. doi: 10.1245/s10434-021-10772-x. Epub 2021 Sep 15. PMID: 34528177.

Egger ME. The Role of Clinical Prediction Tools to Risk Stratify Patients with Melanoma After a Positive Sentinel Lymph Node Biopsy. Ann Surg Oncol. 2021 Aug;28(8):4082-4083. doi: 10.1245/s10434-018-07099-5. Epub 2021 May 28. PMID: 34047858.

Ellis CT, Maykel JA. Defining Anastomotic Leak and the Clinical Relevance of Leaks. Clin Colon Rectal Surg. 2021 Oct 1;34(6):359-365. doi: 10.1055/s-0041-1735265. PMID: 34853555; PMCID: PMC8610631.

Esparaz JR, **Carter SR**, Anderson SA, Russell RT, Radulescu A, Mathis MS, Chen MK. The diminishing experience in pediatric surgery for general surgery residents in the United States. J Pediatr Surg. 2021 Jul;56(7):1219-1221. doi: 10.1016/j.jpedsurg.2021.03.042. Epub 2021 Mar 26. PMID: 33838901.

F

Fallat ME. Fifteen years beyond Institute of Medicine and the future of emergency care in the US health system: Illusions, delusions, and situational awareness. J Trauma Acute Care Surg. 2021 Jul 1;91(1):6-13. doi: 10.1097/TA.0000000000003242. PMID: 34144555.

Fallat ME, Hertweck P, Klipstein S. Swyer Syndrome/46 XY Gonadal Dysgenesis: Remove the Tubes or Not? J Pediatr Adolesc Gynecol. 2021 Dec;34(6):771-772. doi: 10.1016/j.jpag.2021.08.008. PMID: 34742465.

Farmer RW, Saner S, Weingartner LA, Rabalais G. Questioning Aid for Rich, Real-Time Discussion (QARRD): A Tool to Improve Critical Thinking in Clinical Settings. MedEdPORTAL. 2021;17:11132.

Fiechter CR, Hallion JC, Schmidt MN, **Galandiuk S**, **Polk HC Jr**. The Impact of Surgical Research on Career Success: A Forty-Year Follow-up of Undergraduate Experiences. Ann Surg. 2021 Mar 1;273(3):e100-e102. doi: 10.1097/SLA.0000000000004075. PMID: 32740229.

Franklin GA. A Review of "Prehospital Hypotension as a Valid Indicator of Trauma Team Activation" (2000). Am Surg. 2021 Feb;87(2):204-208. doi: 10.1177/0003134820979176. Epub 2020 Dec 19. PMID: 33342294.

Fromer MW, Hawthorne J, **Philips P**, **Egger ME**, **Scoggins CR**, **McMasters KM**, **Martin RCG**. An Improved Staging System for Locally Advanced Pancreatic Cancer: A Critical Need in the Multidisciplinary Era. Ann Surg Oncol. 2021 Oct;28(11):6201-6210. doi: 10.1245/s10434-021-10174-z. Epub 2021 Jun 4. PMID: 34089107.

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.

G

Galandiuk S. Invited Commentary. J Am Coll Surg. 2021 Apr;232(4):395-396. doi: 10.1016/j.jamcollsurg.2020.12.027. PMID: 33771296.

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.

Gomez-Gutierrez JG, Bhutiani N, McNally MW, Chuong P, Yin W, Jones MA, Zeiderman MR, Grizzle WE, McNally LR. The neutral red assay can be used to evaluate cell viability during autophagy or in an acidic microenvironment in vitro. Biotech Histochem. 2021 May;96(4):302-310. doi: 10.1080/10520295.2020.1802065. Epub 2020 Aug 3. PMID: 32744455; PMCID: PMC7861123.

Grabowski J, Goldin A, Arthur LG, Beres AL, Guner YS, Hu YY, Kawaguchi AL, Kelley-Quon LI, McAteer JP, Miniati D, Renaud EJ, Ricca R, Slidell MB, Smith CA, Sola JE, Sømme S, **Downard CD**, Gosain A, Valusek P, St Peter SD, Jagannathan N', Dasgupta R. The effects of early anesthesia on neurodevelopment: A systematic review. J Pediatr Surg. 2021 May;56(5):851-861. doi: 10.1016/j.jpedsurg.2021.01.002. Epub 2021 Jan 19. PMID: 33509654.

Grzeda AL, Moseley MD, Sangroula D, **Wayne EJ**, **Dwivedi AJ**, **Sigdel A**. Endovascular Treatment of Innominate Artery Bifurcation Injury with Balloon-Expandable Covered Stents Utilizing Kissing Stent Technique. Am Surg. 2021 Nov 29:31348211048835. doi: 10.1177/00031348211048835. Epub ahead of print. PMID: 34842483.

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. 2021 Oct 29:S0022-3468(21)00732-6. doi: 10.1016/j.jpedsurg.2021.10.024. Epub ahead of print. 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. 2021 Nov 6:S0022-3468(21)00764-8. doi: 10.1016/j.jpedsurg.2021.10.055. Epub ahead of print. PMID: 34865831.

Guyette FX, Sperry JL, Peitzman AB, Billiar TR, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Putnam T, Duane TM, Phelan HA, Brown JB. Prehospital Blood Product and Crystalloid Resuscitation in the Severely Injured Patient: A Secondary Analysis of the Prehospital Air Medical Plasma Trial. Ann Surg. 2021 Feb 1;273(2):358-364. doi: 10.1097/SLA.0000000000003324. PMID: 30998533.

H

Harbrecht BG. A Review of "Predicting the Need to Pack Early for Severe Intra-abdominal Hemorrhage" (1996). Am Surg. 2021 Feb;87(2):195-198. doi: 10.1177/0003134820986140. Epub 2021 Jan 27. PMID: 33502241.

Hernandez JM, **McMasters KM**. Introducing the Ongoing Clinical Trials in the Surgical Oncology Series. Ann Surg Oncol. 2021 Aug;28(8):4093-4094. doi: 10.1245/s10434-021-10113-y. Epub 2021 May 12. PMID: 33978888.

Hrebinko KA, Sperry JL, Guyette FX, Brown JB, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Neal MD, Zuckerbraun BS, Yazer MH, Nicholson KJ. Evaluating the Cost-effectiveness of Prehospital Plasma Transfusion in Unstable Trauma Patients: A Secondary Analysis of the PAMPer Trial. JAMA Surg. 2021 Dec 1;156(12):1131-1139. doi: 10.1001/jamasurg.2021.4529. PMID: 34550318; PMCID: PMC8459310.

Hsueh EC, DeBloom JR, Lee JH, Sussman JJ, Covington KR, Caruso HG, Quick AP, Cook RW, Slingluff CL Jr, **McMasters KM**. Long-Term Outcomes in a Multicenter, Prospective Cohort Evaluating the Prognostic 31-Gene Expression Profile for Cutaneous Melanoma. JCO Precis Oncol. 2021 Apr 6;5:PO.20.00119. doi: 10.1200/PO.20.00119. PMID: 34036233; PMCID: PMC8140806.

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 SD, Vivace BJ, Meredith LT, Kachare MD, Kapsalis CN, Ablavsky M, Safeek RH, Muresan C, **Choo JH**, Kasdan ML, **Wilhelmi BJ**. Anatomic surface landmarks to guide injection for posterior interosseous nerve block. J Plast Surg Hand Surg. 2021 Feb;55(1):17-20. doi: 10.1080/2000656X.2020.1828895. Epub 2020 Oct 10. PMID: 33043751.

Kavalukas SL, Scheurlen KM, **Galandiuk S**. State-of-the-art surgery for Crohn's disease: Part I-small intestine/ileal disease. Langenbecks Arch Surg. 2021 Nov 4. doi: 10.1007/s00423-021-02324-4. Epub ahead of print. PMID: 34738167.

Kawaguchi AL, Guner YS, Sømme S, Quesenberry AC, Arthur LG, Sola JE, **Downard CD**, Rentea RM, Valusek PA, Smith CA, Slidell MB, Ricca RL, Dasgupta R, Renaud E, Miniati D, McAteer J, Beres AL, Grabowski J, Peter SDS, Gosain A; American Pediatric Surgical Association Outcomes and Evidence-Based Practice (OEBP) Committee. Management and outcomes for long-segment Hirschsprung disease: A systematic review from the APSA Outcomes and Evidence Based Practice Committee. J Pediatr Surg. 2021 Sep;56(9):1513-1523. doi: 10.1016/j.jpedsurg.2021.03.046. Epub 2021 Mar 28. PMID: 33993978; PMCID: PMC8552809.

Kelley-Quon LI, Arthur LG, Williams RF, Goldin AB, St Peter SD, Beres AL, Hu YY, Renaud EJ, Ricca R, Slidell MB, Taylor A, Smith CA, Miniati D, Sola JE, Valusek P, Berman L, Raval MV, Gosain A, Dellinger MB, Sømme S, **Downard CD**, McAteer JP, Kawaguchi A. Management of intussusception in children: A systematic review. J Pediatr Surg. 2021 Mar;56(3):587-596. doi: 10.1016/j.jpedsurg.2020.09.055. Epub 2020 Oct 6. PMID: 33158508; PMCID: PMC7920908.

Kelley-Quon LI, Kirkpatrick MG, Ricca RL, Baird R, Harbaugh CM, Brady A, Garrett P, Wills H, Argo J, Diefenbach KA, Henry MCW, Sola JE, Mahdi EM, Goldin AB, St Peter SD, **Downard CD**, Azarow KS, Shields T, Kim E. Guidelines for Opioid Prescribing in Children and Adolescents After Surgery: An Expert Panel Opinion. JAMA Surg. 2021 Jan 1;156(1):76-90. doi: 10.1001/jamasurg.2020.5045. Erratum in: JAMA Surg. 2021 Apr 1;156(4):403. PMID: 33175130; PMCID: PMC8995055.

L

Ladhani HA, Ho VP, Charbonnet CC, Sperry JL, Guyette FX, Brown JB, Daley BJ, Miller RS, **Harbrecht BG**, Phelan HA, Claridge JA; PAMPer Study Group. Dose-dependent association between blood transfusion and nosocomial infections in trauma patients: A secondary analysis of patients from the PAMPer trial. J Trauma Acute Care Surg. 2021 Aug 1;91(2):272-278. doi: 10.1097/TA.0000000000003251. PMID: 34397951; PMCID: PMC8664092.

Lakshmanan J, Zhang B, Wright K, Motameni AT, Herbst JL, **Harbrecht BG**. Tender Coconut Water Protects Mice From Ischemia-Reperfusion-Mediated Liver Injury and Secondary Lung Injury. Shock. 2021 Nov 1;56(5):762-772. doi: 10.1097/SHK.0000000000001770. PMID: 34652342.

Lawrence AE, Saito J, Onwuka A, Port E, Bowder A, Courtney C, Deans KJ, **Downard CD**, Duran YK, **Fallat ME**, Fraser JD, Gadepalli S, Kabre R, Kalbfell EL, Knaus ME, Kohler J, Lal D, Landman MP, Leys CM, Lu P, Mak GZ, Markel T, Merchant N, Nguyen T, Pilkington M, Rymeski B, Sato TT, St Peter SD, **Wright T**, Minneci PC, Grabowski JE. Management of Pediatric Breast Masses: A Multi-institutional Retrospective Cohort Study. J Surg Res. 2021 Aug;264:309-315. doi: 10.1016/j.jss.2021.01.041. Epub 2021 Apr 10. PMID: 33845414.

Linder MW, **Egger ME**, Van Meter T, Rai SN, Valdes R Jr, Hall MB, Wu X, Alghamdi N, Chesney JA. Longitudinal Relationship between Idylla Plasma ctBRAF V600 Mutation Detection and Tumor Burden in Patients with Metastatic Melanoma. Mol Diagn Ther. 2021 May;25(3):361-371. doi: 10.1007/s40291-021-00528-4. Epub 2021 May 10. PMID: 33970440; PMCID: PMC8827645.

M

McMasters A, **McMasters KM**, Hao H. Exosome to Promote Cancer Progression via Its Bioactive Cargoes. Arch Cancer Biol Ther. 2021 Jun;2(2):29-34. PMID: 34263260; PMCID: PMC8277159.

McMasters KM. Annals of Surgical Oncology: Statement on Diversity, Equity, Inclusion, and Anti-racism. Ann Surg Oncol. 2021 Jan;28(1):1-3. doi: 10.1245/s10434-020-09380-y. Epub 2020 Nov 25. PMID: 33237448.

Miller HA, Yin X, Smith SA, Hu X, Zhang X, Yan J, Miller DM, van Berkel VH, Frieboes HB. Evaluation of disease staging and chemotherapeutic response in non-small cell lung cancer from patient tumor-derived metabolomic data. Lung Cancer. 2021 Jun;156:20-30. doi: 10.1016/j.lungcan.2021.04.012. Epub 2021 Apr 15. PMID: 33882406; PMCID: PMC8138715.

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, **Jones CM**, McClave SA, Christian V, Adamson P, Neel DR, **Bozeman M**, **Benns MV**. Food Access, Food Insecurity, and Gun Violence: Examining a Complex Relationship. Curr Nutr Rep. 2021 Dec;10(4):317-323. doi: 10.1007/s13668-021-00378-w. Epub 2021 Oct 21. PMID: 34676506.

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.

Moore J, **Scoggins CR**, **Philips P**, **Egger M**, Tennant P, **Little J**, **Martin RCG**. Implementation of Prehabilitation for Major Abdominal Surgery and Head and Neck Surgery: a Simplified Seven-Day Protocol. J Gastrointest Surg. 2021 Aug;25(8):2076-2082. doi: 10.1007/s11605-020-04740-1. Epub 2020 Jul 23. PMID: 32705612.

Moore JV, Tom S, **Scoggins CR**, **Philips P**, **Egger ME**, **Martin RCG 2nd**. Exocrine Pancreatic Insufficiency After Pancreatectomy for Malignancy: Systematic Review and Optimal Management Recommendations. J Gastrointest Surg. 2021 Sep;25(9):2317-2327. doi: 10.1007/s11605-020-04883-1. Epub 2021 Jan 22. PMID: 33483914.

Morrissey SM, Zhang F, Ding C, Montoya-Durango DE, Hu X, Yang C, Wang Z, Yuan F, Fox M, Zhang HG, Guo H, Tieri D, Kong M, Watson CT, Mitchell RA, Zhang X, **McMasters KM**, Huang J, Yan J.

Tumor-derived exosomes drive immunosuppressive macrophages in a pre-metastatic niche through glycolytic dominant metabolic reprogramming. Cell Metab. 2021 Oct 5;33(10):2040-2058.e10. doi: 10.1016/j.cmet.2021.09.002. Epub 2021 Sep 23. PMID: 34559989; PMCID: PMC8506837.

Morrissey SM, Geller AE, Hu X, Tieri D, Ding C, Klaes CK, Cooke EA, Woeste MR, Martin ZC, Chen O, Bush SE, Zhang HG, Cavallazzi R, Clifford SP, Chen J, Ghare S, Barve SS, Cai L, Kong M, Rouchka EC, McLeish KR, Uriarte SM, Watson CT, Huang J, Yan J. A specific low-density neutrophil population correlates with hypercoagulation and disease severity in hospitalized COVID-19 patients. JCI Insight. 2021 May 10;6(9):e148435. doi: 10.1172/jci.insight.148435. PMID: 33986193; PMCID: PMC8262329.

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.

Mulcahy MF, Mahvash A, Pracht M, Montazeri AH, Bandula S, **Martin RCG 2nd**, Herrmann K, Brown E, Zuckerman D, Wilson G, Kim TY, Weaver A, Ross P, Harris WP, Graham J, Mills J, Yubero Esteban A, Johnson MS, Sofocleous CT, Padia SA, Lewandowski RJ, Garin E, Sinclair P, Salem R; EPOCH Investigators. Radioembolization With Chemotherapy for Colorectal Liver Metastases: A Randomized, Open-Label, International, Multicenter, Phase III Trial. J Clin Oncol. 2021 Dec 10;39(35):3897-3907. doi: 10.1200/JCO.21.01839. Epub 2021 Sep 20. PMID: 34541864; PMCID: PMC8660005.

N

Narayanan G, Bilimoria MM, Hosein PJ, Su Z, Mortimer KM, **Martin RCG 2nd**. Multicenter randomized controlled trial and registry study to assess the safety and efficacy of the NanoKnife® system for the ablation of stage 3 pancreatic adenocarcinoma: overview of study protocols. BMC Cancer. 2021 Jul 7;21(1):785. doi: 10.1186/s12885-021-08474-4. PMID: 34233640; PMCID: PMC8261981.

Narayanan S, Bhutiani N, **Adamson DT**, **Jones CM**. Pancreatectomy, Islet Cell Transplantation, and Nutrition Considerations. Nutr Clin Pract. 2021 Apr;36(2):385-397. doi: 10.1002/ncp.10578. Epub 2020 Oct 1. PMID: 33002260.

Noe JT, Rendon BE, Geller AE, Conroy LR, Morrissey SM, Young LEA, Bruntz RC, Kim EJ, Wise-Mitchell A, Barbosa de Souza Rizzo M, Relich ER, Baby BV, Johnson LA, Affronti HC, **McMasters KM**, Clem BF, Gentry MS, Yan J, Wellen KE, Sun RC, Mitchell RA. Lactate supports a metabolic-epigenetic link in macrophage polarization. Sci Adv. 2021 Nov 12;7(46):eabi8602. doi: 10.1126/sciadv.abi8602. Epub 2021 Nov 12. PMID: 34767443; PMCID: PMC8589316.

OP

O'Brien SJ, **Ellis CT**, McDowell J, **Galandiuk S**, **Polk HC Jr**. Anal squamous cell carcinoma incidentally found at hemorrhoidectomy. Surgery. 2021 Mar;169(3):610-616. doi: 10.1016/j.surg.2020.08.026. Epub 2020 Sep 29. PMID: 33004218.

O'Brien SJ, Fiechter C, Burton J, Hallion J, Paas M, Patel A, Patel A, Rochet A, Scheurlen K, Gardner S, Eichenberger M, Sarojini H, Srivastava S, Rai S, Kalbfleisch T, **Polk HC Jr**, **Galandiuk S**. Long non-coding RNA ZFAS1 is a major regulator of epithelial-mesenchymal transition through miR-200/ZEB1/E-cadherin, vimentin signaling in colon adenocarcinoma. Cell Death Discov. 2021 Mar 26;7(1):61. doi: 10.1038/s41420-021-00427-x. PMID: 33771981; PMCID: PMC7998025.

O'Brien SJ, Hallion J, Scheurlen KM, Fiechter C, Burton J, Paas M, Schmidt M, Gardner S, Eichenberger MR, Pan J, Rai S, **Galandiuk S**. Crohn's disease-related single nucleotide polymorphisms are associated with ileal pouch afferent limb stenosis. J Gastrointest Surg. 2021 Sep;25(9):2377-2386. doi: 10.1007/s11605-020-04884-0. Epub 2021 Jan 14. PMID: 33443688.

O'Brien SJ, Kalbfleisch T, Srivastava S, Pan J, Rai S, Petras RE, Ronquillo N, **Polk HC J**r, **Galandiuk S**. Decreased Tumoral Expression of Colon-Specific Water Channel Aquaporin 8 Is Associated With

Reduced Overall Survival in Colon Adenocarcinoma. Dis Colon Rectum. 2021 Sep 1;64(9):1083-1095. doi: 10.1097/DCR.0000000000002071. PMID: 33990498.

O'Brien SJ, Netz U, Hallion J, Bishop C, Stephen V, Burton J, Paas M, Feagins K, Pan J, Rai SN, **Galandiuk S**. Circulating plasma microRNAs in colorectal neoplasia: A pilot study in assessing response to therapy. Transl Oncol. 2021 Jan;14(1):100962. doi: 10.1016/j.tranon.2020.100962. Epub 2020 Dec 4. PMID: 33285367; PMCID: PMC7720092.

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'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.

QR

Rajaee A, Sadr-Eshkevari P, **McMasters KM**, **Egger ME**. Predictors of Nonsentinel Lymph Node Metastasis in Cutaneous Melanoma: A Systematic Review and Meta-Analysis. J Surg Res. 2021 Apr;260:506-515. doi: 10.1016/j.jss.2020.11.058. Epub 2020 Dec 23. PMID: 33358194.

Reitz KM, Gruen DS, Guyette F, Brown JB, Yazer MH, Vodovotz Y, Johanssen PI, Stensballe J, Daley B, Miller RS, **Harbrecht BG**, Claridge J, Phelan HA, Neal MD, Zuckerbraun BS, Sperry JL. Age of thawed plasma does not affect clinical outcomes or biomarker expression in patients receiving prehospital thawed plasma: a PAMPer secondary analysis. Trauma Surg Acute Care Open. 2021 Feb 11;6(1):e000648. doi: 10.1136/tsaco-2020-000648. PMID: 33634214; PMCID: PMC7880105.

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.

Richardson JD, Sachdeva AK, Hoyt DB. Importance of Practice Continuity. J Am Coll Surg. 2021 Oct;233(4):554-556. doi: 10.1016/j.jamcollsurg.2021.07.680. Epub 2021 Jul 27. PMID: 34329748.

S

Scheurlen KM, Snook DL, Gardner SA, Eichenberger MR, **Galandiuk S**. Macrophage Differentiation and Polarization into an M2-Like Phenotype using a Human Monocyte-Like THP-1 Leukemia Cell Line. J Vis Exp. 2021 Aug 2;(174). doi: 10.3791/62652. PMID: 34398156.

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.

Schucht JE, Matheson PJ, **Harbrecht BG**, Bond L, Ashkettle GR, **Smith JW**. Plasma resuscitation with adjunctive peritoneal resuscitation reduces ischemia-induced intestinal barrier breakdown following hemorrhagic shock. J Trauma Acute Care Surg. 2021 Jan 1;90(1):27-34. doi: 10.1097/TA.0000000000002916. PMID: 32910075.

Schwarte B, **Sigdel A**, **Dwivedi AJ**, **Wayne EJ**. Use of Indocyanine Green During Repair of a Superior Mesenteric Artery Aneurysm. Ann Vasc Surg. 2021 Aug;75:531.e15-531.e18. doi: 10.1016/j.avsg.2021.02.044. Epub 2021 Apr 7. PMID: 33838240.

Scoggins CR. TACE or TARE for Unresectable Neuroendocrine Liver Metastases: Can we Finally Start to Focus on Value? Ann Surg Oncol. 2021 Apr;28(4):1876-1877. doi: 10.1245/s10434-021-09598-4. Epub 2021 Jan 28. PMID: 33507450.

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.

Shi X, O'Neill C, Wang X, Chen Y, Yu Y, Tan M, Lv G, Li Y, **Martin RC**. Irreversible electroporation enhances immunotherapeutic effect in the off-target tumor in a murine model of orthotopic HCC. Am J Cancer Res. 2021 Jun 15;11(6):3304-3319. PMID: 34249464; PMCID: PMC8263666.

Shoff HW, Huecker M, Davis H, **Smith JW**. Very Low Rate of Positive COVID Infections (<.5%) on Preoperative Screening in the Elective Procedure Population. Am Surg. 2021 Jan 27:3134820983206. doi: 10.1177/0003134820983206. Epub ahead of print. PMID: 33502223.

Smith JW, Garrison RN. A Review of "Direct Peritoneal Resuscitation Accelerates Primary Abdominal Wall Closure After Damage Control Surgery" (2010). Am Surg. 2021 Feb;87(2):219-221. doi: 10.1177/0003134820981676. Epub 2021 Feb 16. PMID: 33591812.

Stover AM, Kurtzman R, Walker Bissram J, Jansen J, Carr P, Atkinson T, **Ellis CT**, Freeman AT, Turner K, Basch EM. Stakeholder Perceptions of Key Aspects of High-Quality Cancer Care to Assess with Patient Reported Outcome Measures: A Systematic Review. Cancers (Basel). 2021 Jul 20;13(14):3628. doi: 10.3390/cancers13143628. PMID: 34298841; PMCID: PMC8306432.

TUV

Vermeulen BD, van der Leeden B, Ali JT, Gudbjartsson T, Hermansson M, Low DE, Adler DG, Botha AJ, D'Journo XB, Eroglu A, Ferri LE, Gubler C, Haveman JW, Kaman L, Kozarek RA, Law S, Loske G, Lindenmann J, Park JH, **Richardson JD**, Salminen P, Song HY, Søreide JA, Spaander MCW, Tarascio JN, Tsai JA, Vanuytsel T, Rosman C, Siersema PD; Benign Esophageal Perforation Collaborative Group. Early diagnosis is associated with improved clinical outcomes in benign esophageal perforation: an individual patient data meta-analysis. Surg Endosc. 2021 Jul;35(7):3492-3505. doi: 10.1007/s00464-020-07806-y. Epub 2020 Jul 17. PMID: 32681374; PMCID: PMC8195755.

W

Weller JH, Peter SDS, **Fallat ME**, Saito JM, Burns CR, Deans KJ, Fraser JD, 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. Thoracoscopic versus open lobectomy in infants with congenital lung malformations: A multi-institutional propensity score analysis. J Pediatr Surg. 2021 Dec;56(12):2148-2156. doi: 10.1016/j.jpedsurg.2021.04.013. Epub 2021 Apr 25. PMID: 34030879.

White RR, Murphy JD, **Martin RCG**. The Landmark Series: Locally Advanced Pancreatic Cancer and Ablative Therapy Options. Ann Surg Oncol. 2021 Aug;28(8):4173-4180. doi: 10.1245/s10434-021-09662-z. Epub 2021 Feb 14. PMID: 33586072.

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 Mar 2:S0039-6060(22)00064-2. doi: 10.1016/j.surg.2022.01.033. Epub ahead of print. PMID: 35248363.

Woeste MR, Bhutiani N, Donaldson M, **McMasters KM**, **Ajkay N**. Evaluating the effect of neoadjuvant chemotherapy on surgical outcomes after breast conserving surgery. J Surg Oncol. 2021 Feb;123(2):439-445. doi: 10.1002/jso.26301. Epub 2020 Dec 1. PMID: 33259649.

Woeste MR, Geller AE, **Martin RCG 2nd**, **Polk HC Jr**. Optimizing the Combination of Immunotherapy and Trans-Arterial Locoregional Therapy for Stages B and C Hepatocellular Cancer. Ann Surg Oncol. 2021 Mar;28(3):1499-1510. doi: 10.1245/s10434-020-09414-5. Epub 2021 Jan 3. PMID: 33393028.

Woeste MR, **McMasters KM**, **Egger ME**. Stage IIIa Melanoma and Impact of Multiple Positive Lymph Nodes on Survival. J Am Coll Surg. 2021 Apr;232(4):517-524.e1. doi: 10.1016/j.jamcollsurg.2020.11.015. Epub 2020 Dec 13. PMID: 33316426.

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. 2021 Oct 1:S0002-9610(21)00563-8. doi: 10.1016/j.amjsurg.2021.09.037. Epub ahead of print. PMID: 34625205.

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.

Wu J, Vodovotz Y, Abdelhamid S, Guyette FX, Yaffe MB, Gruen DS, Cyr A, Okonkwo DO, Kar UK, Krishnamoorthi N, Voinchet RG, Billiar IM, Yazer MH, Namas RA, Daley BJ, Miller RS, **Harbrecht BG**, Claridge JA, Phelan HA, Zuckerbraun BS, Johansson PI, Stensballe J, Morrissey JH, Tracy RP, Wisniewski SR, Neal MD, Sperry JL, Billiar TR; PAMPer study group. Multi-omic analysis in injured humans: Patterns align with outcomes and treatment responses. Cell Rep Med. 2021 Dec 21;2(12):100478. doi: 10.1016/j.xcrm.2021.100478. PMID: 35028617; PMCID: PMC8715070.

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 Jan 19. doi: 10.1158/1078-0432.CCR-21-0664. Epub ahead of print. PMID: 35046061.

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.

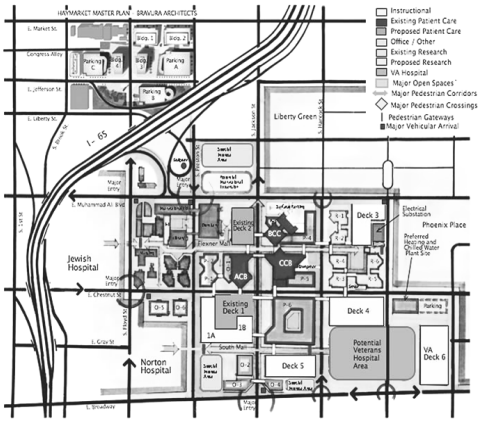
Reconstructive Surgery Research Laboratories:
The Reconstructive Surgery Research Laboratories team consists of clinical and basic science faculty, research fellows, and medical students from diverse educational and training backgrounds who work together to identify clinical problems, design experimental 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**
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University of Louisville & Affiliated Hospitals

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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
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