



2024-2025

University of Louisville

**The Hiram C. Polk, Jr., M.D. Department of Surgery
Surgical Resident Manual**

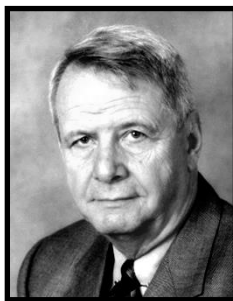
University of Louisville's Pioneers in Surgical Education



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

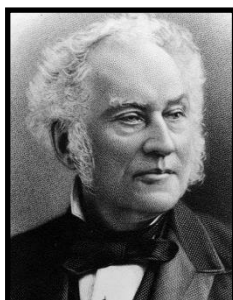
Established the country's first "Accident Service" at Louisville City Hospital. He trained and equipped police to give emergency care en route to the hospital. Griswold also developed autotransfusion and was innovative in the treatment of fractures.



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.	4
▪ Surgical Resident Training Philosophy	5
▪ Surgical Resident Directory 2022-2023	7
▪ Master Schedules 2022-2023	16
▪ Hospital Information	28
▪ Educational Goals and Objectives	33
▪ ACGME Program Requirements	81

Department of Cardiothoracic and Vascular Surgery Cardiac Rotation Expectations (82)

Special Requirement in Laparoscopy and Endoscopy (p. 83)

Policies:

▪ Selection Process of Residency Trainees	84
▪ Supervisory Lines of Responsibility	86
▪ Surgical Resident Responsibilities	90
▪ Role of a Surgical Resident in the Education of Medical Students	101
▪ Transition of Patient Care Policy	104
▪ Resident Assignment/Election to Research/Fellowship Years	107
▪ General Surgical Resident Research Plan and Guidelines	108
▪ Monitoring Resident Stress/Fatigue	110
▪ Uber Transportation Program	111
▪ Faculty/Resident Mentorship	113
▪ Departmental Society Memberships	114
▪ Moonlighting Policy	115
▪ General Policies	117
<i>Includes: Absences, Address/Phone Changes, Admin Problems, Changes to New Services, Impaired Resident/Substance Abuse, Grievance Procedure, Academic Probation, Clergy Act, Mail, Research Projects, & Vacation Scheduling, Resident Assignment, Social Media</i>	
▪ Resident Clinical and Educational Work Hour Policy	122
▪ Promotion Policy	124
▪ Probation, Suspension and Termination for Delinquent Medical Records	125
▪ Faculty and Clinical Competency Committee Evaluation of Residents	126
▪ Evaluations Completed by Residents	127
▪ Resident Time Off Policy	128
▪ Resident Travel Policy	137
▪ ABS General Requirements	140
▪ ABS Training Requirements	141
▪ Application for Examination by the American Board of Surgery	143

House Staff Information:

▪ Intern Survival Guide	145
▪ 2023-2024 Stipend Rates	159
▪ Fringe Benefits	160
▪ KY Medical Licensure Requirements	162
▪ Faculty Clinic Schedules	163
▪ Conferences	166
▪ Average of Cases (2018-2022)	171
▪ Opportunities to Pursue Advanced Degrees	172
▪ KY Division of the American Cancer Society	173
▪ KY Organ Donor Affiliates	174

Faculty & Research Information:

▪ Faculty Listing	175
▪ Clinical Faculty	182
▪ Endowed Professorships & Chairs	184
▪ Departmental Awards & Recipients	185
▪ 2023-2024 Publications	188
▪ Research Facilities	196
▪ Web site Listing & Hospital Numbers	197

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.)**

2024-2025 Surgical Resident & Fellow Directory

GENERAL SURGERY RESIDENTS

	<u>Postgraduate Year V:</u>	<u>Pager</u>	<u>Medical School</u>
	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
	Nicolas Cassata nicolas.cassata@louisville.edu	209-1548	University of Texas-Houston
	Seth Hall seth.hall@louisville.edu	209-1643	University of Louisville
	Brittany Hegde brittany.wiseman@louisville.edu	464-7018	University of Tennessee
	David Keeven david.keeven@louisville.edu	209-1455	University of Kentucky
	*Matthew Woeste matthew.woeste@louisville.edu	209-1366	University of Louisville

**Administrative Chief Resident*

<u>Postgraduate Year IV:</u>	<u>Pager</u>	<u>Medical School</u>
 Pooja Avula pooja.avula@louisville.edu	209-1301	Western Michigan
 Nicholas Caminiti nicholas.caminiti@louisville.edu	209-1344	University of Connecticut
 Hiley Cammock hiley.cammock@louisville.edu	209-1356	University of Cincinnati
 Samuel Dacus samuel.dacus@louisville.edu	209-1357	University of South Carolina
 Alexandra Jones alexandra.jones.1@louisville.edu	209-1300	University of Oklahoma
 Mohammed Ranavaya mohammed.ranavaya@louisville.edu	209-1359	Marshall University
 William Risinger william.risinger@louisville.edu	209-1360	University of Louisville
 Brandon Ryvkin brandon.ryvkin@louisville.edu	209-1361	St. Louis University
 Brittany Sims brittany.sims@louisville.edu	209-1362	University of Louisville
 Alan Sumski alan.sumski@louisville.edu	209-1367	Ohio State University

Postgraduate Year III:



Maggie Durci
maggie.durci@louisville.edu



Zach Hier
zach.hier@louisville.edu



Donya Jahandar
donya.jahandar@louisville.edu



Joel Kramer
joel.kramer@louisville.edu



Grace Osagie
grace.osagie@louisville.edu



Thomas Touma
thomas.touma@louisville.edu



Chinweotuto Uma
vanessa.uma@louisville.edu



Noah Whited
noah.whited@louisville.edu

Medical School

Louisiana State University -
Shreveport

University of Pittsburgh

University of Missouri –
Kansas City

University of Washington

University of North Carolina –
Chapel Hill

University of South Carolina –
Columbia

Baylor

Texas Tech

Postgraduate Year II:



Madison Bulger
madison.bulger@louisville.edu



Mackenize Carroll
mackenize.carroll@louisville.edu



Stephanie Green
stephanie.green.1@louisville.edu



Aryana Jones
aryana.jones@louisville.edu



Quinn Losefsky
quinn.losefsky@louisville.edu



Gabrielle Manno
gabrielle.manno@louisville.edu



Karunesh Polireddy
karunesh.polireddy@louisville.edu



Evan Riggs
evan.riggs@louisville.edu



Daniel Thomas
daniel.thomas.2@louisville.edu

Medical School

University of Missouri -
Columbia

University of Louisville

University of Texas - Houston

West Virginia University -
Charleston

Anne Burnett Marion @ TCU

UTMB Galveston

Emory

Southern Illinois University

University of Mississippi

Postgraduate Year I:

Medical School



Preston Adhikari
preston.adhikari@louisville.edu

Texas A&M



Alex Condra
david.condra@louisville.edu

East Tennessee University



Cheyenne Hall
cheyenne.cook@louisville.edu

University of Louisville



Elissa Dykes
elissa.dykes@louisville.edu

University of Alabama-
Birmingham



Sydney Fitzpatrick
sydney.fitzpatrick@louisville.edu

University of Kentucky



Caroline Forester
mary.forester@louisville.edu

Augusta University



Diane Gillis
barbara.gillis@louisville.edu

West Virginia University



Hannah Houston
hannah.sizemore@louisville.edu

University of Louisville



Patrick O'Dell
patrick.odell@louisville.edu

University of Louisville



Jacob Pottratz
jacob.pottratz@louisville.edu

Indiana University



Bayan Shalash
baran.shalash@louisville.edu

Ohio State University



Krista Spear
krista.spear@louisville.edu

University of Kentucky



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

SURGICAL RESEARCH RESIDENTS

<u>Research Residents</u>	<u>Medical School</u>	<u>Research Years(s)</u>
 Joshua Crane joshua.crane@louisville.edu	Georgetown University	2024-2025
 Walter Donica – PGY-3 walter.donica@louisville.edu	University of Cincinnati	2023-2025
 Toyokazu Endo – PGY2 toyokazu.endo@louisville.edu	University of Nevada	2023-2025
 Victoria Hammond victoria.hammond@louisville.edu	University of Louisville	2024-2025
 Kyle Stephens – PGY-2 kyle.stephens@louisville.edu	University of New Mexico	2023-2025

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

COLON & RECTAL SURGERY FELLOW

	<u>Medical School</u>	<u>Fellowship Year(s)</u>
 Elissa Falconer, MD elissa.falconer@louisville.edu	Georgetown University	2024-2025
 Carly Richards, MD Carly.richards@louisville.edu	Eastern VA Medical School	2024-2025

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

	<u>Medical School</u>	<u>Fellowship Year(s)</u>
Benjamin Smith, MD	University of South Carolina	2024-2025

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

HAND SURGERY

Lamis El Kabab, MD

Mohammad Hammad, MD

Safder Hasan, MD

Geraldine Kong, MD

Rouzbeh Kordestani, MD

Natalia Rodriguez Luquema, MD


Yehia Tfayi, MD

Jackie Hardwick, Education Coordinator, Fellowship Assistant

C.M. Kleinert Institute for Hand and Microsurgery – 225 Abraham Flexner Way, Suite # 850

Phone: 562-0312 ~ Email: jhardwick@kleinertkutz.com

PEDIATRIC SURGERY FELLOWS

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

Lisa Pantoja, Pediatric Surgery Fellowship Coordinator

Norton Healthcare Pavilion – 315 E. Broadway, Suite # 565

Phone: 629-8630 ~ Email: lredwa03@louisville.edu

PLASTIC & RECONSTRUCTIVE SURGERY FELLOWS AND RESIDENTS

<u>Fellow Chief Year:</u>	<u>Independent Plastic Surgery:</u>	<u>Medical School</u>
 Anthony Azzolini anthony.azzolini@louisville.edu		Rutgers
 Jacob Katsnelson jacob.katsnelson@louisville.edu		Ohio State University

Fellow Second Year:



Wilson Huett
wilson.huett@louisville.edu



Joshua Spiegel
joshua.spiegel@louisville.edu

Fellow First Year:



Alessandra Spagnolia
allessandra.spagnolia@louisville.edu

Integrated Plastic Surgery: Resident Fourth Year:



Candice Nguyen
candice.nguyen@louisville.edu



Mitchell Peake
mitchell.peake@louisville.edu

Resident Third Year:



Shelby Graham
shelby.graham@louisville.edu



Brian Paul
brian.paul@louisville.edu

Resident Second Year:



Arrin Brooks
arrin.brooks@louisville.edu



Jon Bruce
jon.bruce@louisville.edu

Resident First Year:



Carter Prewitt
carter.prewitt@louisville.edu



Brandon Rosser
brandon.rosser@louisville.edu

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

Medical School

University of Arkansas

University of Tennessee

Medical School

University of North Dakota

Medical School

University of Louisville

University of Cincinnati

Medical School

Rush Medical College

University of Iowa

Medical School

Marshall University




Texas Tech

Medical School

University of Louisville



University South Alabama

SURGICAL CRITICAL CARE/TRAUMA FELLOWS

<u>Fellow</u>	<u>Medical School</u>	<u>Year(s)</u>
 Vincent Athas Vincent.athas@louisville.edu	Broward Health	2024-2026
 Jacqueline Seoane jacqueline.seoane@louisville.edu	Orlando Health	2024-2025
 Anthony Pecoraro anthony.pecoraro@louisville.edu	Indiana Univ	2024-2025



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

SURGICAL ONCOLOGY FELLOWS

<u>Fellow</u>	<u>Medical School</u>	<u>Year(s)</u>
 Meredith Gunder meredith.gunder@louisville.edu	University of Miami	2023-2025
 Julie Siegel Julie.siegel@louisville.edu	Medical Univ SC	2024-2026

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

VASCULAR SURGERY FELLOWS

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

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

Master Schedule 2022-2023

General Surgery Rotations



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

Professor Russell Strong - Brisbane, Queensland, Australia

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

General Surgery Master Schedule 2024-2025

University of Louisville Hospital	July 2024	August	September	October	November	December
Trauma I	Woeste Kramer Losefsky Fitzpatrick Cummings (OMFS)	Woeste Kramer Losefsky C. Hall Abbe (Uro)	Acton Durci Riggs Adhikari Gillis	Hegde Hier Carroll Dykes Nadar (Ortho)	Hall Touma Jones Pottratz Davidson (OMFS)	Allen Uma Thomas Shalash Croft (Ortho)
Trauma II	Boudreau Touma Bulger Forester O'Dell	Boudreau Whited Bulger Campbell (EM) Samuels (EM)	Allen Jahandar Green Condra Harris (EM)	Keeven Whited Thomas Adesuwa (Uro) Smith (EM)	Keeven Osagie Manno Spear Gronemeyer (EM)	Cassata Durci Polireddy Houston Gosser (EM)
Trauma ICU Day Float	Green Perling (EM)	Riggs Coffmann (EM)	Carroll Hudson (EM)	Jones Webb (EM)	Brooks (PRS) Lyons (EM)	Bruce (PRS) Blair (EM)
University General Surgery	Cammock Whited Pottratz	Sims Jahandar O'Dell	Dacus Osagie Houston	Boudreau Touma	Allen (1-15) Cassata (16-30) Kramer (1-15) Uma (16-30)	Jones Hier
Veterans Hospital						
VAMC Surgery	Sumski Durci Manno Rosser (PRS)	Allen Osagie AR. Jones Adhikari	Risinger (1-15) Keeven (16-30) Hier (1-15) Uma Bulger Spear	Woeste (16-30) Sims (1-15) Losefsky Riggs Pottratz (1-15) Houston (16-31)	Acton Jahandar Polireddy Shalash	Boudreau (1-15) Ranavaya (16-30) Whited Green Riggs Gillis

Norton Hospital / Jewish Hospital General Surgery	July 2024	August	September	October	November	December
Acute Care Surgery (NH, JH) *Norton Float Chief	Keeven Hier	Cassata Touma	Woeste Whited	Acton Uma	Boudreau Durci	Hall Osagie
Minimally Invasive Surgery NH, Kehdy Robotic	Ranavaya Uma	Dacus Carroll	Sumski Touma	Allen Osagie (1-15) Manno (16-31)	Ryvkin Carroll (1-15) Losefsky (16-30)	Keeven Jahandar (1-15) Touma (16-30)
Williams Service (JH, Jewish East)	Risinger	Avula	A. Jones (1-15) Caminiti (16-30)	Dacus (1-15) Ryvkin (16-30)	Ranavaya	Sims
Norton Hospital Interns	Adhikari Dykes Houston PGY2/3 (Supervisory)	Condra Gilis Prewitt (PRS) PGY2/3 (Supervisory)	Forester Shalash Rosser (PRS) PGY2/3 (Supervisor)	Fitzpatrick C. Hall	Houston Condra	Spear Pottratz
Jewish Hospital Interns	C. Hall Percy (Uro) Gupta (ENT) PGY2/3 (Supervisory)	Dykes Adesuwa (Uro) Alvarado (ENT) PGY2/3 (Supervisory)	Fitzpatrick Prewitt (Uro) Azzam (ENT) PGY2/3 (Supervisory)	Rosser (PRS) Abbe (Uro)	Gillis Forester	Adhikari O'Dell
Norton Children's Hospital						
Norton Children's Hospital	Avula Polireddy Nadar (Ortho) Azzam (ENT)	Caminiti Green Dowell (Ortho) Gupta (ENT)	Hegde Brooks (PRS) Pottratz Alvarado (ENT)	Cammock Bruce (PRS) Croft (Ortho) Adhikari	A. Jones Riggs O'Sullivan (Ortho) O'Dell	Dacus Bulger C. Hall Fitzpatrick

Jewish Hospital Specialty Services						
Transplant	A. Jones Thomas	Ranavaya Manno	Avula Losefsky	Sumski Shalash (1-15) Gillis (16-30)	Caminiti	Cammock AR. Jones
Thoracic	Hall AR. Jones	Smith – Fellow Polireddy Forester	Smith – Fellow Thomas	Smith – Fellow Bulger	Griffin – Fellow Green	Griffin – Fellow Manno
Cardiac	Dacus	Acton	Risinger (16-30)			Risinger (1-15)
CVICU				Ranavaya (1-15) Ryvkin (16-30)		Sumski (16-30)

Elective Services	July 2024	August	September	October	November	December
Surgical Oncology	Acton Sims Osagie Riggs Condra Prewitt (PRS)	Keeven A. Jones Durci Bruce (PRS) Fitzpatrick Pottratz	Cassata Ranavaya Paul (PRS) Polireddy C. Hall O'Dell	Hall Sumski Jahandar Green Condra	Woeste Risinger Hier Thomas Dykes	Woeste Avula Kramer Brooks (PRS) Forester
Colorectal Surgery	Allen Jahandar Gillis Shalash	Risinger Hier Spear Houston	Ryvkin (1-15) Hall (16-30) Manno Percy (Uro) Dykes	Cassata Durci (1-15) Polireddy (16-30) Forester (1-15) Spear (16-31)	Hegde Whited (1-15) Bulger (16-31) Fitzpatrick (1-15) Adhikari (16-30)	Ryvkin Losefsky Prewitt (PRS) Dykes (1-15) Condra (16-31)
Vascular	Cassata Caminiti Carroll Spear Abbe (Uro)	Hegde Sumski Brooks (PRS) Shalash Nadar (ortho)	Boudreau Sims Bruce (PRS) Adesuwa (Uro) Dowell (Ortho)	A. Jones Kramer Prewitt (PRS; 1-15) O'Dell (16-30)	Dacus Paul (PRS) C. Hall (1-15) Rosser (PRS; 16-31)	Hegde (1-15) Sumski (16-30) Graham (PRS) Carroll
Plastics	Graham Paul Bruce Brooks	Graham Paul Thomas (1-15) Rosser	Graham AR. Jones (1-15)	Avula Graham Paul Brooks	Graham Bruce Prewitt	Paul Rosser
Bariatrics (Allen)	Hegde	Cammock	Ryvkin (16-31)	Sumski	Sims	
NH Audubon					Sumski	

Mary and Elizabeth	Ryvkin	Hall	Cammock (16-30)	Risinger	Avula (1-15)	Ranavaya (1-15)
Rural General Surgery Madisonville Owensboro* Africa** Missouri***		Uma *Ryvkin	Kramer	Touma *Caminiti	*Cammock	**Caminiti
Vacation		Thomas (16-31)	Caminiti (1-15) Cammock (1-15) Hall (1-15) Keeven (1-15) A. Jones (16-30) AR. Jones (16-30) Hier (16-30) Shalash (16-30)	Forester (1-15) Ryvkin (1-15) Gillis (1-15) Manno (1-15) Pottratz (1-15) O'Dell (1-15) Woeste (1-15) Dacus (16-31) Durci (16-31) Houston (16-31) Osagie (16-31) Polireddy (16-31) Prewitt (16-31) Sims (16-31) Spear (16-31) Ranavaya (16-31)	Adhikari (1-15) Bulger (1-15) Cassata (1-15) Losefsky (1-15) Rosser (1-15) Uma (1-15) Allen (16-30) Avula (16-30) Carroll (16-30) C. Hall (16-30) Fitzpatrick (16-30) Green (16-30) Kramer (16-30) Whited (16-30)	Condra (1-15) Sumski (1-15) Touma (1-15) Acton (16-31) Boudreau (16-31) Dykes (16-31) Hegde (16-31) Jahandar (16-31) Riggs (16-31) Risinger (16-31)

General Surgery Master Schedule 2024-2025

University of Louisville Hospital	January 2025	February	March	April	May	June
Trauma I	Acton Hier Green Fitzpatrick Prewitt (PRS)	Keeven Uma Manno C. Hall Rosser (PRS)	Boudreau Whited Bulger Jella (Ortho) Cummings (OMFS)	Keeven Touma Polireddy O'Dell Rosser (PRS)	Hegde Jahandar AR. Jones Spear O'Sullivan (Ortho)	Hall Osagie Carroll Dowell (Ortho) Davidson (OMFS)
Trauma II	Hegde Osagie AR Jones Adhikari Hitchman (EM)	Woeste Jahandar Carroll Percy (Uro) Scott (EM)	Hall Durci Riggs Condra Ballew (EM)	Allen Uma Manno Houston Angel (EM)	Acton Kramer Thomas Rosser (PRS) Rizzo (EM)	Cassata Hier Green Pottratz Stanforth (EM)
Trauma ICU Day Float	Bulger Marks (EM)	Losefsky Taylor (EM)	Polireddy Kelesis (EM)	Thomas Mattingly (EM)	Riggs Williams (EM)	AR. Jones Harris (EM)
University General Surgery	Boudreau Kramer	Hall Whited	Keeven (1-15) Ranavaya (16-31) Uma	Woeste (1-15) Risinger (16-30) Jahandar	Hall (1-15) Boudreau (16-30) Touma (1-15) Hier (16-30)	Acton Durci
Veterans Hospital						
VAMC Surgery	Cammock Touma Carroll Condra	Hegde Polireddy Bulger Prewitt (PRS)	Avula Osagie Thomas Forester	Sumski Kramer Losefsky C. Hall	Keeven Whited Manno (1-15) Green (16-31) Dykes	Risinger Kramer Thomas Fitzpatrick

Norton Hospital / Jewish Hospital General/Acute Care Surgery	January 2025	February	March	April	May	June
Acute Care Surgery (NH, JH) *Norton Float Chief	Cassata Jahandar	Allen Kramer	Woeste Hier	Acton Durci	Allen Uma	Hegde Jahandar
Minimally Invasive Surgery NH, Kehdy	Woeste Durci	Risinger Touma	Cammock Green	Avula AR Jones	Sims Polireddy	AL Jones Whited
Williams Service (JH, Jewish East)	AL Jones	Cammock	Sumski	Ryvkin	Dacus	Sumski (1-15) Sims (16-30)
Norton Hospital Interns	Percy (Uro) O'Dell	Fitzpatrick Abbe (Uro)	Shalash (1-15) Houston (16-31) Pottratz	Pottratz Adesuwa (Uro)	Adhikari Forester	C. Hall Dykes
Jewish Hospital Interns	Pottratz C. Hall Spear	Condra Houston	Dykes Gillis	Spear Shalash	Condra O'Dell	Gillis Houston
Norton Children's Hospital						
Norton Children's Hospital	Ranavaya Whited Adesuwa (Uro) Jella (Ortho)	Sumski Thomas Forester Dykes	Sims Manno Prewitt (PRS) Percy (Uro)	AL Jones Carroll Condra Gillis	Risinger Losefsky Houston Shalash	Ryvkin Polireddy Spear Rosser (PRS; 1-15) Condra (16-30)

Jewish Hospital Specialty Services						
Transplant	Dacus Bruce (PRS)	Sims Adhikari	Risinger AR Jones (1-15) Losefsky (16-31)	Hegde	Ranavaya	Boudreau Brooks (PRS)
Thoracic	Griffin – Fellow Losefsky	AL Jones Green	Ryvkin Brooks (PRS)	Caminiti Adhikari	Griffin – Fellow Pottratz (1-15) C. Hall (16-31)	Griffin – Fellow O'Dell
Cardiac	Sims	Ranavaya		Cassata 1-15		Caminiti
CVICU	Risinger	Ryvkin			Avula (16-31)	Dacus (16-30)

Elective Services	January 2025	February	March	April	May	June
Surgical Oncology	Allen Ryvkin Uma Manno Gillis Dykes	Boudreau Dacus Osagie AR Jones Shalash Spear	Hegde (1-15) Acton (16-31) Caminiti Touma Carroll C. Hall Rosser (PRS)	Hall Sims Graham (PRS) Bulger Fitzpatrick	Cassata Cammock (1-15) Ryvkin (16-30) Whited Bruce (PRS) Prewitt (1-15) Gillis (16-31)	Keeven Ranavaya Paul (PRS) Losefsky Adhikari Forester
Colorectal Surgery	Keeven Polireddy (1-15) Thomas (16-31) Rosser (PRS) Houston	Avula Durci (16-28) Riggs O'Dell Gillis	Dacus Bruce (PRS) Adesuwa (1-15) Fitzpatrick	Cammock Osagie (1-15) Whited (16-31) Dykes (1-15) Forester (16-30)	Woeste Osagie Brooks (PRS) Abbe (Uro; 1-15) Prewitt (PRS; 16-31)	AL Jones Uma Bulger Shalash
Vascular	Hall Riggs Forester Croft (Ortho)	Acton Hier O'Sullivan (Ortho) Pottratz	Cassata Kramer (1-15) Jahandar (16-31) Rosser (PRS; 1-15) Spear (16-31) Adhikari	Boudreau Hier Green Abbe (Uro)	Caminiti (1-15) Avula (16-31) Bulger 1-15 Carroll 16-31 Fitzpatrick (16-31) Percy (Uro; 1-15)	Allen Touma Graham (PRS) Riggs Jella (Ortho)

Plastics	Peake Nguyen Paul Bruce	Peake Nguyen Graham Paul Brooks	Bruce	Peake Nguyen	Paul	Cammock Manno
Bariatrics (Allen)	Avula	Cassata	Allen (1-15) AL Jones (16-31)	Ranavaya	Sumski	Woeste
NH Audubon						
Mary and Elizabeth	Sumski	Caminiti		Dacus		Avula
Rural General Surgery Madisonville Owensboro* Africa**	**Caminiti				Durci	
Vacation	Thomas (1-15) Polireddy (16-31)	Durci (1-15)	Acton (1-15) Jones (1-15) Houston (1-15) Kramer (1-15) Losefsky (1-15) Ranavaya (1-15) Spear (1-15) Allen (16-31) Jahandar (16-31) Jones (16-31) Hegde (16-31) Keeven (16-31) O'Dell (16-31) Shalash (16-31)	Adhikari (1-15) Risinger (1-15) Whited (1-15) Cassata (16-30) Dykes (16-30) Forester (16-30) Osagie (16-30) Riggs (16-30) Woeste (16-30)	Avula (1-15) Boudreau (1-15) Carroll (1-15) C. Hall (1-15) Gillis (1-15) Green (1-15) Hier (1-15) Ryvkin (1-15) Sims (1-15) Bulger (16-31) Caminiti (16-31) Cammock (16-31) Fitzpatrick (16-31) Hall (16-31) Manno (16-31) Prewitt (16-31) Pottratz (16-31) Sumski (16-31) Touma (16-31) Uma (16-31)	Dacus (1-15) Condra (1-15) Rosser (16-30)

Master Schedule 2024-2025

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 2024-2025

University of Louisville School of Medicine - Division of Plastic Surgery (Rev. 6.24.2024)															
	Fellows					Residents								Rotating Residents	
	PGY 8		PGY 7		PGY 6	PGY 4		PGY 3		PGY 2		PGY 1		Podiatry	Gen Surg
	Azzolini	Katsnelson	Spiegel	Huett	Spagnola	Nguyen	Peake	Graham	Paul	Brooks	Bruce	Prewitt	Rosser	University	
July '24	Oculo	Recon	University	Hand	VA	HN/Cosmetic	Ortho	CMF	ENT	LE	University	SURG ONC Gen Surg	VAMC Gen Surg		
Aug '24	VA	Oculo	Hand	University	Ortho	Recon	HN/Cosmetic	ENT	LE	VAMC Gen Surg	SURG ONC Gen Surg	NORTON Gen Surg	University		Thomas (1-15)
Sept '24	Recon	Hand	University	VA	HN/Cosmetic	LE	Nerve	University	SURG ONC Gen Surg	NCH Gen Surg	VASCULAR Gen Surg	JEWISH Gen Surg	NORTON Gen Surg		AR. Jones (1-15)
Oct '24	Derm	Elective	HN/Cosmetic	University	Hand	PS VA	Recon	LE	Nerve	University	NCH Gen Surg	VASCULAR (1-15) Gen Surg VACATION (16-31)	JH Gen Surg		Avula
Nov '24	Hand	University	Nerve	HN/Cosmetic	Recon	LE	University	CMF	VASCULAR Gen Surg	TRAUMA ICU Gen Surg	PS VA	University	VACATION (1-15) VASCULAR (16-31) Gen Surg	Joe Wisniewski (PGY1)	
Dec '24	University	Hand	VA	Recon	LE	University	HN/Cosmetic	VASCULAR Gen Surg	Nerve	SURG ONC Gen Surg	TRAUMA ICU Gen Surg	VASCULAR Gen Surg	University		
January '25	Elective	Derm	University	LE	HN/Cosmetic	Recon	Hand	PS VA	University	Nerve	TRANSPLANT Gen Surg	TRAUMA I Gen Surg	COLORECTAL Gen Surg	Kaitlyn Loesel (PGY2)	
February '25	Hand	HN/Cosmetic	CMF	University	Recon	Ortho	LE	OMFS	PS VA	University	Nerve	VAMC Gen Surg	TRAUMA I Gen Surg	Anthony Brando (PGY2)	
March '25	LE	Nerve	HN/Cosmetic	Recon	University	Hand	PS VA	University	CMF	THORACIC Gen Surg	COLORECTAL Gen Surg	SURG ONC (1-15) Gen Surg VACATION (16-31)	VACATION (1-15) SURG ONC (16-31) Gen Surg	Adam Henderson (PGY2)	
April '25	Elective	Anes	Hand	HN/Cosmetic	Nerve	University	Recon	SURG ONC Gen Surg	OMFS	PS VA	LE	University	TRAUMA I Gen Surg		
May '25	Anes	Elective	Recon	Hand	University	HN/Cosmetic	LE	Nerve	University	COLORECTAL Gen Surg	SURG ONC Gen Surg	TRAUMA II Gen Surg	PS VA	Brandon Miller (PGY1)	
June '25	HN/Cosmetic	LE	Recon	CMF	Hand	Nerve	University	VASCULAR Gen Surg	SURG ONC Gen Surg	TRANSPLANT Gen Surg	University	PS VA	NCH Gen Surg	Storm Berman (PGY1)	Cammock Manno

Vacation
All Vacation must occur on a PS rotation
2 weeks vacation
2 weeks administrative
prefer 1 week blocks

- Covers Facial Trauma call at Norton Children's Hospital

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

Reconstructive II:

- Covers cases with 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, 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 imaging 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 breast 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

TRANSPLANT SURGERY AT JEWISH HOSPITAL:

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

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

PGY-1:

Patient Care

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

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

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

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

Medical Knowledge

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

... To become familiar with the operative management of transplant patients

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

Practice-Based Learning and Improvement

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

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

...attending quality improvement conference

Interpersonal and Communication Skills

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

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

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

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

PGY-2:

Patient Care

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

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

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

Medical Knowledge

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

... To become familiar with the operative management of transplant patients

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

Practice-Based Learning and Improvement

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

...attending quality improvement conference

Interpersonal and Communication Skills

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

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

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

PGY-4 or PGY-5:**Patient Care**

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

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

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

... to become competent in the operative management of liver and kidney transplants, organ harvests, vascular access, and more complex general surgery procedures in the transplant population, and in the pre-operative decision making such as whether and when to recommend operations to patients for their disease states.

Medical Knowledge

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

...to become familiar with the operative management of liver and kidney transplants, and general surgical disease in this patient population

...to become competent in the outpatient management, workup of complex vascular patients, and alternative therapies such as medical management

Practice-Based Learning and Improvement

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

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

...attending quality improvement conference

Interpersonal and Communication Skills

...interaction with the attending surgeon, junior resident, and medical students as appropriate

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

...supervision of junior residents and direct communication with attendings

Systems-Based Practice

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

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

PEDIATRIC SURGERY AT NORTON CHILDREN'S HOSPITAL:

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

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

PGY-1:**Patient Care**

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

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

Medical Knowledge

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

...to become familiar with suturing techniques, routine peri-operative care, including specific diseases such as inguinal hernia and hydrocele

Practice-Based Learning and Improvement

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

...attending quality improvement conference

Interpersonal and Communication Skills

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

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

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

PGY-2:**Patient Care**

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

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

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

Medical Knowledge

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

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

Practice-Based Learning and Improvement

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

...attending quality improvement conference

Interpersonal and Communication Skills

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

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

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

PGY-4 (Chief Resident):**Patient Care**

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

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

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

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

Medical Knowledge

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

...to become familiar with the operative management of common diseases including complex elective cases such as re-operative cases, advanced hepatobiliary, thoracic, oncologic, and colorectal surgery in the pediatric surgical patient

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

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

Practice-Based Learning and Improvement

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

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

...attending quality improvement conference

Interpersonal and Communication Skills

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

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

...supervision of junior residents and direct communication with attending(s)

Systems-Based Practice

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

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

RURAL SURGERY ROTATION:

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

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

PGY-3 and PGY-4:

Patient Care

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

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

...become competent in the management of both in-patient and outpatient rural general surgery patients and supervision of medical students

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

Medical Knowledge

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

... To become familiar with the operative management of common and more complex general surgical diseases commonly seen in a rural setting

...To become competent in the outpatient management, workup of routine elective general surgical patients, and alternative therapies such as medical management.

Practice-Based Learning and Improvement

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

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

...attending quality improvement conference

Interpersonal and Communication Skills

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

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

Professionalism

...timely completion of medical records and appropriate behavior towards colleagues

Systems-Based Practice

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

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

Revised: April 2021

Reviewed: June 2022

Reviewed: June 2023

Reviewed: May 2024

Department of Cardiothoracic and Vascular Surgery Cardiac Rotation Expectations

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

Expectations:

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

Added: January 2023

ACGME Program Requirements for Residency Education in Surgery

FROM: www.acgme.org

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

Special Requirements in Laparoscopy and Endoscopy

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

Laparoscopy

Basic:

***100 total cases**

- Cholecystectomy
- Appendectomy

Advanced:

***75 total cases**

- Lap, Gastrostomy and Feeding Jejunostomy
- 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:
- Colonoscopy:

***35 procedures**

***50 procedures**

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
Reviewed: May 2024

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
Reviewed May 2024

Surgical Resident Responsibilities

I. Ward Rounds	XI. Consultative Requests
II. Preop Evaluation & Preparation	XII. Radiologic Studies
III. Operating Room	XIII. Laboratory Services
IV. Postop Mgmt & Recovery Room	XIV. Social Services
V. Charts	XV. Dietetics
VI. Discharge Summary	XVI. Release of Medical Information
VII. Deaths	XVII. Night Call
VIII. Clinics	XVIII. Hours on Call
IX. Conferences	XIX. Operative Records
X. Teaching Responsibility	XX. Dress Code

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.

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
Reviewed May 2024

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 required 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
Reviewed May 2024

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
Reviewed May 2024

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
May 2024**

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. Bennis) 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
Reviewed May 2024

**Department of Surgery
University of Louisville School of Medicine**

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.

**Revised July 2018
Reviewed June 2019
Reviewed June 2022
Reviewed May 2024**



SafeRides PROGRAM

The purpose of this program is to ensure that all residents & fellows have a safe transportation option if they are too fatigued to drive home safely following a strenuous shift. Residents/fellows will be given a ride to their home as well as a ride back to their vehicle once they can drive safely. This service is provided free of charge to UofL residents/fellows and is in compliance with ACGME guidelines.

Note to Residents & Fellows:

This service is meant to be used ONLY when residents/fellows are too tired or don't feel safe to operate a vehicle.

- Please use your personal Uber account if you just need a ride to or from campus. This is not a personal car service.
- This service is not to be used recreationally or for convenience, i.e. if your car is in the shop or you don't have a ride to work, or to any location other than your home at the end of a shift. Please use your personal Uber account for these needs.
- This service should not be used for the *prediction* of fatigue, i.e. you use the Uber SafeRides account to take a ride into the hospital because you think you will be too tired to drive home later.

The Graduate Medical Education Office will be reviewing each ride to make sure the service is being used appropriately. If the use of the SafeRides program does not seem appropriate the following actions will be taken.

1. The Graduate Medical Education Office members will be reviewing each ride to make sure the rides are authorized based on the guidelines.
2. If the ride is deemed unauthorized, the trainee will be contacted via the Uber system requesting that they switch the ride cost to their personal Uber account for payment or provide explanation to substantiate the use within the guidelines set.

3. If the trainee fails to respond with an explanation within one week they will be emailed directly from a GME staff member requesting a response within 48 hours from the time the email was sent. The trainee's program will be copied in that email.
4. If the trainee fails to respond within 48 hours to the GME message they will lose access to the Uber SafeRides program until they have rectified the charges.

Uber will send an email directly to residents & fellows with sign-up information.

For questions & concerns, please contact Jennifer Hall in the GME Office at Jennifer.hall.1@louisville.edu or (502) 852-7618.

By signing below, I attest that I have read and understand how to access the Uber SafeRides program and agree to use the program appropriately. I also understand that should I utilize the service inappropriately; I will be expected to pay the associated fees from that trip.

Name

Date

Revised: August 2023

Reviewed: May 2024

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
Reviewed May 2024**

Departmental Society Memberships

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

Southern Surgical Association
American Board of Surgery
Western Surgical Association
Society of University Surgeons
Association for Academic Surgery
Society of Surgical Oncology
American College of Surgeons
American Society of Clinical Oncology
American Association for Cancer Research
Southeastern Surgical Congress
Southwestern Surgical Congress
American Society of Breast Surgeons
Jefferson County Medical Society
Kentucky Medical Association
Louisville Surgical Society
Hiram C. Polk, Jr., M.D. Surgical Society
Society for Melanoma Research
Society of Surgical Chairs
International Sentinel Node Society
The Halsted Society
The Society for Surgery of the Alimentary Tract
American Hepato-Pancreato-Biliary Association
International Hepato-Pancreato-Biliary Association
Brazilian Society of Surgical Oncology
Society of Asian Academic Surgeons
Eastern Association of the Surgery of Trauma
Association of Out Surgeons and Allies (AOSA), AOSA
Society of Black Academic Surgeons (SBAS) SBAS

Updated May 2024

Moonlighting Policy

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

.....

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

1. Programs must not require residents to participate in outside employment activities (moonlighting).
2. Resident physicians who hold either a Regular or a Residency Training (RT) license in Kentucky shall be free to use off-duty hours in appropriate related activities, including engaging in outside employment activities, so long as the resident obtains the prior written approval of the Department Chair or Program Director for such outside employment activities, and so long as such activities do not interfere with the resident's obligations to the University, impair the effectiveness of the educational program engaged in, or cause detriment to, the service and reputation of the hospital to which the resident is assigned.
3. Each program must develop a moonlighting policy that is consistent with the Resident Moonlighting Policy of the University of Louisville. The policy must give guidelines for outside employment activities of residents, including defining the hours and rotations when such outside employment activities may be permitted, and under what circumstances permission may be denied for outside employment activities. Residents are required to comply with individual program policies.
4. The University does not provide professional liability insurance or any other insurance or coverage for resident off-duty activities or employment, and assumes no liability or responsibility for such activities or employment. Confirmation of professional liability insurance for resident off-duty activities or employment will be the responsibility of the moonlighting employer.
5. Residents who wish to moonlight must hold either a Regular or Residency Training license in Kentucky. Institutional Practice (IP) and Fellowship Training (FT) licenses are valid only for duties associated with the University training program for which these licenses are issued, and do not cover outside employment activities. Resident Training (RT) licenses permit moonlighting only in locations authorized and approved by the resident's Program Director.

6. Residents are not to represent themselves to moonlighting employers as being fully trained in their specialty. Further, residents who moonlight are not to present themselves as agents of the University of Louisville during moonlighting activities. University lab coats, name badges, and identification cards are not to be worn outside of the resident's training program activities. It is the resident's responsibility to assure the billing procedures of the moonlighting employer are conducted in an ethical and legal manner.
7. Resident physicians who hold J-1 or H-1B visas are not permitted to engage in activities or have additional income other than what is listed on their forms DS2019 (J-1 holders) or I-797C (H-1B holders). Federal regulations specifically prohibit outside or additional income for individuals with J-1 visas. Employment of H-1B holders is limited to the petitioner (employer) and activities listed on the I-797C.
8. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the University of Louisville School of Medicine Resident Agreement.
9. Program Directors are required to monitor and approve in writing all moonlighting hours and locations for residents and maintain this information in the resident's file.
10. Programs are encouraged to monitor all individual residents moonlighting hours each month to assure outside activity does not contribute to excess fatigue or detrimental educational performance. The Program Director reviews and monitors all work hour entries/reports utilizing the MedHub reporting system to ensure work activity does not contribute to excess fatigue or detrimental educational performance'.
11. Chief residents and research residents will be eligible to take TCV and VA call, which will fall under the moonlighting guidelines. The appropriate forms must be completed and submitted to the Program Coordinator(s) with the signature of the Program Director. All moonlighting policy guidelines apply. All work hours must be entered into the MedHub system. Duties performed outside of resident's assigned training hours must be within the ACGME duty hour restrictions (80 hours per week) and will be closely monitored by the Program Director via the MedHub work hour reporting system.

Approved by GMEC: 4/17/2000

Revision approved by GMEC: 3/21/01

Revision approved by GMEC: 5/21/03

Revision approved by GMEC: 2/18/04

Revision approved by GMEC: 11/15/06

Revised 5.7.20

**Department of Surgery
University of Louisville School of Medicine**

General Policies

- | | |
|---------------------------------------|------------------------------|
| I. Absences | VII. Clergy Act Notification |
| II. Address/Phone Number Changes | VIII. Mail |
| III. Administrative Problems | IX. Research Projects |
| IV. Changes to New Services | X. Vacation Scheduling |
| V. Impaired Residents/Substance Abuse | XI. Social Media Policy |
| VI. Grievance & Academic Probation | |

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 Associate Dean for Graduate Medical Education) of the resident's progress, advising the Dean if the problem is resolved, if an additional period of probation is necessary or if dismissal is recommended. The Dean takes the appropriate action.*

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

* * *

GRIEVANCE PROCEDURES FOR RESIDENTS
UNIVERSITY OF LOUISVILLE
SCHOOL OF MEDICINE

Preliminary Procedures

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

1. *The resident should first discuss the matter with the person involved and attempt to resolve the grievance through informal discussion.*
2. *If there is no resolution, the resident should discuss the matter with that person's supervisor or the person to whom such person reports, who should attempt to mediate a resolution.*
3. *If the resident still has not been able to obtain a resolution, he or she may request the Student Grievance Officer (S.G.O.) (Joseph Steffen, 852-7209) to attempt informal mediation of the problem.*

Grievance Procedures

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

- (1) *A brief narrative of the condition giving rise to the grievance;*
- (2) *A designation of the parties involved; and*
- (3) *A statement of the remedy requested.*

* * *

VII. Clery Act Notification

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

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

VIII. Mail

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

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

IX. Research Projects

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

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

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

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

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

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

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

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

X. Vacation Scheduling

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

* * *

XI. Social Media

Social media 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 an “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

Reviewed May 2024

Resident Clinical & Educational Work Hour Policy

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

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

1. General Surgery resident work hours must not exceed 80 hours per week averaged over 4 weeks. Resident clinical & educational work hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.
2. In-house call must occur no more frequently than every third night, averaged over a 4-week period. Residents must not be scheduled for more than six consecutive nights of in-house night call.
3. General Surgery resident assignments must not exceed 24 hours maximum continuous on-site duty with up to 4 additional hours permitted for patient transfer and other activities defined in RRC requirements. There must be no new patients assigned after 24 hours of continuous duty.
4. General Surgery resident time spent in the hospital during at-home call must be counted toward the 80 hours. At-home call, defined as call taken from outside the assigned institution by pager or phone, is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for residents.
5. All General Surgery residents, including those assigned at-home call, must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
6. Resident clinical & educational work hours will be monitored by the resident and the program director, to ensure that work hour limitations are not exceeded. Work hours are entered into the MedHub system. The program director reviews MedHub reports monthly to ensure the program demonstrates substantial compliance with the clinical and educational work hour requirement.
7. The Program Director has developed and implemented policies to prevent and counteract the effects of resident fatigue and stress. General Surgery Faculty and residents will be constantly on guard for signs of stress and fatigue – and will take appropriate action whenever needed.
8. The Program Director must ensure that General Surgery residents are provided appropriate back-up support when patient care responsibilities are particularly difficult or prolonged.
9. General Surgery Residents must at all times have appropriate support and supervision in accordance with current published ACGME, institutional and program requirements and with the School of Medicine GME Policy on Resident Supervision.

11. Moonlighting will be restricted to vacation and laboratory rotations, and only with advanced, written consent of the Program Director.
12. Residents should have eight hours off for rest and personal activities between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. Work hours will be monitored by the Program Director.
13. Work periods must not exceed 24 hours maximum continuous scheduled clinical assignments. Up to 4 additional hours may be used for activities related to patient safety, such as transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. In rare circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty. This should be justified by needed continuity of care in a single critically ill patient, the humanistic attention to the needs of a patient or family, or a uniquely academic event. The resident must hand over care of all other patients to the team responsible for continuity of care and document the reasons for remaining on duty. This documentation should be submitted via MedHub to the Program Director for every instance of overage. The Program Director must review each submission of additional service and track both individual resident and program-wide episodes.

Revised 7.1.2017

Reviewed 5.7.20

Reviewed June 2022

Reviewed May 2024

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
Reviewed May 2024**

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
Reviewed May 2024

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 Reviewed May 2024

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
Reviewed May 2024

**Department of Surgery
University of Louisville School of Medicine**

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

BACKGROUND (INTENT)

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

DEFINITIONS (AS USED IN THIS POLICY)

Calendar day: all 365 days in a year, including weekends and holidays.

Resident: Any physician in a University of Louisville graduate medical education program recognized by the GME Office, including interns, residents, and fellows. The term "resident" in this document refers to both specialty residents and subspecialty fellows.

It is the responsibility of the resident and Program Director to discuss, in advance, information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations by the relevant certifying board(s).

- The GME sets parameters for paid time off limits; however, this does not guarantee that board eligibility will not be impacted by the duration of paid time off or the duration of paid or unpaid leave.
 - Each program must consult the American Boards of each specialty to determine whether the resident remains Board eligible or whether a training extension is necessary. As guidelines vary widely across Boards, each Board must be consulted to ensure compliance.
 - If total time away from training (within a given PGY or through the duration of the training program) extends beyond the maximum allowed by the specialty Board, and makeup time is required, the trainee's reappointment dates may be delayed by an amount equal to the makeup time (i.e., delay of promotion to the next PGY level or program completion). In effect, all future training years would become off-cycle by an amount equal to the makeup time. Any required makeup time will be paid and all fringe benefits provided.
-
1. Program Directors are responsible for assuring that all leaves of absence are granted in accordance with institutional, ACGME, and certifying board eligibility requirements. Should this policy be in conflict with the respective ACGME or Board Certification requirements, those requirements will take precedence.
 - a. Any leave of absence must be in compliance with the ACGME Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program.
 - b. The leave must also be in compliance with the eligibility requirements for certification

by the appropriate certifying board for the specialty.

2. Leaves of absence may require additional training time to fulfill ACGME and/or Board Certification requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. Program Directors must inform residents in writing, using the Resident Leave of Absence Request Worksheet, of any make-up time required.
 - a. If residents are required to make-up, time missed, that time must be covered by a Resident Agreement, with the resident being paid at the appropriate Resident Level and all fringe benefits provided.
3. The GME Office sets parameters for paid time off limits. A leave of absence may be paid, unpaid or a combination of paid and unpaid. Pay status of the leave does not impact board eligibility nor if a training extension is necessary.
 - a. Paid leave time may be taken intermittently following the initial leave event, at the discretion of the Program Director. A separate leave worksheet must be completed for each segment.

TYPES OF LEAVE

Caregiver Leave

1. Definition of Caregiver Leave: leave granted to care for the resident's spouse, child, or parent who has a serious health condition.
2. Eligibility:
 - a. Must be taken for the purpose of caring for a spouse, child, or parent
 - b. There is no minimum duration of service requirement and eligibility will start on the day the resident is required to report (orientation date or the first day of payroll for the resident).
 - c. If the resident is also Resident/Family Leave eligible, Resident/Fellow Family Leave will run concurrently with Caregiver Leave.
3. Salary & Benefits:
 - a. 100% of salary for up to six weeks (42 calendar days) is guaranteed only for the first instance of caregiver leave within a program. Subsequent leaves may be partially paid using any combination of eligible available vacation and program director discretionary leave. Once this time is exhausted, the resident may be permitted to take additional time off without pay up to a total of twelve (12) weeks of leave per academic year under Resident/Fellow Family Leave.
 - b. Full health and disability insurance continue while the resident is on paid leave for six weeks (42 calendar days). Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck. Residents must check with U of L Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence and make arrangements for continuity of health insurance benefit coverage.

4. Funding: A resident may be paid during the leave by utilizing any unused vacation days (up to 21 calendar days per contract year). Additionally, residency Program Directors may allow up to two additional weeks (14 calendar days) of paid leave per contract year (Program Director's Discretionary Leave). One additional week of GME paid leave may be utilized. By utilizing 21 days of annual vacation leave and granted two weeks of discretionary time by the Program Director, and one week of GME paid leave, the resident can achieve a six-week (42 calendar days) paid leave
 - a. If the resident has taken less than one-week of vacation time in the current academic year prior to the beginning of the leave, they will be eligible to take additional vacation days separate from the leave, up to the point where the one-week total of vacation has been taken during the current PGY.
 - b. If one-week of vacation has been taken prior to leave, additional vacation time will not be granted.
 - c. In the event the resident has taken more than one-week of vacation in the current academic year prior to their leave, the program should contact the GME Office for review and consideration of additional funding.

Educational or Personal Leaves (Program Director Discretionary Leave) (if allowed by the RRC or Board)

1. Definition for Educational or Personal Leaves (Program Director Discretionary Leave): leave granted for educational or personal reasons
2. Eligibility: At the discretion of the Program Director, a maximum of 14 calendar days of educational or personal leave may be granted to the Physician per academic year.
3. Salary & Benefits
 - a. If approved by the Program Director, 100% of salary for up to 14 calendar days will be paid.
 - b. Full health and disability insurance continue while the resident is on paid leave for up to 14 days.
4. Funding: a resident is paid during the leave at the normal stipend and PGY levels
5. Requests for personal leave of absence for a period longer than 14 calendar days must be approved by the Vice Dean for Graduate Medical Education.
6. Educational and personal leave may vary by program according to departmental guidelines, RRC/ACGME requirements, and/or board certification requirements.

Medical (Sick) Leave, excluding Parental (Maternity/Paternity) Leave

1. Definition: Medical (Sick) Leave shall be defined as any medical condition of the individual resident, including complications of pregnancy up to time of delivery, which necessitates an absence from a resident's training program.
2. Eligibility:
 - a. Available to residents with a serious health condition that makes the resident unable to perform essential training functions.

- b. There is no minimum duration of service requirement and eligibility will start on the day the resident is required to report (orientation date or the first day of payroll for the resident).
- c. An additional period of paid medical leave for any prolonged injury or illness may be requested in writing by the Program Director and Department Chair and submitted for approval by the Vice Dean for Graduate Medical Education.
- d. If the resident is also Resident/Family Leave eligible, Resident/Fellow Family Leave will run concurrently with Medical Leave.

3. Salary & Benefits:

- a. 100% of salary for up to 90 days is guaranteed only for the first instance of medical leave within a program. Subsequent leaves may be partially paid using any combination of eligible available vacation and program director discretionary leave. Once this time is exhausted, the resident may be permitted to take additional time off without pay up to a total of twelve (12) weeks of leave per academic year under Resident/Fellow Family Leave.
 - b. Full health and disability insurance continue while the resident is on paid leave for 90 days.
 - c. After 90 calendar days of total paid medical leave, leave of absence without pay will begin. Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck. Residents must check with U of L Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence, and make arrangements for continuity of health insurance benefit coverage.
 - d. The Resident Disability Program begins its coverage 90 calendar days from the date of initial disability. Residents who require more than 90 calendar days for medical leave should apply for disability coverage as soon as they become aware that they will need more than 90 days. Applications for resident disability coverage should be requested from the Graduate Medical Education Office. If disability is denied or the individual requests leave of absence without pay, the University is not responsible for reimbursement while in this status.
4. Funding: A resident may be paid during the leave for a maximum of 90 days by utilizing any unused vacation days (up to 21 calendar days per contract year) and Program Director Discretionary Leave, and GME approved leave. The resident is expected to apply for disability coverage for leave beyond 90 days.
5. Residents on medical leave for more than seven consecutive calendar days must furnish a physician's or medical provider's statement to the Program Director that he/she cannot work for medical reasons. The resident may be requested to provide additional statements at any time during the leave and upon return must furnish a physician or medical provider's statement that he/she is medically fit to resume residency training.
6. The Program Director must inform the Vice Dean for Graduate Medical Education in writing of any medical leave of more than seven (7) calendar days. This notification must include an explanation and a completed "Request for Leave" worksheet (available from the Graduate Medical Education Office).

7. Any modifications of duty assignment related to a medical condition or returning to duty after illness, will be at the discretion of the Program Director and Department Chair, but must conform to state and federal laws relating to disabilities, if any.

Military Leave*

1. Definition of Military Leave: A resident ordered to uniform service,
2. Eligibility: upon presentment of military orders to his/her program director, a resident must fill out a Resident Leave of Absence Request Worksheet and be placed on military leave.
3. Salary and Benefits: While on military leave, the resident shall receive up to 14 calendar days of paid leave in a federal fiscal year (This is equivalent to the Program Director's Discretionary time). All other military leave shall be unpaid.
 - a. However, at the resident's option, the resident may request use of annual leave vacation time in order to remain in pay status. The resident may not be required to use vacation time.
4. While on military leave, the resident is entitled to reemployment without loss of position in the residency/fellowship program.
5. A resident requesting Military Leave should refer to the University of Louisville Policy on Military Leave. (https://louisville.edu/policies/policies-and-procedures/index_policies)

Parental (Maternity/Paternity) Leave

1. Definition of Parental Leave shall be defined as leave following birth to bond with a newborn, new adoption or foster placement of a child, or granting of legal guardianship of a minor child.
2. Eligibility:
 - a. Available to birthing and non-birthing parents, adoptive/foster parents, surrogates, and legal guardians.
 - b. Must be taken within one year of birth, adoption, foster placement, or granting of legal guardianship of a child.
 - c. The birth, adoption, foster placement, or granting of legal guardianship must occur on or after the resident's report (orientation) date or first day on payroll.
 - d. There is no minimum duration of service requirement and eligibility will start on the day the resident is required to report (orientation date, or the first day of payroll for the resident).
 - e. If the resident is also Resident/Family Leave eligible, Resident/Fellow Family Leave will run concurrently with Parental Leave.
3. Salary & Benefits:
 - a. 100% of salary for up to six weeks (42 calendar days), per event. Additional time may be approved by the Program Director and would be paid via a combination of vacation time, Program Director Discretionary Leave, and unpaid leave under the Resident/Family Leave Policy.
 - b. Full health and disability insurance continue while the resident is on paid leave for six weeks (42 calendar days). Once the resident is on leave without pay status, the university will continue to provide his/her health benefits, provided the resident pays the portion of the premiums that normally would come out of his/her paycheck. Residents

must check with U of L Human Resources Department to determine the status of the health insurance benefits during unpaid leave of absence and make arrangements for continuity of health insurance benefit coverage.

4. **Funding:** A resident may be paid during the leave at their current stipend level for 42 calendar days. Residents may request additional leave time beyond 42 days by using approved vacation leave (up to 21 days), Program Director Discretionary Leave (up to 14 days), or unpaid days.
5. Residents requiring additional leave due to complications of pregnancy or delivery should refer to the Medical Leave section. In cases of extended Medical leave (90 days or greater) residents should contact the resident disability insurance carrier to initiate a possible claim, or request an application from the GME Office.

Resident/Fellow Family Leave

1. **Definition of Resident/Fellow Family Leave:** Similar to the Federal Family and Medical Leave Act (FMLA), the Resident/Fellow Family Leave program allows qualified residents (male or female) to take up to 12 weeks (84 calendar days) of unpaid leave each year with no threat of job loss.
2. **Eligibility:** Residents who have been enrolled in a training program for one year and have worked 1,250 hours in the 12 months prior to leave are eligible for resident/fellow family leave.
 - a. Qualifying events include the birth of a newborn, the adoption of a child or newborn, taking a state-approved foster child into one's home, time off to care for a parent, spouse or child under 18 with a serious health condition, and time off to care for children who are older than 18 if they are unable to care for themselves, because of either mental or physical reasons. It will not, however, allow resident/fellow family leave time for the care of parents-in-law, or other relatives.
 - b. Resident/fellow family leave does not cover time off for, among other things: the care of a parent-in-law; death in the family; cold, flu, earaches, upset stomach, minor ulcers, headaches other than migraine, routine dental and orthodontia problems, periodontal disease or cosmetic treatments.
3. A resident may take intermittent leave or work on a reduced leave schedule where he/she works fewer hours a day or week than normally scheduled. The schedule should be designed to cause the minimum amount of disruption to the training program as is possible.
4. Resident/fellow family leave cannot exceed 12 weeks (84 calendar days), but GME may also provide for situations that go beyond the 12 weeks (84 calendar days). Additional information about extended leave is available from the Graduate Medical Education Office. Any time that exceeds available vacation/PD discretionary time will be unpaid time.
5. **Exclusion:** If both spouses are enrolled in U of L training programs, they are entitled to only 12 weeks of graduate medical student leave combined for the birth and care of a newborn or the placement of a child in their home. Otherwise, they are entitled to 12 weeks each.

PROCEDURE

1. For any Leave of Absence, a **Resident Leave of Absence Request Worksheet or a Parental Leave of Absence Worksheet** (available from the Graduate Medical Education Office) must be completed and signed by the Program Director and resident (if available) and approved by the Vice Dean for Graduate Medical Education.
 - a. Program Directors must inform residents in writing, using the Resident Leave of Absence Request Worksheet, of any make-up time required. If residents are required to make-up time missed, that time must be covered by a Resident Agreement,
2. After approval by the Vice Dean of GME, the Leave of Absence will be recorded in the institutional Residency Management System, MedHub, by the Administrator of the Program. The Leave of Absence will become part of the resident's official training record. MedHub allows for documentation of four types of resident absences: Vacations, Sick Days, Away Conferences, and Leaves of Absences. See Guidelines for MedHub Use document for more information.

REFERENCES & RELATED POLICIES

ACGME Institutional Requirements, Effective July 1, 2022, section IV.H. Resident Vacation Policy & Procedure

APPROVALS

Approval of this policy will replace all prior leave policies. Approved by GMEC: April 1, 2019. Revised January 20, 2021 to allow a medical provider statement under Medical Leave. Revised February 17, 2021 to clarify PD Discretionary Leave limitations. Revised and GMEC approval March 24, 2022 effective July 1, 2022. Revision and GMEC approval May 15, 2023 effective July 1, 2023.

Revised: September 2018

Reviewed June 2019

Revised: August 2022

Revised: May 2023

Reviewed: May 2024

**UOFL GRADUATE MEDICAL EDUCATION LEAVE OF ABSENCE REQUEST
WORKSHEET**

NAME: _____ **PROGRAM:** _____ **PG level** _____

A. Number of calendar days requested (Sunday through Saturday) _____ a.

B. REASON (Circle one) CAREGIVER EDUCATIONAL/PERSONAL MEDICAL MILITARY

Anticipated Actual

Start of Leave: _____

Last Day of Leave _____

C. Unused Vacation Days (maximum 21 calendar days per year) ¹ _____ b.

Indicate # days advanced, from other years, if any _____, included on line B.

Exact Dates _____

D. Program Director's discretionary personal/educational paid days

(maximum 14 calendar days per year) ² _____ c.

Exact Dates _____

E. Vice Dean for Graduate Medical Education

Additional Paid Days requested from GME office ³ (requires signature of Vice Dean for Graduate Medical Education)

Exact Dates _____ d.

F. Number of Paid Days (add lines b + c + d) = _____ e.

Exact dates: _____

G. Number of Unpaid Days (subtract line e from a) = _____ f.

Exact dates: _____

H. Amount of Time to be Made-up to meet Board Certification _____ days.

Requirements⁴:

Dates: _____

Resident Signature

Program Director/Chair Signature

Date

Date

Vice Dean for Graduate Medical Education

Date

¹ Per the ACGME regulation providing residents/fellows with a minimum of one week of paid time off reserved for use outside of the first six weeks (42 calendar days) of the first approved medical, parental, or caregiver leave(s) of absence taken. Any leave that utilizes only vacation time should not be reported as a leave of absence.

² At the discretion of the Department Chair and Program Director, two weeks (14 days) of additional paid leave may be granted (Resident Leave of Absence Policy, Types of Leave, Program Director Discretionary Time).

³ Additional paid leave may be requested by the Program Director and Departmental Chair and approved by the Vice Dean for Graduate Medical Education (Resident Leave of Absence Policy, Types of Leave: Medical).

⁴ Resident Leave of Absence Policy item #2: Leaves of absence may require additional training time to fulfill ACGME and/or Board Certification requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. Program Directors must inform residents in writing, via this worksheet, of any make-up time required.

**UOFL GRADUATE MEDICAL EDUCATION
PARENTAL LEAVE REQUEST
WORKSHEET**

NAME: _____ **PROGRAM:** _____ **PG level** _____

A. Total number of calendar days requested (Sunday through Saturday) _____

	Anticipated	Actual
Start of Leave	_____	_____
Last day of leave	_____	_____
Number of Paid Days		_____

Exact dates: _____

Number of Unpaid Days _____

Exact dates: _____

Amount of Time to be Made-up to meet Board Certification Requirements (if applicable) ¹

Number of days _____

Proposed Dates: _____

Resident Signature

Program Director/Chair Signature Date

Date

Vice Dean for Graduate Medical Education Date

¹ *Leaves of absence may require additional training time to fulfill ACGME and/or Board Certification requirements. Program Directors are responsible for determining, in accordance with RRC and Board requirements, how much time must be made up. Program Directors must inform residents in writing, via this worksheet, of any make-up time required.*

Resident Travel Policy

INSTRUCTIONS FOR RESIDENT TRAVEL

Please follow instructions below to ensure processing of reimbursements are completed in a timely manner with minimal issues.

Scientific Meetings:

Time off is readily granted when a resident is presenting a paper at a scientific meeting, but also needs to be approved. Please refer to the benefits and policies links below for additional details.

The basis for travel approval will be as follows:

- 2 night hotel stay (increased stay will be at the discretion of the Division Chief)
 - Oral Presentations only (poster presentations may be approved on an individual basis)
 - Registration **MUST** be paid through the Department
 - Flight and hotel will be paid through the Department
 - International travel will not be approved
1. There is a new University policy in place wherein you must use the University Travel Card to pay for all travel expenses with the except of personal meals. Please notify Lois **as soon as you submit a paper/poster**. There are several people who will need to approve the travel so the sooner you start the better chance of getting it approved in time for travel.
 2. The resident **MUST** complete a Request for Resident Travel Approval Form and obtain the signatures from the **Faculty Sponsor and Executive Director** as soon as the paper is accepted for presentation. Once the project is accepted, travel arrangements can only be made if this form is on file. The completed form must be returned to Lois Inlow before any travel or registration can be paid/booked.
 3. Lois will request registration information from the traveler (online registration link, login, and password if applicable) to pay for the registration through the department Accounting Office.
 4. Once registration is complete, Lois will send the traveler notification and instructions for choosing a preferred flight/transportation as well as hotel preferences. Once the flight and hotel information has been chosen, she will begin booking through Anthony Travel and send all confirmations to the traveler.
 5. Travelers must submit original receipts when possible. If an original receipt is not offered, an electronic receipt can be submitted in its place. All receipts must be submitted to Lois Inlow upon return for reimbursement. There will not be a per diem for meals; therefore, the traveler is required to submit original receipts for any food purchases acquired.
 6. Once all receipts have been submitted, Lois will enter and process the reimbursement through the PeopleSoft Financials System. The traveler will be sent an email containing a link. The traveler must login and approve the expenses before the reimbursement can be processed. This must be done within 10 business days or the reimbursement will be deleted from the system. Once all signatures are obtained, payment will be sent to the bank account on file with payroll for the traveler.

7. Lois will submit a request for the traveler to apply for an UofL Travel Card. Once you have completed the necessary “quiz” you will be sent an application for the travel card. Please forward the application to Lois and she will obtain the necessary signatures and submit the application for you.
8. When you are not traveling, please return your UofL Travel Card to Lois. You will check the card in and out with Lois for travel as necessary.
9. If you receive any emails from the Controller’s Office regarding processing of reimbursements, please forward those emails directly to Lois.
10. Personal credit cards **CANNOT** be used for travel and any expenses on your personal credit card other than meals will **NOT** be reimbursed.

Any and all travel and reimbursement questions should be directed to Lois Inlow at 852-8017 or lois.inlow@louisville.edu.

Reviewed August 2021

Reviewed April 2022

Reviewed May 2024

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

Authorized User/Owner Approval

**(If different than Division Leader)*

Signature

Source

Amount

Speedtype#1 _____

Speedtype#2 _____

Total \$ 0.00

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.)*

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 May 2024

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.

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:

➤ <u>SBBN</u>	+65	➤ <u>Thoracic</u>	+25
➤ <u>Breast</u>	+40	➤ <u>Pediatrics</u>	+75
➤ <u>HN</u>	+25	➤ <u>Plastics</u>	+10
➤ <u>ALTR</u>	180	➤ <u>Surgical Critical Care</u>	+40
➤ <u>AB</u>	250	➤ <u>Lap-Basic</u>	100
➤ <u>Liver</u>	+5	➤ <u>Endoscopic</u>	+100
➤ <u>Pancreas</u>	+5	Upper Endoscopy	50
➤ <u>Vascular</u>	75	Colonoscopy	50
➤ <u>Endo</u>	+25	➤ <u>Lap-Complex</u>	70
➤ <u>Operative Trauma</u>	30-40	➤ <u>Total Major</u>	1300
➤ <u>Non-Op Trauma</u>	80-100	➤ <u>Total Chief</u>	220
(20 as Team Leader)		➤ <u>Total Teaching</u>	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 2024-2025

Goals for Intern Year

1. Take care of yourself
2. Figure out what a sick patient looks like
3. Gathering accurate and complete information
4. Begin to develop your clinical acumen
5. Communicate like a doctor
6. Learn how to “load the boat”
7. Become comfortable and competent with bedside procedures
8. Finish a surgical textbook
9. Do well on ABSITE

Helpful Links

To access the EMR from home/other hospitals

ULH/Jewish: myapps.ulh.org

Norton: Myresources.nortonhealthcare.org or 502a.org

You will need to set up/download the Duo Mobile apps to verify your identity before it will let you log on: <https://nortonhealthcare.com/pages/remote-access-setup.aspx>

[Science Library \(can access McGraw Hill Surgery, Clinical Key\)](https://library.louisville.edu/kornhauser)

<https://library.louisville.edu/kornhauser>

Core Surgery Curriculum

<https://Surgicalcore.org>

True Learn Question Bank

<https://Truelearn.net>

Uptodate (use for drug dosing)

<https://Uptodate.com>

One Page ICU Cheat Sheets

<https://onepagericu.com>

Articles/Chapters on Critical Care

<https://emcrit.org>

General Advice

- Take a deep breath, the year is a marathon and not a sprint. You will be taking in more information and handling more responsibility than you ever have before.
- Congratulations. You have graduated from medical school and matched into a strong surgery residency program. You will work harder and be more tired than you could ever imagined. Your patience will be tested with ancillary staff and your co-residents. You are going to have sh***y days, nights and wonder why you are doing all of this. It is important to remember why you are

here and why you are doing this. Develop a routine (as much as possible) and don't lose touch with whatever support system you have at home. **If you are having problems, please talk to someone** – your co-residents, midlevel, or chief. We are a family and need to watch out for each other.

- Don't lie. If you don't know the answer to a question, just say "I don't know, but I will find out." – and then find out the answer. It is not a problem to not know every single thing about a patient, just be honest.
- There is always help available, you just have to ask for it. Please call (don't text) if you are feeling overwhelmed, confused about a clinical situation or concerned about a patient.
- Make sure you can access all hospital EMRs (including remotely). Multitasking by preop-ing a patient at one hospital while filling out post op orders on another patient at another hospital will save you invaluable time. Majority of the time, the operating resident will place post op orders unless specified otherwise.
- Try to stay as organized as possible. You will come up with a method of staying organized. But in general, try to make your list the same for every patient, every day. Write the plans down from the morning and check the group chat for updated plans after the midlevel/chief runs the list with the chief/attending.
- Keep your team in the loop. There will be group chats for each service (some have more than others [looking at you Surg Onc]). These can become very overwhelming with the volume and size of text messages. In general, keep your team in the loop. Do not text consults, always call with a new consult. Try to RTL with your midlevel or chief a couple times throughout the day. They will be chart checking as much as possible but remember most of their time is spent in the operating room. Go to the OR if there is an important update or new consult while they are operating.
- **Document. If it is not in the chart, it never happened**
- **Trust but Verify.** This goes for everyone (even co-residents). Double check orders, perform your own physical exam, etc.
- Try to be nice and kind to everyone (nurses, scrub techs, RTs, pharmacists, etc). We are all a part of the same team and trying to take care of patients. Treat them with respect and listen to what they have to say. If you are having a problem with a certain ancillary staff member, do not yell/scream/throw things. Be respectful and address it with one of your superiors if needed.
- Try to answer pages as soon as possible, especially on the floors/units where you have sick patients. If you keep on getting pages about the same patient (>2 times), then there is likely a problem that you are missing or isn't being addressed. Go examine the patient yourself, retake vitals, take a more thorough history, review their chart, etc.
- If you feel "stuck" or can't figure out a solution to a problem you're having, talk to someone because almost certainly someone else has been through the same issue and we probably will have a way to work through it. A good rule of thumb is to try two moves, then phone up the ladder. I.e. improving pain control, and then fluid bolus a tachycardic patient who remains tachycardic afterwards.
- Several services have nurse practitioners that function in different capacities (Norton General, CRS, Trauma floors, and Surg Onc). They know the attendings/service preferences before than the mid-levels/chiefs and are very helpful when they are around. Please treat them with respect. Remember, medicine is a team sport. Much like the floor nurses, they have the ability to save your butt or throw you under the bus; don't be a jerk.
- You will have medical students to teach and mentor. You will be their closest contact. It is normal to feel like you barely know more than they do. Let them help you with things (graduated autonomy – med students have removed g/j tubes instead of JPs before). They are not your slaves. You were very recently in their shoes, so try not to lose sight of what you wish your

interns/residents would have taught you as a medical student. Only the chiefs/fellows can send the medical students home early.

- Read patient's charts, review their surgical history/anatomy and read about the operation/procedure you are about to do before you do it.
- When you're doing something for the first time – ask for help/guidance. Patient safety always comes first.
- Some services PM round as a team (run through the list, see sick patients together), on others you should do your own PM rounds – make sure action items have been taken care of, etc.
- Your notes are a part of the medical record. These are used for billing and lawsuits. Be cognizant of what you write. Be respectful about other services and individuals. Be careful when cutting and pasting. Make sure it is accurate before finalizing it.
- For the first few months, you should be asking your upper level before ordering new medications, blood transfusions. When you make these recommendations provide your reasoning if that's what you think the patient needs.

HELPFUL INFORMATION

General Day Time Stuff

- Chart check on patients before rounding. Get in the habit of going through your system the same way for each patient. Mine is vitals, labs, I's and O's, meds history, micro, notes over the past 24 hrs, etc.
- Every day you should be looking for ways to advance your patients care. As their diet advances postop, you should be adding PO pain meds, decreasing IV pain meds, d/c'ing IV fluids. PT/OT consults on POD1. Assess the need for lines and tubes.
- Begin thinking about rehab consults in early postop period. Assess home meds and when/if they should be restarted on POD1.
- Look at drains, wounds, hematomas and incisions every day. Take pictures of drains (drain character can change). Take pictures of wounds you're worried about.
- Flush the NGT when you round. Make sure it is functioning properly.
- Dressings should be taken down on POD2 unless otherwise instructed.
- If a nurse calls you twice with concerns about the same patient, go see the patient
- Incentive spirometry and pulmonary toilet → every patient should have an IS at bedside and know how to use it.
- Talk to/consult social workers and case management on disposition plans. Frequently patient require insurance precertification (precerts) prior to being approved for rehab/nursing homes/home health. It is best to get this process started early, especially before the weekend.
- Always check to see if DVT prophylaxis is prescribed/needs to be added. At minimum SCD/TED hose. Typically, enoxaparin (40mg BID for trauma patients [non-head/spine], 40mg daily for neurosurg patients and everyone else as long as they aren't actively bleeding) or subQ heparin (5000u q8h) for people with renal disease. No enoxaparin for patients in renal failure/Cr >1.2.

Overnight advice

- Never advance a diet; never remove a foley
- Never give sleep aids; Never give 2mg IV hydromorphone; Never give 2mg Ativan. Melatonin is usually safe to give most people if you need something.
- Don't give Benadryl, Phenergan, or other anticholinergics to people over the age of 60

- If you get called for "anxiety" or "confusion," go see the patient. Often "anxiety" is caused by hypoxia.
- Always perform a **"Night of Surgery"** check on every day of surgery patient and document it. Take note of vitals, UOP, abdominal exam, and pain control. For these as well as other visits to patients, **if you don't document it, it didn't happen**. Get in this habit for every time you see a patient. It also certainly helps those cross covering who have never seen a particular patient before and have no idea what their exam is like.
- If you are unsure about something, call someone higher up than you.
- Be succinct with your presentations. If you are worried about a patient, start off with that. Always state what the consult is for before going into your presentation
- Use the supervisor during the first three months to your advantage. They are there to guide and teach you.

Procedures

- Go over the steps of bedside procedures (central lines, art line, chest tubes, etc) in your head at night. Visualize the steps you're going to do and what you'll do if you have complications. This is how you will help develop muscle memory and create back-up plans. 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

- Lines are procedures that are done under the supervision of attendings. Ultimately, they are responsible for the line, do not place a central line without getting approval from the chief/attending on call.
- Before placing a line, make sure the patient has an indication for a central line. Are they hemodynamically unstable, unable to get IV access (after multiple attempts, IV team, ultrasound etc), need emergent dialysis, etc.
- **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 one before help you the first time because the catheter set up is a little different from Shiley/central lines); Cordis (7-9F, used in trauma for quick access, the dilator comes inside the sheath so have someone who has placed on before help you your first few times; this is the catheter to use for Swan-Ganz lines too)
- If not emergent, check coags. Attendings vary on placing lines in patients with underlying coagulopathies. Some will say place a groin line and some will say don't place a line. When in doubt, ask your chief or attending before placing it. You don't want to be put in a position holding pressure on a line you couldn't get for hours because the patient's INR is 5 and their platelet count is 10.
- At Norton, the nurse will get consent for you. At Jewish/ULH, you will need to get your own consent. Regardless of who is getting consent, talk to your patient or the patient's power of attorney about what you are going to do, risks/benefits, etc. It is INFORMED consent, so inform accordingly.
- Be smart about site placement. No subclavians unless instructed. Usually, IJ unless coags abnormal. If emergent, femoral. Subclavians need to be preserved in renal failure patients because if they go down, it severely impacts your ability to create an AV fistula for long term dialysis access. When possible, go to the University ICU when the second years are doing lines in order to learn how to place subclavian lines (preferred in trauma patients).

- 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.
- If you stick an artery, remove your needle and hold pressure.
- Never attempt a central line on the opposite neck/chest until you have a confirmatory chest X-ray showing that you did not cause a pneumothorax (AKA don't try on the right and then immediately try on the left). Worst case scenario is that you drop both lungs without knowing it and then the patient is in really bad (dying) shape.
- Do not place a shiley in the subclavian, ever.
- CXR after IJ/subclavian to **confirm placement** and **check for a pneumothorax**. This needs to be emphasized—pneumothorax is rare but does happen. Many residents before and many residents after you will drop lungs. Make sure the patient knows this risk.

Chest tubes

- Always start with indication for the chest tube. PTX, hemothorax, large pleural effusion.
- If at Norton, call chief/attending prior to placement. At ULH, call wedge (PGY3).
- Check coags if able.
- Need: Chest tube (could be 28Fr versus pigtail/14Fr), atrium, suction tubing, chest tube kit, suture, lidocaine and needles, prep, vaseline gauze, 4x4, foam tape
- In a controlled situation, chest tube insertion should take 15-30 minutes. In a code/room 9 situation, it should take 30-60 seconds.

Replacing electrolytes:

Potassium (K) 10meq=0.1. 40mEq

- Oral KCl can be absorbed q4h; it makes patients nauseated. Alternatively you can give up to 40mEq KCl IV (4 runs) and then recheck/replace as needed. Potassium burns. You can include lidocaine (per pharmacy) at Jewish only. Be careful replacing K in **burns** and **renal failure patients**.
- Goal is 4.0

Magnesium (Mg) = magnesium sulfate or magnesium oxide. 1.5-1.8 and taking PO = mag ox 800mg

- <1.5 or not taking PO = mag sulfate 1mg or 2mg. Recheck/replace as needed.
- Goal is 2.0

Phosphorus = sodium phos, potassium phos, or PhosNAK.

- Give Sodium phos if Na<140, typically 15mmole phos 2.5-2.9, 30mmol 2.0-2.5 recheck/replace as needed.
- Give Potassium phos if K <4.3, 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 or check an ionized calcium. You should be giving patients calcium gluconate after transfusing pRBCs.

Hyperkalemia – recheck BMP. Most common cause of hyperkalemia is a hemolyzed sample. If still high, 1g calcium gluconate first (stabilizes cardiac membranes), 1 amp D50, 10u insulin (IV or subQ, it doesn't matter) then recheck K after 1 hour. Don't get caught up on memorizing the dosages, there are ordersets at the hospitals. Get EKG (looking for peaked T waves). If patient is in renal failure,

contact the renal service because they may just need dialysis. Renal team should be managing their electrolytes, but clarify who is doing what so you don't overdose/underdose the patient.

Initial workup for common things

- Go see the patient if it sounds like an acute issue (e.g. hemodynamic instability, behavioral problems, nurse asks you to come evaluate the patient)
- Always ask for new vitals (HR, BP, SaO₂, UOP, I's and O's)
- Review patient's past medical history and home meds (time permitting)
- Always see the patient first, come up with your plan then discuss with your midlevel/chief
- ABGs are great, make sure you understand how to interpret them
- Document your findings and plan in the chart at night.

Tachycardia

- Common causes: hypovolemia, sepsis, anastomotic leak, pulmonary embolus, pain, lack of home medications (especially beta blockers)
- Assess the patient's volume status
 - Can check cap refill, mucous membranes, straight leg raise, pulse pressure variation
 - Be careful bolusing elderly, CKD patients, CHF, COPD. You can cause flash pulmonary edema in these patients.
- Recent surgery with anastomosis?
 - May have leak. Perform an abdominal exam and obtain an acute abdominal series
 - Tend to have new onset atrial fibrillation
- Shortness of breath, new onset hypoxia → concern for pulmonary embolism
 - Check ABG, CXR, pulse ox, EKG
 - May need lower extremity duplex, CT PE protocol, heparin gtt. Talk to someone prior to ordering these studies
- Cardiac history or history concerning for ACS?
 - EKG, troponins, BMP/Mg/Phos
- Atrial fibrillation
 - Please notify your higher up when patients are in new onset atrial fibrillation
 - Common after thoracic surgery
 - Two separate ways of managing: rhythm versus rate control. No benefit for choosing one over the other, except if you rhythm control a patient and don't know how long they've been in atrial fibrillation, there is a hypothetical risk of throwing a clot. That is why the cardiology service prefers to start with a beta or calcium channel blocker instead of amiodarone.
 - Recommend starting with metoprolol 5 mg Q5 min up to 3 doses. If this does work then consider starting oral metoprolol (succinate for single daily dose, tartrate is short acting). If this does not work then they will need either a diltiazem or amiodarone drip. Do not use diltiazem if the patient is hypotensive, as the calcium channel blocker causes vasodilation.

Low UOP

- Does the patient have a foley? Is it flushable? Is it kinked? How much on bladder scan?
 - You don't want to bolus patients with acute urinary retention. This is very uncomfortable.

Dyspnea

- Common causes: hypoxia, PE, MI, fluid overload, pain control, anxiety
- Your general work up is going to include SaO₂, ABG, CXR and physical exam

- Hypoxia. May need nasal cannula, non-rebreather, intubation. If you are using more than a face mask then you should likely upgrade the patient to the ICU. Discuss with your upper level prior to doing this.
 - 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
 - Venturi mask (set O2 rate) 60-100%
 - Hi-Flow nasal cannula
 - Up to 35L, up to 60%
 - CPAP/BiPAP – common home regimen for OSA
- PE? May need duplex low extremities, CT PE protocol, heparin drip. Discuss with your wedge/upper level before ordering heparin drip or CT PE.
- Fluid overload? BNP, lytes, UOP, fluid balance, physical exam (pitting edema, wet lungs, etc). May need furosemide (check first). Check what IV fluids are running at.

Confusion

- Common causes: sun-downing, hypoxia, sepsis, EtOH withdrawal. This is HYPOXIA until proven otherwise
- Sepsis? Cultures (UA, Blood, CXR), CBC. May need antibiotics (check first)
- Hypoxia? See above
- Sun-downing/Delirium? Supportive care, minimize narcotics and sedatives, lights off during night and on during day. Make sure they have their home hearing aids, glasses, family support at bedside if available.
- EtOH/Benzo withdrawal? EtOH history, tachycardia, hypertension, new onset anxiety.
 - Call upper level. May need CIWA protocol (lorazepam, etc.) and transfer to ICU.

Hypotension

- Common causes: shock (4 types)
- Work up
 - Manual BP in both arms, maybe try a lower extremity as well
 - Physical exam
 - CXR
 - If you're comfortable with the ultrasound, could check an e-fast (checks lung sliding) or RUSH (checks IVC).
 - Labs depending on the scenario
 - Recent surgical patients are either hemorrhaging, septic or have an anastomotic leak until proven otherwise → CBC, ABG, physical exam, call for help
 - Cardiac history or story concerning for ACS? → EKG, troponins, lytes
 - Fluid challenge (again, be careful in renal failure, CHF, COPD)
- Call someone above you, may need ICU transfer, **no pressors without someone higher up knowing** (usually levophed first), may need central line and arterial line, etc

- If a patient is receiving pressors, they should be going through a central line. Prolonged pressors through peripheral IVs can result in gangrenous extremities requiring amputations, so if they need pressors, think about dropping a central line or getting a PICC.

Dialysis

- **Indications for dialysis:** AEIOU

- Acidosis, electrolyte imbalance, intoxication, overload (fluid), uremia.

Trauma Rotation

Service setup:

- Two teams (trauma I and 2) that alternate call every other day
- An elective team takes calls on Tuesday and Friday nights
 - The trauma fellows rotate taking call these nights
- Team consists of: interns, PGY2 (ICU), PGY3=wedge (ER/floor), chief (floor/ICU), fellow (mostly ICU), NPs (Trauma 1 – Michelle Fox, Beth Zangalino and Diana Blevins, Trauma 2 – Kim Broughton-Miller and Michelle Frisbie)
- Trauma I attendings: Franklin, Smith
- Trauma II attendings: Harbrecht
- Attendings that switch: Coleman, Bozeman, Miller, Nash, Benns, Pera, Marshall
- Where you spend your time: trauma workroom on the second floor beside the ORs
- Clinics are every Tuesday (even team one week, odd week the next) on 7th floor of HCOC building (Panera building). You are expected to be there after morning rounds at 8 AM.
- ORs: 2nd floor
- *Pick up your level one pager in the Trauma Institute on the basement floor by the cafeteria.
- EMR: Cerner for inpatient; EPIC for clinic
- You are the first call for floor problems. There is a 2nd year that runs the ICU. Your 3rd year will be running the ER/OR. The 5th year oversees everything. People that are admitted from the ER will come to the floor. Your 3rd year (wedge) will try to tell you about them, but this is not always possible in a timely manner, especially during the busy trauma season. Be patient. Look in the chart.
 - Review all of the final reads of the imaging for new trauma admits. Sometimes final reads change from initial reads. At the minimum, review imaging the morning after admission and the day of discharge to ensure all issues have been resolved.
 - Make sure all of the consulting services that have been called have actually seen the patient.
- Keep a list of the things in your patients: Foleys, trachs, chest tubes, IVs, central lines, PICC lines, etc and how long each of them have been there. This will make your life easier when knowing when they need to be changed.
- When downsizing a trach, have a wedge/second year/NP/chief help you the first few times
- **Come to every Level 1.** This is very important for learning how to apply the ABCs you have learned about to real life. Take initiative. This is a good time to see how code/trauma lines/tubes/intubations are done.
- Learn by watching then ask the wedge to take you through it **in less critical patients**
- Go to the OR any time you can. Take initiative to know when/what cases are going on. This is hard to do sometimes with all of the floor things that need to be done. Once you get all of your floor tasks done, you should be reading/operating/learning how to do procedures
- Burn debridements are family affairs – the whole team is expected to be there.

- At night you will cover all the floor patients for the other surgical services. Cross-covering is hard, no doubt. You will be essentially responsible for a bunch of patients who have had procedures you are not yet familiar with and that you do not know very much about. The trauma interns are fortunate that they have several resources in house – the 2nd, 3rd, and 5th years. Use these resources when you have questions or concerns.
- Complete the night of surgery visits on a timely manner. This should include wound check, urine output, vitals, pain control, diet (or NPO status), if IV fluids are running (or not supposed to be), having incentive spirometer at bedside, and seeing if the nursing staff has any concerns.
- A good rule of thumb is to not change too much for the services you are cross-covering unless absolutely necessary. This includes downgrading their status (TCU to med/surg), removing Foleys/NG tubes, advancing diets, etc.
 - You will get these phone calls. Do not get bullied into doing things you aren't sure need to be done in the middle of the night. Majority of the time these things can wait for the day team.
- Go see patients you get called about
- Don't give benzos on the floor without asking your upper level first
- Watch out for older patients. They can get sick very fast without much warning. They have little reserve.
- Medicines to be careful about giving: Benadryl, phenergan, promethazine, ativan, ambien, seroquel, haldol, dilaudid, morphine, amongst others. These can have a lot more negative side effects than they are worth at times, especially in older patients. Just because you get called asking "for something to help them sleep," doesn't mean you have to prescribe something.
- You may get called about direct admits to the floor for other services at night. You may not have a "heads up" from signout if the attending accepts a transfer at night. Go see them when you get called about them. If you have any questions about the patient, run it by your wedge, otherwise, call the chief/fellow for that service and they will guide you on what admission orders they need.
- Go see any floor consults you get called about. Then present them to your wedge in a timely manner. You don't want the team to just be finding out about patients you have know about for hours on morning rounds the next day.
- Harbrecht: if he asks a question, he probably already knows the answer. Don't bullshit him. He wants to see your thought process.

VA Rotation

Service Setup:

- Team consist of: chief, two midlevels (one covers thoracic and one covers vascular), intern, NP (Jane Kittle)
- Gen Surg attendings: Gaar, Franklin (Dr. Scoggins, Dr. Pera, Dr. Kavalukas and Dr. Simon have/are getting privileges)
- Vascular attending: Yancey, Davis
- Thoracic attending: Wrightson (in the process of leaving)
- OR cases MWF plus add ons
- Gaar Rounds on Tues am where he will do mock oral board type questions and walk you through theoretical cases
- Minor procedure clinic on Tues am – intern and upper level take out small lumps/bumps under local
- Endoscopy with Gaar on Thurs am
- Clinics – Tues pm Gaar clinic, Thurs am Franklin clinic, Thurs pm Vascular clinic. EVERYONE is expected to go. They are located on the first floor.

- Where you spend your time: workroom on 4th floor next to the surgery waiting room (Room 402, code: 55363)
- call rooms are hidden on the 3rd floor (have a 2nd or 3rd year show you where).
- ORs: 4th floor

Paperwork:

- Contact Security about getting a parking pass.
- Make sure your login and access codes/passwords work a week prior to starting; there inevitably is something that has been reset and it's a very slow process
- Codes:
 - ICU 123#
 - Locker rooms: 46808
 - ER 309*
- Chiefs are your main go-to. You will call them about the new consults you get.
- If you need something done on the floor, you should just go ahead and do it yourself. It is difficult to count on the nursing staff.
- Please help preop patients. This includes marking, H&P, iConsent, and a brief narcotic form. Your team will be able to show you how to complete these initially.
- Complete your discharges ASAP. Discharge planners will call you every morning around 0730. There is a whole discharge process that has to be initiated prior to discharge. This will be in your VA paperwork.
- Get into the OR as much as possible. This is the rotation where you have time to operate, so take advantage.
- Teach your medical students
- Food options are limited; the canteen/starbucks during the day, nothing at night. There is a resident lounge by the call rooms that periodically gets stocked with food. I recommend just bringing your own food. There is a refrigerator and microwave in the lounge.

Norton General Surgery

Service Setup

- Team consists of ACS chief and midlevel, and 2 interns, NP (Stacy Block)
 - Previously this used to consist of two teams ACS and Kehdy/Minimally invasive
- Attendings: ACS/trauma faculty (this rotates)
- Where you spend your time: the "nerve" is on the second floor in the service building
- ORs: basement
- ICUs: 4B, 4F, 5B, 5F, 5H, 6 ICU beds in 4 Giles
- ER: lower level
- Cafeteria: first floor; MD lounge 2nd floor has free food
- Norton call is hard. Prioritize your to do list. You will inevitably get called about new lines/consults when you are swamped.
- Lines/consults should be called into the attending by the consulting service or nurse prior to being called to you (excluding codes).
- Go to all of the code blues and help provide airway/access/management as needed
- Make sure to read the Martin Manifesto in the nerve. Basically, it's very specific things for Dr. Martin i.e. no zofran, no diuretics, must have incentive spirometry/be out of bed, etc. He is very particular. Ask the surg onc chief/fellow if you have questions regarding his patients.
- To reach Dr. Vitale at night, you may need to call his house if he does not answer his cell
- To reach Dr. Dwivedi, your best bet is his pager, but your first call for vascular should be chief/fellow

- When you get called to put in central lines, make sure you know the indication for the line, anticoagulation status, what their INR/PTT/platelets are, if they have AV fistulas or some other contraindication to a particular side, and that the attending has been called about the line.
- Dr. Kehdy has specific instructions for his postop paraesophageal hernias and Nissen, which are listed in the Nerve.
- There are several “dot phrase” notes already created for H&Ps, central lines, art lines, consults, etc. Ask your upper levels to share these with you.

Jewish General Surgery

Service Setup:

- There are two teams: ACS chief and midlevel, Williams chief, and 2 interns (cover both services)
- Attendings: Williams, ACS/trauma staff
- Where you spend your time: OR lounge on 2nd floor; call rooms on 3rd floor by 3E/transplant offices
- OR: 2nd floor
- ER: 1st floor
- Cafeteria: first floor; MD lounge: first floor (breakfast and lunch provided during the week)
- Codes:
 - Call rooms: 75337 (spells SLEEP) (our rooms are 3rd on the left 1221 and third on the right 8477)
 - ER 1234*
 - Endoscopy 4080*
 - Dialysis 4688
- Much of the information above (from Norton) applies
- Thursdays are Dr. Williams’ busiest day; two rooms and constant. Expect to be swamped. It is called Russellmania for a reason.
- Williams likes to round at night, so if you are the night resident, be familiar with his patients from checkout. Preferably see your night of surgeries prior to walking around with him. Also, make sure you have access to scripts for narcotics in the event he wants to send people home at night.

Norton Children’s

Service Setup

- Team consists of: fellow, chief, PGY2, 2 interns, NP (Katie Cecil)
- Attendings: Fallat, Bond, Foley, Downard, Wright, Carter, Bounpane
- 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
- Clinic: Thursday afternoon and every other Tuesday afternoon
- There is always an attending/chief/fellow in house.
- Present your consults to the attending as soon as you see the patient. Downard will want to know (in order) – patient’s name, DOB, location, reason for consult, HPI, exam, imaging, plan. The others are more laid back in terms of presentation expectations.
- Add new patients to EPIC list as soon as possible. NO list fails.
- Be as patient as possible with the pediatric residents and nurses. It is hard some time. You will get written up on this service. Be overly nice to everyone. Patience is key. If you get frustrated just say, “Thank you. I’ll see the patient/address the issue/discuss with my

chief/fellow/attending” and walk away. Try to remember that when kids are sick, people’s anxiety goes up and this includes parents, nurses, and other residents. You are used to taking care of very sick people, they are not.

- Don’t put in orders on PICU/NICU patients; write recommendations in your notes and discuss with the primary team. This is a HIGH COMMUNICATION rotation.
- IV fluid calculations are very important: 4/2/1 rule
- It is your job to help preop patients in the mornings and help discharge the outpatients
- Make sure consulting services fill out a “line sheet” for central line requests
- Pretty much every little procedure will be done in the OR (abscesses, lines). Do NOT do procedures out of the OR without your attending present.
- Make sure to read the handbook (provided at start of rotation) for specific Norton Children’s information

Transplant

Service Setup

- Team consists of: chief, PGY2
- Attendings: Jones, Eng, Adamson, Al-Salmay
- Where you spend your time: Jewish; OR lounge, call rooms on 3E
- Hospital: Jewish
- All transplants get postop labs and an ultrasound within 4 hours of transplant; ALWAYS follow this up promptly and update chief and attending on results
- Always try to do the organ back table during a transplant. Double scrub the transplant if your other responsibilities are completed.
- This month can be very busy or very slow. If busy, just keep up. If slow, double scrub as many cases as possible. Go to transplant clinics throughout the week. Read/study for ABSITE...
- Immunosuppression levels and adjustments are made by pharmacist and attending during the week. You follow up levels and call attending for adjustments over the weekend. Know the level today, the level yesterday, and the dose they are on.
- Attendings are very involved and particular about the care of their patients. Run things up the chain before making any big moves.
- **A specific template must be used for all Transplant notes.** This will be sent to all residents prior to the start of the academic year.

Surg Onc (SO):

Service Setup

- Team consists of: PGY 5/4/3/2/1, ERCP Fellow, Surg Onc Fellows x2 (2nd year is clinical, 1st year only has a couple clinical months), NP (Ashley Higdon)
- Attendings: McMasters, Scoggins, Martin, Philips, Ajkay, Egger, Javid, Quillo
- Hospitals: University, Jewish, Norton
- SO Fellowship is apprenticeship style. The fellows will primarily round, put in orders and take night calls on the patients for the attending they are with that month.
- ERCP fellow will cover night calls for Vitale’s patients, but team is responsible for rounding on them in the morning.
- Can be a very busy service. Get access to the online calendar and check the OR boards before leaving each day.

- Endocrine (thyroid/parathyroid) patients all get calcium, ionized calcium, magnesium, and phosphorus levels drawn the night of surgery. The night intern follows these up and texts them to chief on call.
- McMasters: always wear the headlight. Always hand tie knots (don't instrument tie). Don't put the plastic cap on the end of the radiation probe. Know the cut-off for taking nodes (10% of radiation signal of sentinel node). Know margins for melanoma. He is the primary author of the Sunbelt Melanoma Trial, so please know this like your birthday.
- Scoggins: don't suction Bovie smoke. He likes small bites on deep dermals. Don't palm the needle driver (leave fingers in the holes). Milk of mag is his first line bowel reg of choice. Pay attention to ROS and PE on all H&P and Consult notes. He likes 12 components on ROS with 2 items each, and 10 components on PE with 2 items each—he is in charge of most fiscal matters within the department so he knows documentation requirements for billing like the back of his hand. If you mess it up, he will text you about it. Also, document that imaging and labs were reviewed in your Assessment/Plan. Make sure there is an assessment in your plans. Update your assessment and plan daily. Do not copy forward your notes.
- All Surg Onc patients: gentle fluids. Don't just bolus if low UOP but look at EBL from the operation and consider sending urine lytes or giving lasix. Call/text chief if you are ever uncertain
- Ajkay: know his breast cancer algorithm (can get from midlevel resident or chief). Don't scrub without first knowing the patient's story. He likes large deep dermal bites, and instrument ties most of the time (in contrast to Scoggins/McMasters).
- Martin: very particular about the care of his patients, and there is a proverbial method to his madness. Please understand his preferences and the reasons for them. If you are unsure about the "why," ask your chief/fellow or Dr. Martin. They will be happy to explain.
- Vitale: Typically will run the list with the fellow in the morning. Afternoon list running, often requires a resident to physically be sitting next to him and ask to run the list and discuss plans about his patients to avoid having this happen later in the evening. For many of his chronic pancreatitis patients, admission comprises NPO, IV fluids, serum amylase, and possibly a CT A/P with IV contrast (pending discussion with Dr. Vitale). Please be patient with his chronic pancreatitis patients. They have a complex problem with few good solutions. Be mindful of this and compassionate when you start to get frustrated.
- As a general rule of thumb, ask up (chief, attending) before making move on Surg Onc patients because they can be very particular (attendings) and fragile (patients).
- Lots of clinic; have dress clothes in the call room/car. Carry a phone charger with you.
- Check clinic schedule. Some are HCOC, some BCC
 - Martin Monday (multiple days of clinic)
 - Phillips Tuesday
 - Scoggins Thursday, Ajkay Thursday
 - McMasters Friday

Colorectal:

Service Setup

- Team consists of: fellow x 2, chief, midlevel, intern, NP (Janice Fietcher)
- Attendings: Galandiuk, Farmer, Jorden, Kavalukas, Simon
- Hospitals: University, Norton, Jewish
- Examine drains, incisions, and ostomies and pay close attention to abdominal exams daily.
- As a general rule of thumb, ask your chief/fellow/attending before making major changes on these patients given their complexity.

- Enhanced recovery (ERAS) order sets are available and used for many patients on this service. Please be familiar with their components and use them during all phases of care (preop AND postop) when appropriate.
- Lots of clinic; have dress clothes in the call room/car. Carry a phone charger with you.
- Case conference: Monday and Tuesday 0700, Polk Conference Room
- Clinics throughout the week on HCOC 7th floor
- Please help prepare patients for the operating room when able. At University Hospital, patients should be consented as early as possible, ideally before running the list, since they must have consent prior to epidural placement.
- These patients, particularly those with IBD, can be challenging. Like Dr. Vitale's chronic pancreatitis patients, they have a **complex, debilitating problem with few good treatments**. Be mindful of this and **compassionate, particularly when you start to get frustrated**.

Vascular:

Service Setup:

- Team consists of: 2 fellows, chief, midlevel, and intern(s). NPs cover Jewish Hospital only during the week from 7/8 - 5PM
- Attendings: Dwivedi, Wayne, Sigdel, Clark, Cheadle
- Hospitals: University, Norton, Jewish
- 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.
- This is an extremely busy service that covers all three hospitals.
- You need to preop cath labs cases each day. Also, you are responsible for cath lab discharges after outpatient procedures. Help keep up with preoping OR cases as there are often more than one room going and attendings will hop from room to room.
- You usually run the list in the cath lab each morning. Dr. Dwivedi will run by around 630-7am and run the list with you. Get orders, discharges, and Shiley consults done efficiently.
- If there is a new consult for a procedure that can be done the same day, they will want to do it the same day. Immediately see and preop new consults for procedures (tunneled lines, Shileys, IVC filters, EKOS, etc).
- Carry around marking pens and a Doppler with you during morning rounds.
- Check pulses and wounds every morning. Mark sites for surgery during morning rounds to expedite things downstairs later.
- All cath lab patients at Norton will need a Sedation Document note. Ask your upper level to share this with you.
- Sigdel clinic Tuesday mornings, Dwivedi clinic Wednesday and Thursday mornings, Wayne clinic Friday mornings. All in HCOC 7th floor.

Revised May 2023
Revised June 2024

University of Louisville School of Medicine

Resident Stipend Rates 2024-2025

<u>PG Level</u>	<u>Annual</u>
PG Level 1	\$61,867.64
PG Level 2	\$64,179.69
PG Level 3	\$66,251.94
PG Level 4	\$69,244.93
PG Level 5	\$72,601.03
PG Level 6	\$75,877.94
PG Level 7	\$79,034.94
PG Level 8	\$83,236.00

Fringe Benefits

Professional Liability Insurance

Malpractice coverage is provided by U of L, VAMC, and/or private affiliated hospitals under terms of your contract. However, *this coverage does not apply to any off-duty activities of employment*. Questions regarding malpractice coverage should be directed to the Risk Management Office (852-4652).

Medical/Hospitalization Insurance

Single and family coverage is available to all residents. You may sign up for insurance at House Staff Orientation. For more information, call 852-6555.

Life and Accident Insurance

Each resident receives, free of charge, life insurance for the value of twice the annual salary. Workers compensation, accidental death and dismemberment insurance are also provided. For details, please contact U of L's Human Resources Department (852-6258 / HRhelp@louisville.edu).

Mental Health Services

Confidential counseling or psychiatric consultation provided at no charge to the resident through a contractual arrangement between the Dean's office and the Campus Health Services Office. Residents desiring or in need of personal counseling, psychiatric consultation and/or treatment should contact the HSC Campus Health Services Office, located on the 1st floor of the Health Care Outpatient Center (HCOC); phone 852-6446. Residents may also contact the following individuals directly:

Dr. Gordon Strauss
Psychiatrist
Office 852-7256
Belknap

Dr. Jessica Reis
Psychiatrist
Office 852-7256
Belknap

Dr. Erik Goodwin
Psychiatrist
Office 852-7256
Belknap

Shivaun Nafsu
HSC Counselor
Office: 852-6446

Dr. Angela Pyle
Education Learning Specialist
Office 852-0755
HSC

Miscellaneous Benefits

Each member of the house staff has the following privileges:

- 1 - Kornhauser Health Sciences Library / Ekstrom Library – U of L's Main Campus
- 2 - Discount for higher priced seats for U of L athletic events.
- 3 - Use of:
 - U of L swimming pools (852-0948; 852-6648)
 - Fitness facility at Student Activities Center (852-7850) on Main Campus
 - HSC Fitness Center (852-3115) on Chestnut Street
 - Bass Rudd Tennis Center (852-1682) on Main Campus
- 4 - Free annual PPD may be obtained from the General Internal Medicine Clinic/Student Health Services (ACB – 1st Floor), every weekday except Thursdays, 8:30 a.m. to 11:30 a.m. and 1:00 p.m. to 4:00 p.m.
- 5 - Free U of L parking permits for the Chief Residents. All other PGY levels will receive a parking pass through the GME office. (*details at General Orientation*).

In order to receive fringe benefits 1-5, a resident **must have a University identification card – “Cardinal Card,” which is issued during GME new resident orientation. Please note that there may be a membership fee required for the use of some of the University's facilities, such as the Wright Natatorium.*

If you need to obtain a replacement Cardinal Card, stop by the security station on the 1st floor of the Abell Administration Building on Tuesdays between 2 and 4 pm. Should you have any questions, please call the Cardinal Card Office on main campus at 852-7520.

- 6 - White coats provided for each resident by the Department of Surgery.
- 7 - Computers for residents are available for use at all times – located in the Resident Education Room, the Resident Conference Room, the Laparoscopic Skills Lab, the Trauma Call Room, and in all integrated hospitals.
- 8 - Laparoscopic Skill Trainers are available 24-hours a day for surgery residents to hone their laparoscopic techniques.
- 9 - The J David Richardson Memorial Library and the Polk Conference Room (ACB – 2nd Floor) house a collection of textbooks and journals in general surgery and its specialties. Residents are welcome to borrow these materials. The lending procedure is based on the honor system.

Revised March 2020
Reviewed March 2020
Reviewed May 2024

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 Macheize 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 postgraduate 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.

FACU LTY CLINIC SCHEDULES

<u>BARIATRIC TELEHEALTH</u>	
<i>Monday</i> Bruenderman – AM/PM	
<u>TRAUMA/ELECTIVE CLINICS</u>	
<i>Monday</i> Harbrecht – PM	<i>Tuesday</i> Trauma – AM Elective – AM (2 week)
<i>Wednesday</i> Benns – PM Bozeman – PM Miller – AM	<i>Friday</i> Coleman – AM Nash – AM
<u>Minimally Invasive</u>	
<i>Tuesday/Thursday</i> Kehdy – AM (HCOC)	
<u>VA CLINICS</u>	
<i>Tuesday/Thursday AM/PM</i>	
<u>GENERAL SURGERY CLINIC</u>	
<i>Friday</i> Bruenderman – AM/PM (HCOC)	
<u>NORTON CHILDREN'S CLINICS</u>	
<i>Monday</i> Foley – AM	<i>Tuesday</i> Wright – AM
<i>Wednesday</i> Bond – AM/PM	<i>Thursday</i> Buonpane – AM Downard – PM
<i>Friday</i> Carter – AM	

TRANSPLANT CLINICS

Monday

Kidney/Pancreas – AM/PM
(Trager Transplant)

Wednesday

Liver Clinic – AM (Trager Transplant)
General Surgery – PM (HCOC)

Thursday

General Surgery Clinic – AM (HCOC)
Kidney/Pancreas – PM (Trager Transplant)

THORACIC CLINICS

Monday

van Berkel –AM
Black – AM

Wednesday

van Berkel –AM/PM
Fox – AM
Black – PM

Thursday

Fox – PM

Friday

Fox –AM

SURGICAL ONCOLOGY CLINICS

Monday

Martin – 9am-3pm
Aj kay – PM (HCOC)

Tuesday

Philips – 8:30am-12pm
HCOC 1st, 3rd and 5th
MCNE 2nd

Wednesday

Martin – 8-10 (NCI)
BG 4th

Egger – 1pm-4pm
MCNE 2nd Tuesday
McMasters – AM (BCC 3rd FI)
Philips – 8:30-12 (MCNE) (2nd T)

Thursday

Vitale –AM
Aj kay – AM/PM (BCC)
Scoggins – AM/PM

Friday

Egger – AM/PM
Philips – PM (Alternating weeks)
Martin – 8-10 (Audubon)
Javid – 8am-5pm (HCOC)

COLORECTAL CLINICS

Monday

Jorden – PM (MCNE)
Kavalukas – PM (MCE 2nd & 4th)

Tuesday

Galandiuk – AM/PM
Kavalukas – AM/PM

Wednesday

Jorden – AM/PM
Simon – AM/PM

Thursday

Farmer – AM/PM

VASCULAR CLINICS

Monday

Cheadle – AM/PM

Wednesday

Dwivedi – AM
Wayne – Jewish – PM

Friday

Wayne – AM

Tuesday

Sigdel – AM (1st Tuesday)
Sigdel – Jewish - PM

Thursday

Dwivedi – AM
Dwivedi – Jewish – PM

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

<u>GENERAL SURGERY</u>	
Surgical ICU Rounds ACB, JDR Memorial Library 7:00 am – 8:00 am	Burn Rounds ULH, Burn Unit ~ 5 th FI 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	<u>HAND SURGERY</u> Kleinert Institute Hand Conference 6:30 am – 7:30 am *Virtual via Teams
<u>PLASTIC SURGERY</u>	
Plastic Surgery Research Conference ACB, JDR Memorial Library ~ 2 nd Floor 1:00 pm – 1:30 pm	Cosmetic, Craniofacial, & Hand Case Presentations *Cosmetic – Third Monday of the Month ACB, JDR Memorial Library 1:30 pm – 2:00 pm
In-Service Board Review Course ACB, JDR Memorial Library ~ 2 nd Floor 2:00 pm – 2:30 pm	Indications Conference ACB, JDR Memorial Library ~ 2 nd Floor 2:30 pm – 3:30 pm
Workshops As Needed ACB, JDRichardson Memorial Library ~ 2 nd Floor 3:30 pm – 4:30 pm	Hand Conference ACB, JDR Memorial Library ~ 2 nd Floor (1 st & 4 th Monday) 3:30 pm – 4:30 pm
Cosmetic Clinic *Third Monday of the Month 7 th 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	
<u>SURGICAL ONCOLOGY</u>	
Gastrointestinal Multidisciplinary Conference 12:00 pm – 1:00 pm *For location details, please refer to the Surgical Oncology Surgery Calendar	
<u>Surgical Oncology Endocrine (Monthly)</u> *For location details, please refer to the Surgical Oncology Surgery Calendar	<u>Surgical Oncology Journal Club Dinner (Quarterly)</u> For location details, please refer to the Surgical Oncology Surgery Calendar

<u>COLON / RECTAL SURGERY</u> Colon and Rectal Surgery Conference ACB, Polk Conference Room ~ 2 nd Fl 7:00 am – 8:00 am	<u>PEDIATRIC SURGERY</u> Pediatric Surgery M&M Conference Norton Children's Hospital ~ Varies 7:00 am M&M Conference – PGY2 Weekly Case Preview – PGY2 Article presentation (Interns/Students)
-----------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<u>HAND SURGERY</u> Christine M. Kleinert Institute Hand Conference 6:30 am – 7:30 am *Virtual via Teams	<u>VASCULAR</u> Kosair Charities Board Room; 15 th Floor Frazier Rehab Institute 6:30 am – 7:30 am
---------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------

TUESDAYS

<u>GENERAL SURGERY</u> Teaching Rounds VA Hospital, SICU ~ 4 th Fl 8:00 am – 9:00 am	
<u>HAND SURGERY</u> Christine M. Kleinert Institute Hand Conference 6:30 am – 7:30 am *Virtual via Teams	
<u>PEDIATRIC SURGERY</u>	
Pediatric Surgery Residents' Conference- SCORE Topics Norton Children's Hospital ~ Varies 1:00 pm – 2:00 pm	Radiology Conference *First Tuesday of the Month (Pediatric Surgery Faculty & Radiology Staff) Norton Children's Hospital ~ Varies 12:00 pm – 1:00 pm
Pediatric Device/Other Presentations/Extra Time 3 rd Tuesday of the Month Norton Children's Hospital ~ Varies 1:00 pm – 2:00 pm	Pediatric Surgery Tumor Conference *Fourth Tuesday of the Month Norton Hospital ~ Varies 12:00 pm – 1:00 pm
Pediatric Surgery Grand Rounds *Fourth Tuesday of the Month Norton Children's Hospital ~ Varies 1:00 pm – 2:00 pm	Norton Children's– Tumor Conference *Second Tuesday of the Month Norton Hospital Auditorium 12:00 pm – 1:00 pm
Pediatric Ethics/Resident's Conference Division Retreat 5 th Tuesday of the Month Norton Children's Hospital 12:00 pm – 1:00 pm+	

THORACIC & CARDIOVASCULAR SURGERY

Case Presentations

*First Tuesday of the Month
UofL Health Heart Hospital
CTS Conference Room ~ 12th FI
5:00 pm – 6:00 pm

Journal Club

*Second Tuesday of the Month
UofL Health Heart Hospital
CTS Conference Room ~ 12th FI
5:00 pm – 6:00 pm

M & M Conference

*Third Tuesday of the Month
UofL Health Heart Hospital
CTS Conference Room ~ 12th FI
5:00 pm – 6:00 pm

Scholarly Activity / Grand Rounds

*Fourth Tuesday of the Month
UofL Health Heart Hospital
CTS Conference Room ~ 12th FI
5:00 pm – 6:00 pm

COLON / RECTAL SURGERY

Colon and Rectal Surgery Tumor Board Conference

*First and Third Tuesday of the Month
Brown Cancer Center – 4th FI Conference Room
7:00 am – 8:00 am

COLON / RECTAL SURGERY

Interesting Cases

Second Tuesday of the Month
ACB, Polk Conference Room – 2nd FI
7:00 am – 8:00 am

COLON / RECTAL SURGERY

Division QI

Fourth Tuesday Every Other Month (Alternates months with Faculty Mtg)
ACB, Polk Conference Room – 2nd FI
7:00 am – 8:00 pm

SURGICAL ONCOLOGY

Melanoma Conference

12:30-1:30 pm

***For location details, please refer to the Surgical Oncology Surgery Calendar**

WEDNESDAYS

PLASTIC SURGERY

Plastic Surgery Grand Rounds

*1st, 2nd and 4th Wednesday of the Month
ACB, JDR Memorial Library
7:00 am – 8:00 am

Plastic Surgery Conference

ACB, JDR Memorial Library
8:00 am – 9:00 am
*1st Week – Journal Review / 3rd Week - Quality
4th Week – Indications / 5th Week – Division Mtg*

Facial Trauma Conference

*Second Wednesday of the Month
ACB Auditorium ~ 7:00 am – 8:00 am

Plastic Surgery Grand Rounds

*Second Wednesday of the Month
ACB, J David Richardson, MD
Memorial Library
8:00 am – 9:00 am

THORACIC & CARDIOVASCULAR SURGERY

Pediatric Lecture: Fetal Heart Board

2nd Wednesday of the Month
Scheen Conf Cntr, Room 3, Norton Children's Hospital
4:00 pm – 5:00 pm

SURGICAL ONCOLOGY

General/UGI Tumor Board

7:00 am – 8:00 am

***For location details, please refer to the Surgical Oncology Surgery Calendar**

HPB Grand Rounds Videoconference Series

*Monthly ~ 5:00 pm- 6:00 pm

***For location details, please refer to the Surgical Oncology Surgery Calendar**

CGSO National Videoconference

*Quarterly 6:00 pm- 7:00 pm

***For location details, please refer to the Surgical Oncology Surgery Calendar**

TRAUMA/CRITICAL CARE**Trauma Multi-Disciplinary Conference**

ACB ~ Glassroom (Basement)

*Third Wednesday of the Month 7:00 am – 8:00 am

HAND SURGERY**Christine M. Kleinert Institute Hand Conference**

6:30 am – 7:30 am

***Virtual via Teams**

THURSDAYS**SURGICAL ONCOLOGY****Breast Multidisciplinary Conference**

8:00 am – 9:00 am

***For location details, please refer to the Surgical Oncology Surgery Calendar**

Sarcoma Conference

*Quarterly

***For location details, please refer to the Surgical Oncology Surgery Calendar**

Surgical Oncology Residence Conference

4:00 pm – 5:00 pm

***For location details, please refer to the Surgical Oncology Surgery Calendar**

HAND SURGERY**Christine M. Kleinert Institute Hand Conference**

6:30 am – 7:30 am

***Virtual via Teams**

SURGICAL CRITICAL CARE**Critical Care & Basic Science Surgical Conference**

*Second, Fourth & Fifth Thursday of the Month
ACB ~ JDR Memorial Library ~7:00 am – 8:00 am

Trauma Quality Improvement Conference

*First Thursday of the Month
ACB ~ Glassroom (Basement) ~7:00 am – 8:00 am

FRIDAYS**GENERAL SURGERY****Surgical Grand Rounds**

ACB ~ Auditorium (Basement)

7:00 am – 8:00 am

**Mandatory for All General Surgery Residents*

Quality Improvement Conference

ACB ~ Room 1 (Basement)

8:00 am – 9:00 am

**Mandatory for All General Surgery Residents*

Resident Teaching Conference

ACB ~ Auditorium (Basement)

9:00 am – 10:00 am

**Mandatory for All General Surgery Residents*

THORACIC & CARDIOVASCULAR SURGERY**Wet Labs**

Topics: CABG, Aortic Valve, Mitral Valve, Aortic Root
Cardiovascular Innovation Institute, 4th Floor Lab

3:00 pm – 4:00 pm

HAND SURGERY

Christine M. Kleinert Institute Hand Conference

6:30 am – 7:30 am

***Virtual via Teams**

Surgical Oncology

Fellows SCORE Review and Oral Prep

(Weekly)

Combined Journal Club

(Quarterly)

For location details, please refer to the Surgical Oncology Surgery Calendar

Department of Surgery
University of Louisville School of Medicine
Average of Cases
2018-2022

	<i>2020-2021 U of L Averages</i>	<i>2021-2022 U of L Averages</i>	<i>2022-2023 U of L Averages</i>	<i>2023-2024 U of L Averages</i>	<i>Total Average</i>	ACGME Targets
Skin and Soft Tissue/Breast	87	65	60	67	70	25/40
Head and Neck	82	85	67	75	77	25
Alimentary Tract	348	361	312	326	337	180
Abdomen	351	364	309	354	345	250
Liver	16	16	17	18	17	5
Pancreas	12	12	10	11	11	5
Vascular	156	160	152	205	168	50
Endocrine	40	40	30	34	36	15
Trauma (Operative)	67	72	51	71	65	10
Trauma (Non-Operative)	51	56	45	44	49	40
Thoracic	34	36	35	63	42	20
Pediatrics	54	55	51	58	55	20
Plastics	33	37	21	45	34	10
Laparoscopic Basic	195	202	167	187	188	100
Endoscopy	140	146	158	158	151	85
Laparoscopic Complex	162	168	150	148	157	75
<u>Case</u>						
Surgeon Chief	316	344	244	313	304	200
Teaching Assistant	48	59	45	49	50	25
Total Major Cases	1,216	1,259	1,081	1,284	1,210	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

	<u>Office</u>	<u>Fax</u>
<i>Chair, Ben A. Reid, Sr. Professor of Surgery</i>		
Kelly M. McMasters, M.D., Ph.D.	852-5447	852-1704
Robert Wood Johnson Medical School	583-8303	
mcmasters@louisville.edu		
<i>Contact Person: Pam Schmidt</i>	852-5447	

*Professor and Vice-Chair of Academic Affairs
Chair of Surgery, University of Louisville Hospital
Hiram C. Polk, Jr., M.D. Endowed Chair in Surgery
Chief of Trauma*

Brian G. Harbrecht, M.D.	852-5452	852-8915
University of Louisville		
briang.harbrecht@louisville.edu		
<i>Contact Person: Sharlene Dillander</i>	852-5452	

Colorectal Surgery

PROFESSORS:

Kelli Bullard Dunn, M.D.	681-1359	852-8915
Harvard University		
kbdunn01@louisville.edu		
<i>Contact Person: Lynn Daugherty</i>	681-1359	

*Price Endowed Professorship in Surgery
Chief, Colorectal Surgery
Program Director – Colorectal Surgery
Director – Price Institute of Surgical Research*

Susan Galandiuk, M.D.	852-4568	852-8915
Universitat Wurzburg, Germany	583-8303	
s0gala01@louisville.edu		
<i>Contact Person: Julie Watkins</i>	852-4568	

ASSOCIATE PROFESSORS:

Russell Farmer, M.D.	852-1897	852-8915
University of Texas-Houston	583-8303	
Russell.w.farmer@gmail.com		
<i>Contact Person: Debbie Davenport</i>	852-1897	

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

	<u>Office</u>	<u>Fax</u>
<u>ASSISTANT PROFESSORS:</u>		
<i>Associate Program Director – Colorectal Surgery</i>		
Sandra L. Kavalukas, M.D.	852-1897	852-8915
Pennsylvania State University	583-8303	
sandra.kavalukas@louisville.edu		
<i>Contact Person: Debbie Davenport</i>	852-1897	
 Hillary Simon, D.O.	852-1897	852-8915
Edward Via College of Osteopathic Medicine		
Virginia Campus	583-8303	
hillary.simon@louisville.edu		
<i>Contact Person: Debbie Davenport</i>	852-1897	

General Surgery

<u>PROFESSORS:</u>		
William G. Cheadle, M.D.	852-5675	852-8915
University of California – Irvine	583-8303	
wqchea01@louisville.edu		
<i>Contact Person: Brenda Dawson</i>	852-5676	
 <i>Surgical Services - VAMC</i>		
Earl Gaar, M.D.	287-6847	287-6825
University of Louisville	583-8303	
earl.gaar@med.va.gov		
<i>Contact Person: Kelli Peters</i>	287-6804	
 <i>Berel L. Abrams, M.D. Endowed Chair in Surgery</i>		
<i>Chief of Division of General Surgery</i>		
<i>Associate Program Director – Trauma and Critical Care Surgery</i>		
<i>Chief Medical Officer University of Louisville Health</i>		
Jason Smith, M.D, PhD, MBA	562-5619	852-8915
The Ohio State University	583-8303	
j0smit19@louisville.edu		
<i>Contact Person: Tiffany Gantt</i>	562-5619	

<u>ASSISTANT PROFESSORS:</u>		
Mason B. Holbrook, M.D.	852-1897	852-8915
University of Louisville	583-8303	
mbholb01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
 Samuel Pera, M.D.	852-1897	852-8915
Rush University	583-8303	
Samuel.pera@louisville.edu		
<i>Contact Person: Debbie Davenport</i>	852-1897	

Institute for Cellular Therapeutics

<i>Jewish Hospital Distinguished Chair in Transplantation Research</i>		
<i>Professor and Program Director</i>		
Suzanne T. Ildstad, M.D.	852-2080	852-2079
Mayo Medical School		
suzanne.ildstad@louisville.edu		

	<u>Office</u>	<u>Fax</u>
<u>Minimally Invasive Surgery</u>		
<u>PROFESSORS:</u>		
<i>Associate Program Director – General Surgery Residency</i>		
Farid Kehdy, M.D.	852-4140	852-8915
American University of Beirut		
fjkehd01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
<u>ASSISTANT PROFESSORS:</u>		
Elizabeth H. Bruenderman, M.D.	852-9627	852-8915
University of Louisville	583-8303	
ehbrue01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
<u>Pediatric Surgery</u>		
<u>PROFESSORS:</u>		
Sheldon Bond, M.D.	629-8630	583-9735
Medical College of Wisconsin	583-7337	
sbond01@louisville.edu		
<i>Contact Person: Lauren Wiley</i>	629-8632	
<i>Hirikati S. Nagaraj MD Endowed Chair for Pediatric Surgery</i>		
<i>Program Director - Pediatric Surgery</i>		
<i>Chief, Pediatric Surgery</i>		
Cynthia Downard, M.D.	629-8630	583-9735
Vanderbilt University		
c0down01@louisville.edu		
<i>Contact Person: Lisa Pantoja</i>	629-8630	
Mary E. Fallat, M.D.	629-8638	583-9735
Health Science Center – Syracuse	583-7337	
mefall01@louisville.edu		
<i>Contact Person: Emerson Bryne</i>	629-8638	
David S. Foley, M.D.	629-8632	583-9735
State University of New York – Buffalo	583-7337	
dsfole01@louisville.edu		
<i>Contact Person: Lauren Wiley</i>	629-8632	
<u>ASSOCIATE PROFESSOR:</u>		
<i>Associate Program Director – Pediatric Surgery</i>		
Tiffany N. Wright, M.D.	629-8630	583-9735
University of Kentucky		
tnwrig02@louisville.edu		
<i>Contact Person: Lisa Pantoja</i>	629-8630	583-9735
<u>ASSISTANT PROFESSORS:</u>		
Christie L. Buonpane, M.D.	629-8632	583-9735
Rutgers New Jersey Medical School		
Clbuon01@louisville.edu		
<i>Contact Person: Lauren Wiley</i>	629-8632	583-9735

	<u>Office</u>	<u>Fax</u>
Stewart R. Carter, M.D.	629-8632	583-9735
University of Louisville		
stewart.carter@louisville.edu		
Contact Person: Lauren Wiley	629-8632	583-9735

Plastic and Reconstructive Surgery

PROFESSORS:

Leonard J. Weiner Professorship in Plastic and Reconstructive Surgery

Chief Plastic Surgery

Program Director – Plastic and Reconstructive Surgery

Bradon J. Wilhelmi, M.D.	852-6880	852-8915
---------------------------------	----------	----------

Rush Medical College

bjwilh01@louisville.edu

Contact Person: Amory Alvey	852-6880	
-----------------------------	----------	--

ASSOCIATE PROFESSORS:

Associate Program Director – Plastic and Reconstructive Surgery

Joshua Choo, M.D.	852-6880	852-8915
--------------------------	----------	----------

Baylor College of Medicine

jhchoo01@louisville.edu

Contact Person: Amory Alvey	852-6880	
-----------------------------	----------	--

Terry McCurry, M.D.	852-6880	852-8915
----------------------------	----------	----------

University of Louisville

terrymc Curry@hotmail.com

Contact Person: Amory Alvey	852-6880	
-----------------------------	----------	--

ASSISTANT PROFESSOR:

Ryan L. Shapiro, MD	852-6880	852-8915
----------------------------	----------	----------

Wright State University

Rlshap01@louisville.edu

Contact Person: Amory Alvey	852-6880	
-----------------------------	----------	--

Dexter Weeks, MD	852-6880	852-8915
-------------------------	----------	----------

University of Louisville

dexter.weeks@louisville.edu

Contact Person: Amory Alvey	852-6880	
-----------------------------	----------	--

Surgical Oncology

PROFESSORS:

Sam and Lolita Weakley Endowed Chair in Surgical Oncology

Chief, Surgical Oncology

Robert C.G. Martin, II, M.D., Ph.D.	629-3355	629-3030
--------------------------------------------	----------	----------

University of Louisville

robert.martin@louisville.edu

Contact Person: Tracy Miller	629-3355	
------------------------------	----------	--

Chair, Ben A. Reid, Sr. Professor of Surgery

Kelly M. McMasters, M.D., Ph.D.	582-5447	852-1704
----------------------------------------	----------	----------

Robert Wood Johnson Medical School

mcmasters@louisville.edu

Contact Person: Pam Schmidt	852-5447	
-----------------------------	----------	--

	<u>Office</u>	<u>Fax</u>
<i>Vice Chair, Surgery for Operations and Finance</i>		
Charles R. Scoggins, M.D., M.B.A.	629-6950	629-3183
University of Texas		
crscog01@louisville.edu		
<i>Contact Person: Rachel Wietecha</i>	629-6950	
Gary C. Vitale, M.D.	629-2278	629-7421
Yale University	583-8303	
garyvitale@gmail.com		
<i>Contact Person: Judy Slaughter</i>	629-2278	
<u>ASSOCIATE PROFESSORS:</u>		
Nicolas Ajkay, M.D.	629-3355	629-3030
Rosario University		
nicholas.ajkay@louisville.edu		
<i>Contact Person: Tracy Miller</i>	629-3355	
Michael Egger, MD	629-6950	629-3183
Emory University		
michael.egger@louisville.edu		
<i>Contact Person: Rachel Wietecha</i>	629-6950	
<i>Kenneth F. Von Roenn, MD Family Endowed Chair in Surgical Endocrinology in the Department of Surgery</i>		
<i>Associate Program Director – General Surgery Residency</i>		
Mahsa Javid, M.D.	629-6950	629-3030
University of Cambridge Clinical School – England		
mahsa.javid@louisville.edu		
<i>Contact Person: Tracy Miller</i>	629-3355	
<i>Program Director – Surgical Oncology</i>		
Prejesh Philips, M.D.	629-6950	629-3183
Maulana Azad Medical College		
p0phil02@louisville.edu		
<i>Contact Person: Rachel Wietecha</i>	629-6950	
<u>ASSISTANT PROFESSOR:</u>		
Neal Bhutiani, M.D.	629-3355	629-3030
Johns Hopkins University School of Medicine		
Neal.bhutiani@louisville.edu		
<i>Contact Person: Tracy Miller</i>	629-3355	
<u>Transplant Surgery</u>		
<u>PROFESSORS:</u>		
<i>Dr. Hiram C. Polk, Jr and Mrs. Lily Banerjee Endowed Chair in Surgery</i>		
<i>Chief, Division of Hepatobiliary and Transplantation</i>		
<i>Program Director – Hepatobiliary and Transplant Surgery</i>		
Christopher Jones, M.D.	852-8017	852-8915
Georgetown University		
christopher.jones.1@louisville.edu		
<i>Contact Person: Lois Inlow</i>	852-8017	

	<u>Office</u>	<u>Fax</u>
<u>ASSOCIATE PROFESSORS:</u>		
<i>Surgical Director of Kidney Transplantation, Division of Transplantation</i>		
Mary Eng, M.D.	852-8017	852-8915
Rush Medical College		
mary.eng@louisville.edu		
<i>Contact Person: Lois Inlow</i>	852-8017	

<u>ASSISTANT PROFESSOR:</u>		
<i>Surgical Director of the Living Donor Program</i>		
<i>Director, Liver Transplantation</i>		
Dylan Adamson, M.D.	852-8017	852-8915
Tulane University		
dylan.adamson@louisville.edu		
<i>Contact Person: Lois Inlow</i>	852-8017	
 Yaser Al-Salmay, M.D.	 852-8017	 852-8915
Weill Cornell Medicine in Qatar		
yaser.alsalmay@louisville.edu		
<i>Contact Person: Lois Inlow</i>	852-8017	

Trauma and Critical Care Surgery

<u>PROFESSORS:</u>		
Glen A. Franklin, M.D.	852-9627	852-8915
University of Louisville	583-8303	
glen.franklin@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	

Vice-Chair of Academic Affairs
Chair of Surgery, University of Louisville Hospital
Hiram C. Polk, Jr., M.D. Endowed Chair in Surgery
Chief of Trauma

Brian G. Harbrecht, M.D.	852-5452	852-8915
University of Louisville		
brian.harbrecht@louisville.edu		
<i>Contact Person: Sharlene Dillander</i>	852-5452	

<u>ASSOCIATE PROFESSOR:</u>		
<i>Program Director – General Surgery Residency</i>		
Matthew Benns, M.D.	852-9627	852-8915
Indiana University	583-8303	
m0benn02@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
 Matthew Bozeman, M.D.	 852-9627	 852-8915
Texas Tech University	583-8303	
Mcboze01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
 Jamie Coleman, M.D.	 852-9627	 852-8915
University of Tennessee College of Medicine	583-8303	
Jicole03@louisville.edu		
<i>Contact Person: Lois Inlow</i>	852-8017	

	<u>Office</u>	<u>Fax</u>
<i>Associate Program Director – General Surgery Residency</i>		
Keith Miller, M.D.	852-9627	852-8915
Indiana University	583-8303	
krmill01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
<i>Program Director – Surgical Critical Care</i>		
Nick Nash, M.D.	852-9627	852-8915
University of Louisville	583-8303	
Nanash01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
<u>ASSISTANT PROFESSORS:</u>		
George Ryne Marshall, M.D.	852-9627	852-8915
Indiana University	583-8303	
grmars01@louisville.edu		
<i>Contact Person: Laura Lukat</i>	852-9627	
<u>Vascular Surgery and Endovascular</u>		
<u>PROFESSORS:</u>		
<i>Montgomery Endowed Professorship in Vascular Surgery</i>		
<i>Chief of Vascular Surgery and Endovascular Therapeutics</i>		
<i>Program Director – Vascular Surgery</i>		
Amit Dwivedi, M.D.	852-0864	852-8915
Mumbai University		
amit.dwivedi@louisville.edu		
<i>Contact Person: Monica Sivori</i>	852-0864	
<u>ASSOCIATE PROFESSOR:</u>		
Abindra Sigdel, M.D.	852-0864	852-8915
B.P. Koirala Institute of Health Science		
amsidg01@louisville.edu		
<i>Contact Person: Monica Sivori</i>	852-0864	
<u>ASSISTANT PROFESSORS:</u>		
Gerald “Jack” Cheadle, M.D.	852-0864	852-8915
University of Louisville		
gerald.cheadle@louisville.edu		
<i>Contact Person: Monica Sivori</i>	852-0864	
<i>Associate Program Director – Vascular Surgery</i>		
Erik Wayne, M.D.	852-0864	852-8915
University of Iowa		
eric.wayne@louisville.edu		
<i>Contact Person: Monica Sivori</i>	852-0864	

Clinical Surgical Faculty Listing

A

Allen, Jeffrey W., M.D. (*General Surgery*) (502) 899-6405

B

Bhandari, Panambur, M.D. (*General Surgery*) (502) 562-0312

Blandford, Jr., Joseph M., M.D. (*General Surgery*) (502) 366-1090

Boodry, Courtney I, M.D. (*General Surgery*) (502) 637-3311

Brown, Carter M., M.D. (*General Surgery*) (502) 637-3311

Burke, Charity S., M.D. (*Plastic Surgery*) (502) 629-4263

C

Calobrace, M. Bradley, M.D. (*Plastic & Reconstructive*) (502) 899-9979

Campbell, Michael, M.D. (*General Surgery*) (270) 843-7557

Carson, Samuel W., M.D. (*General Surgery*) (270) 683-3720

Chapman, Darren C., M.D. (*General Surgery*) (270) 326-4780

Chariker, Mark, M.D. (*Plastic & Reconstructive*) (502) 568-4800

Citak, Michael S., M.D. (*General Surgery*) (606) 451-0300

Cornell, Roy B (*General Surgery*) (270) 683-3720

D

Darnell, Robert E., M.D. (*General Surgery*) (502) 637-3311

Davis, Kathryn L., M.D. (*Vascular Surgery*) (270) 769-2568

Decker, Philip A., M.D. (*General Surgery*) (270) 683-3720

Derr, John W. Jr., M.D. (*Plastic & Reconstructive*) (502) 589-6000

Digenis, Alexander G., M.D. (*Plastic & Reconstructive*) (502) 589-5544

E F

Falcone, John L., M.D. (*General Surgery*) (270) 683-3720

G

Garmon, Joel, M.D. (*General Surgery*) (502) 366-1090

George, Salem M. Jr., M.D. (*General Surgery*) (502) 897-0635

Gerard, Robert R., M.D. (*General Surgery*) (502) 637-3311

Glaser, Christopher C., M.D. (*General Surgery*) (270) 683-3720

H

Hamman, Jack L., M.D. (*General Surgery*) (270) 326-3800

I J

Juhl, Gregory, M.D. (*General Surgery*) (502) 899-6150

K

Kasdan, Morton L., M.D. (*Plastic & Reconstructive*) (502) 852-6880

L

Larson, Gerald, M.D. (*General Surgery*) (502) 629-4242

Lusco, Vincent C. III, M.D. (*General Surgery*) (502) 366-1090

M

Maki, Alexandra, M.D. (*General Surgery*) (502) 637-3311

Maldonado, Alberto R., M.D. (*Plastic & Reconstructive*) (502) 627-1112

Mays, Chet, M.D. (*Plastic & Reconstructive*) (502) 899-9979

McMillin, Rodney, M.D. (*General Surgery*) (502) 366-1090

Moseley, Marcus D., D.O. (*General Surgery*) (270) 683-3720

Mullins, Alan P., M.D. (*General Surgery*) (270) 683-3720

Muradov, Johongir, M.D. (*General Surgery*) (270) 377-2440

N

Napolitano, Margaret, M.D. (*Hand Surgery*) (502) 561-4263

Nebel, Thomas C., D.O. (*General Surgery*) (270) 683-3720

Noel, R. Thomas, M.D. (*Plastic & Reconstructive*) (502) 895-5466

O P

O'Daniel, T. Gerald, M.D. (<i>Plastic & Reconstructive</i>)	(502) 584-1109
Olsofka, John, M.D. (<i>General Surgery</i>)	(502) 366-1090
Polk, Jr., Hiram C., M.D. (<i>General Surgery</i>)	(502) 852-1897
<u>Q R</u>	
Quillo, Amy R., M.D. (<i>General Surgery</i>)	(502) 815-7830
Rao, Mohan, M.D. (<i>General Surgery</i>)	(270) 825-7324
Raque, Jessica L, M.D. (<i>General Surgery</i>)	(270) 683-3720
Reid, Benjamin A. Jr., M.D. (<i>General Surgery</i>)	(502) 361-6070
Romines, Robert B., M.D. (<i>General Surgery</i>)	(502) 465-2821
Rosenbloom, Philip, Ph.D. (<i>General Surgery</i>)	(502) 636-0574
<u>S</u>	
Salzman, Marc J., M.D. (<i>Plastic & Reconstructive</i>)	(502) 894-9900
Schory, Thomas J., M.D. (<i>General Surgery</i>)	(502) 350-5492
Stewart, Robert, M.D. (<i>General Surgery</i>)	(502) 366-1090
Strothman, Gregory B., M.D. (<i>General Surgery</i>)	(502) 899-6470
<u>T U V</u>	
Theuer, Christopher, M.D. (<i>General Surgery</i>)	(502) 633-6062
Tuckson, Wayne, M.D. (<i>General Surgery</i>)	(502) 583-8005
Verbist, Daniel E., M.D. (<i>Plastic Surgery</i>)	((502)882-6500
<u>W</u>	
Wermeling, F. Ryan, M.D. (<i>Plastic Surgery</i>)	(270) 683-3720
Williams, Russell A., M.D. (<i>General Surgery</i>)	(502) 583-5948
<u>X Y Z</u>	

Emeritus Surgical Faculty List

Barbara M. Baker, Ph.D.
Michael B. Flynn, M.D.
R. Neal Garrison, M.D.
Diller B. Groff, M.D.
Morton L. Kasdan, M.D.
Gerald M. Larson, M.D.

Serge A. Martinez, M.D.
Michael H. McCafferty, M.D.
Hirikati S. Nagaraj, M.D.
Hiram C. Polk, Jr., M.D.
Eugene H. Shively, M.D.
Heshan Sam Zhou, M.D.

Chairs

Jewish Hospital Distinguished Chair in Transplantation Research:

Jewish Hospital Foundation established this chair along with a gift matched by the state's Research Challenge Trust Fund.

~ The chair is held by **Suzanne T. Ildstad, M.D.**

Hiram C. Polk, Jr., M.D. and Mrs. Lily Banerjee Chair in Surgery:

Established through contributions from more than 80 alumni and friends of Dr. Timir Banerjee.

~ The chair is held by **Christopher M. Jones, M.D.**

Ben A. Reid, Sr., Professor of Surgery:

Established through contributions from more than 90 friends, alumni and principle benefactor, Ben A. Reid, Sr.

~ The first occupant of the professorship is **Hiram C. Polk, Jr., M.D.**

~ The chair is held by **Kelly McMasters, M.D., Ph.D.**

Kenneth F. Von Roenn, M.D. Family Chair in Surgical Endocrinology

This chair was created through the estate of Dr. Kenneth F. Von Roenn.

~ The chair is held by **Masha Javid, M.D.**

Sam and Lolita S. Weakley Endowed Chair in Surgical Oncology:

Drs. Sam and Lolita Weakley endowed this chair to provide resources to attract a world-class cancer surgeon to the University of Louisville.

~ The chair is held by **Robert C.G. Martin, II, M.D., Ph.D.**

Leonard J. Weiner Endowed Professor and Chair in Plastic and Reconstructive Surgery:

This endowment was provided by the contributions from Plastic and Reconstructive Surgery alumni and a matching gift from Jewish Hospital Foundation.

~ The chair is held by **Bradon Wilhelmi, M.D.**

Hirikati S. Nagaraj, M.D. Professor in Surgery

This gift was provided by contributions from the Children's Hospital Foundation and Norton Healthcare, Inc.

~The chair is held by **Cynthia Downard, M.D.**

Berel L. Abrams, M.D. Chair in Surgery

This endowment was established through contributions by Kenny Abrams, the Hiram C. Polk, Jr., M.D. Department of Surgery and the University of Louisville.

~The chair is held by **Jason Smith, M.D., Ph.D.**

Hiram C. Polk Jr., M.D Chair in Surgery

This endowment was established by the Oxley Foundation in consideration of the importance of Hiram C. Polk, M.D. to the growth and success of the Department of Surgery.

~The chair is held by **Brian Harbrecht, M.D.**

Departmental Awards & Recipients

JOHN W. PRICE and WILLIAM L. BROHM MEMORIAL AWARD: A surgeon in Louisville for many years, the late John W. Price, Jr. was particularly interested in surgical education and, with his wife Barbara Thruston Atwood Price, endowed the Price Institute of Surgical Research. After Dr. Price's death, friends made gifts in his memory to the Department. Each year a resident of the Department is selected for excellence in undergraduate instruction by vote of the surgical students.

Recipients:

2016	Nathan Ludwig, M.D.	2021	Seth Hall, M.D. & Mason Holbrook, M.D.
2017	Mark Nicolas, M.D.	2022	Mohammed Ranavaya, M.D.
2018	Mark Nicolas, M.D.	2023	Matthew Peters, M.D.
2019	Joseph Sweeney, M.D.		
2020	Gianna Karsaros, 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.	2021	Neal Bhutiani, M.D.
2017	Charles Kimbrough, M.D.	2022	Elizabeth Bruenderman, M.D.
2018	Andrea "Annie" Nagengast, M.D. & Johangir Muradov, M.D.	2023	Anthony L. Grzeda, M.D. & Jessica E. Schucht, M.D.
2019	Emily Bond, M.D.		
2020	Mark Nicolas, 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.	2020	Keith R. Miller, M.D.
2017	Nicolas Ajkay, M.D.	2021	Michael Egger, M.D.
2018	Kelly M. McMasters, M.D.	2023	Prejesh Philips, M.D.
2019	Russell W. Farmer, 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.	2020	Amelia Rogers, M.D.
2017	Erin Schumer, M.D.	2021	Anthony Grzeda, M.D.
2018	Jonathan Vacek, M.D.	2022	William Risinger, M.D.
2019	Tim Dawson, M.D.	2023	Matthew R. Woeste, 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.	2019	Natalia Paez, M.D.
2017	Neal Bhutiani, M.D. Natalia Paez, M.D. Erin Schumer, M.D. & Jessica Weaver, M.D.	2020	Matt Woeste, M.D. & Jessica Schucht, M.D.
2018	Neal Bhutiani, M.D. Natalia Paez, M.D. & Jessica Weaver, M.D.	2021	Elizabeth Bruenderman, M.D. & Aaron Marshall, M.D.
		2022	Michael Carr, M.D. & Amelia (Rogers) Collings, M.D.
		2023	Amelia T. Collings, M.D. & Matthew R. Woeste, 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.	2020	Timothy Dawson, M.D.
2017	Jessica Raque, M.D.	2021	Elizabeth Bruenderman, M.D.
2018	Lindsay Arnold, M.D. & Lela Posey, M.D.	2023	Amelia T. Collings, M.D.
2019	Alexis Nickols, 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.		Nicholas Caminiti, M.D., Brittany Hegde, M.D., Amelia Rogers, M.D. & Matthew Woeste, M.D.
2017	Jessica Schucht, M.D.,		
2018	No Recipients		
2019	Michael Carr, M.D., Andrew Tumen, M.D. & Jonathan Vacek, M.D.	2022	Nicholas Caminiti, M.D., Brittany Hegde, M.D., David Keeven, M.D., William Risinger, M.D. & Chinweotuto Uma, 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.	2023	Hiley Cammock, M.D. Walter Donica, M.D. Toyokazu Endo, M.D. Alexandra Jones, M.D. William Risinger, M.D. Kyle Stephens, M.D. Chinweotuto Uma, M.D.
2021	Matthew Acton, M.D., Logan Bond, M.D.,		

MORGAN WILLIAMS AWARD: The Department of Surgery presents an annual award in memory of Morgan Williams to the junior student who demonstrates the best overall performance in surgery.

Recipients:

2017 Courtney Lattimore
2018 Lauren R. Moore
2019 Seth Hall
2020 Victoria Hammond

2021 Katherine Whitehouse

WATERMAN/ABRAMS FELLOWSHIP AWARD: Presented by Martha McCoy, M.D., in recognition of compassionate patient care.

Recipients:

2016 Lindsay Arnold, M.D. &
Andrea "Annie" Nagengast, M.D.
2017 Jessica Schucht, M.D. &
Sam Carson, M.D.
2018 Joshua Clapp, M.D. &
Lindsay Arnold, M.D.
2019 Brittany Hegde, M.D. &
Christopher Murter, M.D.
2020 Elizabeth Bruenderman, M.D. &

Christopher Murter, M.D.
2021 Amy Wise, M.D. &
Jessica Masch, M.D.
2022 Amy Wise, M.D. &
Alyssa Simpson, M.D.
2023 Dylan T. Carroll, M.D. &
Victoria R. Hammond, M.D.

Frank B. Miller, M.D. Excellence in Teaching Award: Given in recognition of Excellence in Undergraduate Instruction as Voted by Senior Students. This award was chosen from list of PGY-4 and 5 Surgical Residents

Recipients:

2016 Tathiana Fensterer, M.D.
2017 Jessica Raque, M.D.
2018 Nathan Ludwig, M.D.
2019 Nathan Ludwig, M.D.

2020 Alexis Nickols, M.D.
2021 Gerald "Jack" Cheadle, M.D.
2022 Jonathan Vacek, M.D.
2023 Jahanzeb Kaikaus, M.D.

VASCULAR SURGERY AWARD: Given in Recognition for Leadership to one Senior Resident and one Junior Resident on the Vascular Surgery Service.

Recipients:

2016 Karen Parks, M.D. &
Lindsay Arnold, M.D.
2017 Johongir Muradov, M.D.,
Christopher Murter, M.D. &
Eric Anderson, M.D.
2018 Jordan Bond, M.D. &
Christopher Murter, M.D.
2019 Christopher Murter, M.D.,
Beau Bush, M.D. &
Adam Hicks, M.D.

2020 Gerald "Jack" Cheadle, M.D. &
David Keeven, M.D.
2021 Gerald "Jack" Cheadle, M.D.
Anthony Grzeda, M.D. &
Logan Bond, M.D.
2022 Anthony Grzeda, M.D. &
Kelsey Cage, M.D.
2023 Logan M. Bond, M.D.
Jahanzeb Kaikaus, M.D.
Sellers Boudreau, M.D.

2023-2024 Publications

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

A

Abahuje E, Reddy S, Rosu C, Lin KA, Mack L, Valukas C, Shapiro M, Alam H, Halverson A, Bilimoria K, **Coleman J**, Stey AM. Relationship between residents' physiological stress and Faculty leadership skills a department of surgery. J Surg Educ. 2023 Aug;80(8):1129-1138. Epub 2023 Jun 17. PMID: 37336667.

Annam A, Alexander ES, Cahill AM, **Foley D**, Green J, Himes EA, Johnson DT, Josephs S, Kulungowski AM, Leonard JC, Nance ML, Patel S, Pezeshkmehr A, Riggle K. Society of Interventional Radiology position statement on endovascular trauma intervention in the pediatric population. J Vasc Interv Radiol. 2024 Apr 10. Online ahead of print. PMID: 38631607.

Appelbaum RD, Butler D, Stirparo JJ, **Coleman J**, Hartwell JL, Cunningham K, EAST Quality, Safety and Outcomes Committee. Eastern Association for the Surgery of Trauma (EAST) system wellness white paper: An evaluation of wellness from a systems perspective. J Trauma Acute Care Surg. 2024 Mar 5. Online ahead of print. PMID: 38439151.

Are C, Murthy SS, Sullivan R, Schissel M, Chowdhury S, Alatis O, Anaya D, Are M, Balch C, Barlett D, Brennan M, Cairncross L, Clark M, Deo SVS, Dudeja V, Ilbawi A, Jani P, Kingham TP, Lorenzon L, Leiphakpam P, Leon A, Martinez-Said H, **McMasters KM**, Meltzer DO, Mutebi M, Zafar SN, Naik V, Newman L, Oliveira AF, Park DJ, Pramesh CS, Rao S, Subramanyeshwar R, Bargallo-Rocha E, Romanoff A, Rositch AF, Rubio IT, de Castro Ribeiro HS, Sbaity E, Senthil M, Smith L, Toi M, Turaga K, Yanala U, Yip CH, Zaghloul A, Anderson BO. Global cancer surgery: Pragmatic solutions to improve cancer surgery outcomes worldwide. Lancet Oncol. 2023 Dec; 24(12):e472-e4518. Epub 2023 Nov 2. PMID: 37924819.

B

Benns MV, Gaskins JT, **Miller KR**, **Nash NA**, **Bozeman MC**, **Pera SJ**, **Marshall GR**, **Coleman JJ**, **Harbrecht BG**. Persistent long-term opioid use after trauma: Incidence and risk factors. J Trauma Acute Care Surg. 2024 Feb 1;96(2):232-239. Epub 2023 Oct 24. PMID: 37872666.

Bergus KC, Knaus ME, Onwuka AJ, Afrazi A, Breech L, Corkum KS, Dillon PA, Ehrlich PF, **Fallat ME**, Fraser JD, Gadepalli SK, Garbowski JE, Hertweck SP, Kabre R, Lal DR, Landman MP, Leys CM, Mak GZ, Markel TA, Merchant N, Overman RE, Rademacher BL, Raiji MT, Rymeski B, Sato TT, **Wright T**, Aldrink JH, Hewitt GD, Minneci PC, Deans KJ, Midwest Pediatric Surgery Consortium. Diagnostic performance of magnetic resonance imaging for pediatric ovarian neoplasms: A multi-institutional review. J Pediatr Adolesc Gynecol. 2024 Apr;37(2):192-197. Epub 2023 Nov 25. PMID: 38008283.

Boatman S, Seraphine C, Staley C, Jahansouz C, **Kavalukas S**. Different primary locations of Crohn's Disease are associated with unique microbiome profiles. J Gastrointest Surg. 2023 Aug;27(8):1727-1729. PMID: 37069459.

C

Cheadle GA, **Dwivedi AJ**, **Wayne EJ**, **Cheadle WG**, **Sidgel A**. Transcaval coil embolization of type 2 endoleak after endovascular aortic repair: An institutional review. Vasc Endovascular Surg. 2024 Jan; 58(1):47-53. Epub 2023 Jul 9. PMID: 37424087.

Clark A, Hicks AC, Cheadle G, **Wayne E**, **Dwivedi A**, **Sidgel A**. Endovascular management of a symptomatic giant hepatic artery aneurysm. Am Surg. 2023 Sep;89(9):3922-3923. PMID: 37191979.

Clements NA, Gaskins JT, **Martin 2nd RCG**. Predictive ability to comorbidity indices for surgical morbidity and mortality: A systematic review of meta-analysis. *J Gastrointest Surg*. 2023 Sep; 27(9):1971-1987. Epub 2023 Jul 10. PMID: 37430092.

Clements NA, **Philips P, Egger ME, McMasters KM, Scoggins CR, Martin 2nd RCG**. Combined pre-operative risk score predicts pancreatic leak after pancreatic resection. *Surg Endos*. 2024 Feb;38(2):742-756. Epub 2023 Dec 4. PMID: 38049669.

Coleman JJ, Robinson CK, von Hippel W, Holmes KE, Kim J, Pearson S, Lawless RA, Hubbard AE, Cohen MJ. What happens on call doesn't stay on call. The effects of in-house call on acute care surgeons' sleep and burnout: Results of the surgeon performance (SuPer) trial. *Ann Surg*. 2023 Oct 1;278(4):497-505. Epub 2023 Jun 27. PMID: 37389574.

Coleman JJ, Davis KA, Savage SA, Staudenmayer K, Coimbra R. Emergency general surgery verification: Quality improvement and the case for optimal resources and process standards. *J Trauma Acute Care Surg*. 2024 Jan 1;96(1):e1-e4. Epub 2023 Sep 6. PMID: 37678150.

Coleman JJ, Robinson CK, von Hippel W, Lawless RA, **McMasters KM**, Cohen MJ. Home is not always where the sleep is: Effect of home call on sleep, burnout, and surgeon well-being. *J Am Coll Surg*. 2024 Apr 1;238(4):417-422. Epub 2024 Mar 15. PMID: 38235790.

Collings AT, Farazi M, Arendonk KJ, **Fallat ME**, Minneci PC, Sato TT, Speck KE, Gadepalli S, Deans KJ, Falcone Jr. RA, **Foley DS**, Fraser JD, Keller MS, Kotagel M, Landman MP, Leys CM, Merkel T, Rubalcava N, St Peter SD, Flynn-O'Brien KT, Midwest Pediatric Surgery Consortium. Evaluating the regional differences in pediatric injury patterns during the COVID-19 pandemic. *J Surg Res*. 2023 Sep;289:61-68. PMID: 37086597.

D

Deeb AP, Lu L, Guyette FX, Peitzman AB, Daley BJ, Miller RS, **Harbrecht BG**, Phelan HA, Sperry JL, Brown JB. Optimal prehospital crystalloid resuscitation volume in trauma patients at risk for hemorrhagic shock. *J Am Coll Surg*. 2023 Aug 1;237(2):183-194. Epub 2023 Mar 28. PMID: 36975122.

Donohue JK, Gruen DS, Iyanna N, Lorence JM, Brown JB, Guyette FX, Daley BJ, Eastridge BJ, Miller RS, Nirula R, **Harbrecht BG**, Claridge JA, Phelan HA, Vercruysse GA, O'Keeffe T, Joseph B, Neal MD, Billiar TR, Sperry JL. *Sci Rep*. 2024 Feb 2;14(1):2747. PMID: 38302619.

E

Egger ME. Identifying high-risk stage IIIA cutaneous melanoma patients who might benefit from adjuvant therapy: The importance of micrometastatic tumor burden. *Ann Transl Med*. 2023 Aug 30;11(10):371. PMID: 37675308.

Egger ME, Feygin Y, Kong M, Poddar T, Ghosh I, Xu Q, McCabe RM, **McMasters KM, Ellis CT**. Variation in lymph node assessment for colon cancer at the tumor, surgeon and hospital level. *J Am Coll Surg*. 2024 Apr 1;238(4):520-528. Epub 2024 Mar 15. PMID: 38205923.

Egger ME, Alexander E, Van Meter T, Kong M, Maung AA, Valdes Jr. R, Hall MB, Linder MW. Corresponding ctDNA and tumor burden dynamics in metastatic melanoma patients on systemic treatment. *Transl Oncol*. 2024 Apr;42:101883. Epub 2024 Feb 2. PMID: 38306914.

Endo T, Peters MG, Hopkins CD, Slaughter MS, **Miller KR**. Management of contained penetrating cardiac injury in a patient with prior cardiac surgery. *BMJ Case Rep*. 2024 Mar 5;17(3):e257855. PMID: 38442974.

Eruchalu CN, Etheridge JC, Hammaker AC, Kader S, Abelson JS, Harvey J, Farr D, Stopenski SJ, Nahmias JT, Elsaadi A, Campbell SJ, Foote DC, Ivascu FA, Montgomery KB, Zmijewski P, Byrd SE, Kimbrough MK, Smith S, Postlewait LM, Dodwad SHM, Adams SA, Markesbery KC, Meister KM, Woeste MR, **Martin 2nd RCG**, Callahan ZM, Marks JA, Patel P, Anstadt MJ, Nasim BW, Willis RE, Patel JA, Newcomb MR, Stahl CC, Yafi MA, Sutton JM, George BC, Quillin 3rd RC, Cho NL, Cortez AR, Racial and ethnic disparities in operative experience among general surgery residents: A multi-institutional study from the US ROPE consortium. *Ann Surg*. 2024 Jan 1;279(1):172-179. Epub 2023 Mar 17. PMID: 36928294.

F

Fallat ME. Invited Commentary: A common-sense approach to improving pediatric trauma care in mixed trauma centers. *J Am Coll Surg*. 2024 Mar 1;238(3):251-253. Epub 2023 Dec 22. PMID: 38134431.

Filson A, **Martin RCG**. Infection reporting in patients undergoing irreversible electroporation of locally advanced pancreatic cancer. *J Surg Oncol*. 2023 Sep;128(4):531-539. Epub 2023 May 11. PMID: 37165984.

Fromer MW, **Scoggins CR, Egger ME, Philips P, McMasters KM, Martin II RCG**. Reply to “Current challenges in defining futile liver resection and predicting early recurrence after curative-intent treatment for colorectal liver metastases” by Wong, Geoffrey Yuet Mum et al. *Ann Surg Oncol*. 2023 Sep; 30(9):5461-5462. Epub 2023 Jun 12. PMID: 37306848.

Fromer MW, Xu Q, Shindorf ML, Mouw TJ, Kong M, Myers J, Feygin Y, Ghosh I, **Martin 2nd RCG, McMasters KM, Philips P, Scoggins CR, Ellis CT, Egger ME**. Diagnosis of pancreatic cancer after cholecystectomy in the elderly. *Am Surg*. 2024 Jan 11. Online ahead of print. PMID: 38205662.

G

Galandiuk S. Making journal more relevant than ever. *Surgery*. 2024 Feb;175(2):552-553. Epub 2023 Oct 31. PMID: 37914571.

Georgeades C, Collings AT, Farazi M, Bergner C, **Fallat ME**, Minneci PC, Speck E, Van Arendonk KJ, Deans KJ, Falcone JR RA, **Foley DS**, Fraser JD, Gadepalli SK, Keller MS, Kotagal M, Landman MP, Leys CM, Market TA, Rubalcava NS, St Peter SD, Sato TT, Flynn-Brian KT. Relationship between the COVID-19 pandemic and structural inequalities within the pediatric trauma population. *Inj Epidemiol*. 2023 Nov 28;2023 Nov 28;10(Suppl 1):62. PMID:38017506.

Glass NE, Salvi A, Wei R, Lin A, Malveau S, Cook JNB, Mann NC, Burd RS, Jenkins PC, Hansen M, Mohr NM, Stephens C, **Fallat ME**, Lerner EB, Carr BG, Wall SP, Newgard CD. Association of transport time, proximity, and emergency department pediatric readiness with pediatric survival at US Trauma Centers. 2023 Oct 1;158(10):1078-1087. PMID: 37556154.

Gonzalez R, Poenaru D, Woo R, Trappey 3rd AF, **Carter S**, Darcy D, Encisco E, Gulack B, Miniati D, Tombash E, Huang EY, Pediatric Surgery ChatGPT Collaborative Group. ChatGPT: What every pediatric surgeon should know about its potential uses and pitfalls. J Pediatr Surg. 2024 May;59(5):941-947. Epub 2024 Jan 14. PMID: 38336588.

H

Harbrecht BG, Miller KR, Egger ME, Nash NA, Doan R, Georgel J, **Franklin GA, Smith JW, Bozeman MC, Bennis MV**. A decade of analysis of unplanned extubation etiology in trauma patients including the impact of the COVID pandemic. Respir Care. 2023 Sep 26;69(1):15-23. PMID: 37751930

IJK

Johnson KN, Vacek J, **Carter S**. Applications for ultrasound in pediatric surgery. Semin Pediatr Surg. 2024 Feb;33(1):151383. Epub 2024 Jan 4. PMID: 38190770.

Jones AN, Scheurlen KM, Macleod A, **Simon HL, Galandiuk S**. Obesity and inflammatory factors in the progression of early-onset colorectal cancer. Cancers (Basel). 2024 Apr 3;16(7):1403. PMID: 38611081.

Jones JM, Agarwal A, Moorman AC, Hofmeister MG, Hulse JC, Meneveau MO, Mixon-Hayden T, Ramachandran S, **Jones CM**, Kellner S, Ferrell D, Sifri CD. Donor-derived transmission of Hepatitis A virus following kidney transplantation: Clinical course of two cases from one donor. Transplant Direct. 2023 Jul 12;9(8):e1506. PMID: 37456591.

Kaikaus J, Cheadle G, Dwivedi AJ, Sigdel A. Endovascular repair of traumatic infrarenal aortic injury in an 8-year-old. Am Surg. 2023 Sep;89(9):3879-3880. PMID: 37147572.

Kavalukas S, McClave SA. Immunonutrition vs standard nutrition for patients with cancer. Nutr Clin Pract. 2023 Aug;28(4):924-931. PMID: 36788760.

Kelley KM, Toscano N, Gestring ML, Capella J, Newton C, Bukur M, Shatz DV, Winfield RD, Fox A, **Fallat ME**, Kuhls DA, Glinik G, Doucet J, Gates J, Remick KN. Disaster planning for a surgical surge: When mass trauma threatens to overwhelm your operating rooms. Trauma Surg Acute Care Open. 2023 Nov 9;8(1):e001224. PMID: 38020853.

Klimberg VS, **McMasters KM**. Heroes and legends in surgical oncology series: Legacies and lessons. Ann Surg Oncol. 2024 Feb;31(2):720-721. Epub 2023 Nov 19. PMID: 37980707.

L

Luckhurst CM, Wiberg HM, Brown RL, Bruch SW, Chandler NM, Danielson PD, Draus JM, **Fallat ME**, Gaines BA, Haynes JH, Inaba K, Islam S, Kaminski SS, Kang HS, Madabhushi V, Murray J, Nance ML, Qureshi FG, Rubsam J, Stylianou S, Bertsimas DJ, Masiakos PT. Pediatric cervical spine injury following blunt trauma in children younger than 3 years: The PEDSPINE II study. JAMA Surg. 2023 Nov 1;158(11):1126-1132. PMID: 37703025.

M

Macleod A, Scheurlen KM, Burton JF, Parks MA, Sumy MSA, Gaskins JT, **Galandiuk S**. Systemic adiponectin levels in colorectal cancer and adenoma: A systematic review and meta-analysis. *Int J Obes (Lond)*. 2023 Oct;47(10):911-921. Epub 2023 Aug 25. PMID: 37626126.

Macleod A, Parks MA, Cook CN, Petras RE, **Galandiuk S**. Long-term behavior and functional outcomes of ileal-pouch anal anastomosis in inflammatory bowel disease with changing phenotype. *Surgery*. 2024 Mar;175(3):765-775. Epub 2023 Oct 4. PMID: 37802743.

Martin CH, **Martin RCG**. Optimal dosing and patient selection for electrochemotherapy in solid abdominal organ and bone tumors. *Bioengineering (Basel)*. 2023 Aug 18;10(8):975. PMID: 37627860.

Minneci PC, Bergus KC, Lutz C, Aldrink J, Bence C, Breech L, Dillon PA, **Downard C**, Ehrlich PF, **Fallat M**, Fraser JD, Grabowski J, Helmrath M, Hertweck PF, Hewitt G, Hirschl RB, Kabre R, Lal DR, Landman M, Leys C, Mak G, Markel T, Pressey J, Raiji M, Rymeski B, Saito J, Sato TT, St. Peter SD, Cooper J, Deans K, Midwest Pediatric Surgery Consortium. Reducing unnecessary oophorectomies for benign ovarian neoplasms in pediatric patients. *JAMA*. 2023 Oct 3;330(13):1247-1254. PMID: 37787794.

Murphy PB, **Coleman J**, Maring M, Pokrzywa C, Deshpande D, Al Tannir AH, Biesboer EA, Morris RS, Figueroa J, de Moya M. Early career acute care surgeons' priorities and perspectives: A mixed-methods analysis to better understand full-time employment. *J Trauma Acute Care Surg*. 2023 Dec 1;95(6):935-942. PMID: 37418689.

N

Newgard CD, Babcock SR, Song X, Remick KE, Gausche-Hill M, Lin A, Malveau S, Mann NC, Nathens AB, Cook Jennifer NB, Jenkins PC, Burd RS, Hewes HA, Glass NE, Jensen AR, **Fallat ME**, Ames SG, Salvi A, McConnell KJ, Ford R, Auerbach M, Bailey J, Riddick TA, Xin H, Kupperman N, Rediatric Readiness Study Group. Emergency department pediatric readiness among US Trauma Centers: A machine learning analysis of components associated with survival. *Ann Surg*. 2023 Sep 1;278(3):e580-e588. Epub 2022 Nov 1. PMID: 36538639.

OP

Parks MA, Gaskins JT, Jin A, **Galandiuk S**, **Kavalukas SL**. You want to be a surgical leader? Consider training elsewhere – An observation of how training background may impact leadership selection. *J Surg Educ*. 2024 Apr;81(4):564-569. Epub 2024 Feb 21. PMID: 38388306.

Pierce K, **Philips P**, **Egger ME**, **Scoggins CR**, **Martin 2nd RCG**. Developing sarcopenia during neoadjuvant therapy is associated with worse survival in esophageal adenocarcinoma patients. *Surgery*. 2024 Mar;175(3):718-725. Epub 2023 Oct 20. PMID: 37867097.

Polk HC. A lineage of excellence: Kirby I. Bland, M.D. *Am J Surg*. 2023 Sep; 226(3):304-305. Epub 2023 Jun 17. PMID: 37451937.

Posner MC, **McMasters KM**. Great debates in surgical oncology: An *Annals of Surgical Oncology* series. *Ann Surg Oncol*. 2023 Oct;30(11):6318. PMID: 37464137.

QR

Risinger WB, **Smith JW**. Damage control surgery in emergency general surgery: What you need to know. *J Trauma Acute Care Surg*. 2023 Nov 1;95(5):770-779. PMID: 37439768.

Risinger WB, Nickols AK, Harris AN, **Benns MV**, **Nash NA**, **Bozeman MC**, **Pera SJ**, **Coleman JJ**, **Franklin GA**, **Smith JW**, **Harbrecht BG**, **Miller KR**. Applying the antecedent, behaviour, and consequence taxonomy to unintentional firearm injury as determined by a collaborative firearm injury database. *Inj Prev*. 2024 Jan 25;30(1):39-45. PMID: 37857476.

Risinger WB, **Pera SJ**, Cage KE, **Benns MV**, **Nash NA**, **Bozeman MC**, **Coleman JJ**, **Franklin GA**, **Miller KR**, **Smith JW**, **Harbrecht BG**. Predictors of oliguria in post-traumatic acute kidney injury. *Surgery*. 2024 Mar;175(3):913-918. Epub 2023 Nov 10. PMID: 37953144.

Risinger WB, Uma CV, **Benns MV**, Ruther MH, **Nash NA**, **Bozeman MC**, **Coleman JJ**, **Smith JW**, **Harbrecht BG**, **Miller KR**. Six square miles of urban America: Association between firearm discharge, injury and fatality. *J Am Coll Surg*. 2024 Mar 5. Online ahead of print. PMID: 38441159.

Risinger WB, Dye CN, Thompson SK, Uma CV, Keeven DD, **Nash NA**, **Smith JW**, **Bozeman MC**. Distance to burn center does not impact long-term anxiety and depression risk following burn injury. *J Burn Care Res*. 2024 Apr 13. Online ahead of print. PMID: 38609181.

Risinger WB, **Smith JW**. Author reply: What do we mean by source control and what are we trying to accomplish with an open abdomen in severe complicated intra-abdominal sepsis? *J Trauma Acute Care Surg*. 2024 May 1;96(5):e40. Epub 2024 Feb 14. PMID: 38351497.

Ross SW, Campion E, Jensen AR, Gray L, Gross T, Namias N, Goodloe JM, Bulger EM, Fischer PE, **Fallat ME**. Prehospital and emergency department pediatric readiness for injured children: A statement from the American College of Surgeons Committee on Trauma Emergency Medical Services Committee. *J Trauma Acute Care Surg*. 2023 Aug 1;95(2):e6-e10. Epub 2023 May 1. PMID: 37125944.

Scheurlen KM, Parks MA, Macleod A, **Galandiuk S**. Umnet challenges in patients with Crohn's disease. *J Clin Med*. 2023 Aug 27;12(17):5595. PMID: 37685662.

Schucht JE, **Harbrecht BG**, Bond LM, Risinger WB, Matheson PJ, **Smith JW**. Plasma resuscitation improves and restores intestinal microcirculatory physiology following haemorrhagic shock. *Vox Sang*. 2023 Oct;118(10):863-872. Epub 2023 Aug 10. PMID: 37563931.

Silver DS, Sperry JL, Beiriger J, Lu L, Guyette FX, Wisniewski S, Moore EE, Schreiber M, Joseph B, Wilson CT, Cotton B, Ostermayer D, Fox EE, **Harbrecht BG**, Patel M, Brown JB. Association between emergency medical service agency volume and mortality in trauma patients. *Ann Surg*. 2024 Jan 1;279(1):160-166. Epub 2023 Aug 28. PMID: 37638408.

Sisak S, Price AD, Foote DC, Montgomery KB, Lindeman B, Cho NL, Sheu NO, Postlewait LM, Smith SR, Markesbery KC, Meister KM, Kader S, Abelson JS, Anstadt MJ, Patel PP, Marks JA, Callan ZM, Kimbrough MK, Byrd SE, Stopenski SJ, Nahmias JT, Patel JA, Wilt W, Dodwad SJM, Adams SD, Willis RE, Farr D, Harvey J, Woeste MR, **Martin RCG**, Yafi MA, Sutton JM, Cortez AR, Holm TM. A multi-institutional study from the US ROPE consortium examining factors associated with endocrine surgery exposure for general surgery residents. *Surgery*. 2024 Jan;175(1):107-113. Epub 2023 Nov 10. PMID: 37953151.

Smith JW. 2024 EAST Presidential Address: One Day. *J Trauma Acute Care Surg*. 2024 Apr 30. Online ahead of print. PMID: 38685199.

Stephens CQ, **Fallat ME**. Setting an agenda for a national pediatric trauma system: Operationalization of the Pediatric Trauma State Assessment Score. *J Trauma Acute Care Surg*. 2023 Nov 16. Online ahead of print. PMID: 37962143.

Stephens Kyle, **Philips PP**, **Egger ME**, **Scoggins CR**, **McMasters KM**, **Martin 2nd RCG**. Multi-institutional review of adverse events associated with irreversible electroporation in the treatment of locally advanced pancreatic cancer. *Surgery*. 2024 Mar;175(3):704-711. Epub 2023 Oct 16. PMID: 37852831.

TUV

Tejuoso A, George A, Johnson S, Geller AE, Kapple P, Ziegler C, **Miller K**, Choi K. Gunshot wound injury to the genitourinary tract: A 4-year retrospective review at an academic level 1 trauma center. *Transl Androl Urol*. 2024 Mar 31;13(3):406-413. Epub 2024 Mar 11. PMID: 38590963.

Tran BV, Moris D, Markovic D, Zaribafzadeh H, Henao R, Lai Q, Florman SS, Tabrizian P, Haydel B, Ruiz RM, Klintmalm GB, Lee DD, Taner CB, Hoteit M, Levine MH, Cillo U, Vitale A, Verna EC, Halazun KJ, Tevar AD, Humar A, Chapman WC, Vachharajani N, Aucejo F, Lerut J, Ciccirelli O, Nguyen MH, Melcher ML, Viveiros A, Schaefer B, Hoppe-Lotichius M, Mittler J, Nydam TL, Markmann JF, Rossi M, Mobley C, Ghobrial M, Langnas AN, Carney CA, Berumen J, Schnickel GT, Sudan DL, Hong JC, Rana A, **Jones CM**, Fishbein TM, Busuttil RW, Barbas AS, Agopian VG. Development and validation of a REcurrent Liver cAnCER Prediction Score (RELAPSE) following liver transplantation in patients with hepatocellular carcinoma: analysis of the us multicenter hcc transplant consortium. *Liver Transpl*. 2023 Jul 1;29(7):683-697. Epub 2023 Apr 10. PMID: 37029083.

Tsai AY, **Carter SR**, Greene AC. Artificial intelligence in pediatric surgery. *Semin Pediatr Surg*. 2024 Feb;33(1):151390. Epub 2024 Jan 6. PMID: 38242061.

Udoh K, Wessel C, Branch R, Mahler J, Holland J, Coleman B, Allui S, Jordan S, Ahmed A, Polzin B, Dye C, Smith K, Brown A, Gully Z, Sawning S, Ziegler C, Ruther M, Christopher 2X, **Jones CM**, **Miller K**. Evaluating the feasibility of a novel firearm injury prevention program for pre-adolescent children through health care and community-based partnerships: The *Future Healers* Program pilot study. *Am Surg*. 2024 May;90(5):10150-1058. Epub 2023 Dec 13. PMID: 38093402.

Uma CV, Risinger WB, Nath S, **Pera SJ**, **Smith JW**. Not so vats: How early is too early in the operative management of patients with traumatic hemothorax? *Am Surg*. 2024 Apr 4. Online ahead of print. PMID: 38575393.

W

West NL, Wadhwa S, Ayars C, **Philips P**, **Martin 2nd RCG**, **Scoggins CR**, **McMasters KM**, **Egger ME**. Interval sentinel lymph nodes with the use of routine lymphoscintigraphy in extremity melanoma. *J Surg Res*. 2024 Jan;293:613-617. Epub 2023 Oct 12. PMID: 37837816.

Winer LK, Kader S, Abelson JS, Hammaker AC, Eruchalu CN, Etheridge JC, Cho NL, Foote DC, Ivascu FA, Smith S, Postlewait LM, Greenwell K, Meister KM, Montgomery KB, Zmijewski P, Byrd SE, Kimbrough MK, Stopenski SJ, Nahmias JT, Harvey J, Farr D, Callahan ZM, Marks JA, Stahl CC, Al Yafi M, Sutton JM, Elsaadi A, Campbell SJ, Dodwad SM, Adams SD, Woeste MR, **Martin RCG**, Patel P, Anstadt MJ, Nasim BW, Willis RE, Patel JA, Newcomb MR, George BC, Quillin RC 3rd, Cortez AR. Disparities in the Operative Experience Between Female and Male General Surgery Residents: A Multi-Institutional Study from the US ROPE Consortium. *Ann Surg*. 2023 Jul 1;278(1):1-7. PMID: 36994704.

XYZ

Zadorozny EV, Lin HHS, Luther J, Wisniewski SR, Cotton BA, Fox EE, **Harbrecht BG**, Joseph BA, Moore EE, Ostenmayer DG, Patel MB, Schreiber MA, Tatebe LC, Todd SR, Wilson C, Gruen DS, Sperry JL, Martin-Gill C, Brown JB, Guyette FX. Prehospital time following traumatic injury is independently associated with the need for in-hospital blood and early mortality for specific injury types. *Air Med J.* 2024 Jan-Feb;43(1):47-54. Epub 2023 Nov 28. PMID: 38154840.

Zemmar A, Sinofsky A, Sheng Z, **Pera S**, **Harbrecht B**, Neimat J. Ogilvie's syndrome after paddle spinal cord stimulator implantation: An experience report. *Pain Pract.* 2023 Jul;23(6):684-688. Epub 2023 Apr 6. PMID: 36975778.

Research Facilities

Cardiovascular Innovation Institute:

The Cardiovascular Innovation Institute (CII) consists of research labs, fabrication facilities, operating rooms, recovery rooms, diagnostic equipment, training facilities, mock circulation labs, administrative offices, conference rooms, storage areas, sterile supply rooms, necropsy rooms and medical imaging areas. Led by Dr. Stuart Williams, a team of researchers at Louisville's CII have recently been awarded a grant from the National Institutes of Health (NIH) for more than \$1.25 million to study new ways of fighting diabetes and cardiovascular disease.



Interior of the Cardiovascular Institute

Price Institute of Surgical Research Laboratories:

Founded in 1957 by John W. Price, Jr., MD, the Institute strives to enhance the care of patients through advances in surgical techniques and technology and through basic and clinical research. Each of our 12 laboratories focuses on a specific field of surgical research, including digestive disease, cardiovascular biomechanics and circulatory support, reconstructive hand surgery, and traumatic injury.

Reconstructive Surgery Research Laboratories:

The Reconstructive Surgery Research Laboratories team consists of clinical and basic science faculty, research fellows, and medical students from diverse educational and training backgrounds who work together to identify clinical problems, design experimental protocols, develop animal models, perform experiments, collect/organize/evaluate and interpret data. The specific research focuses on facial and hand transplantation, ischemia/reperfusion Injury, dynamic myoplasty and microcirculation.

The Institute of Cellular Therapeutics:

Several research core facilities have been established to enhance collaborative efforts between academic programs and limit the necessity for duplication of laboratory resources, including instrumentation, personnel and research space. To date, these core facilities include: flow cytometry, specimen repository, clinical data management, and informatics. The Institute occupies the 4th floor of the Donald E. Baxter Biomedical Research Building at the University of Louisville's Health Sciences Center campus.



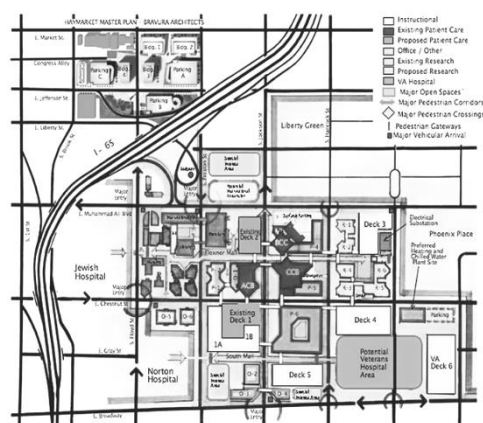
Baxter Research Buildings & U of L Research Tower

Christine M. Kleinert Institute of Hand Surgery:

The Christine M. Kleinert Institute's fellowship program is affiliated with Kleinert, Kutz, and Associates Hand Care Center. Fellows are encouraged to participate in research opportunities, which may be developed independently or with the assistance and supervision of faculty members and the research department.

Louisville Veterans Affairs Medical Center:

Dr. Smith maintains extensive research laboratories at the Louisville VAMC. There are full-time investigators, fellows, and students who assist with various surgical research projects.



The “20-Year Master Plan” for the University of Louisville’s Health Sciences Campus (above) includes new research space and buildings for patient care.

Websites

University of Louisville:	www.louisville.edu
Department of Surgery:	www.louisvillesurgery.com
<i>Website contains links to: Colon & Rectal Surgery, ERCP, Pediatric Surgery, Plastic & Reconstructive Surgery, Surgical Critical Care, Surgical Oncology & Price Institute of Surgical Research.</i>	
UofL, Department of Surgery Alumni:	www.facebook.com
ACGME:	www.acgme.org
MedHub:	www.louisville.medhub.com
Clinical Trials Information:	www.AboutMelanoma.com www.AboutBreastHealth.com www.AboutLiverTumors.com
University of Louisville Social Media	louisvillesurgery.com/residGen.html

University of Louisville & Affiliated Hospitals

University of Louisville Hospital:	(502) 562-3000	OR: (502) 562-3504
VA Medical Center:	(502) 287-4000	OR: (502) 287-6808
Norton Hospital:	(502) 629-8000	OR: (502) 629-7100
Norton Audubon	(502) 636-7111	
Norton Children's Hospital:	(502) 629-6000	OR: (502) 629-4800
Norton Women's & Children Hospital:	(502) 893-1000	OR: (502) 893-1010
UofL Health - Jewish Hospital:	(502) 587-4011	OR: (502) 587-4234
Baptist Health Madisonville	(270) 825-5100	OR: (270) 825-5115
Owensboro Health Regional Hospital	(270) 417-2000	OR: (270) 417-5500
UofL Health Mary & Elizabeth Hospital	(502) 361-6000	