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.

William Owen Roberts, M.D.
Chair, 1896-1912
Dr. Roberts performed the first successful operation on a human abdominal stab wound.

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.
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  *Special Requirement in Laparoscopy and Endoscopy (p. 83)*

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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.

Rick Pitino, the acclaimed basketball coach who led the University of Louisville team to multiple Final Four advents, and who previously led the University of Kentucky team to three Final Four appearances, two national title games, and national championships, wrote a best-selling book entitled Success Is a Choice. In the book, he drives home the point that success is not an accident, but a choice. Success is deserved and involves an uncompromising work ethic and dedication to achieving common goals as a team. The Pitino basketball playbook and the Polk Surgery Handbook have shared this common theme for a long time.

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 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 manpower 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 duty 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.)
## General Surgery Residents

### Postgraduate Year V:
- **Valerie Emuakhagbon**
  - Pager: 464-4688
  - Medical School: University of Missouri-KC
- **Tathyana Fensterer**
  - Pager: 478-0517
  - Medical School: Faculdade de Ciencias-Brazil
- **Paul Linsky**
  - Pager: 478-6023
  - Medical School: University of Alabama
- **Michael Mackowski**
  - Pager: 478-0480
  - Medical School: Chicago Medical School
- **John Majjub**
  - Pager: 478-0003
  - Medical School: Marshall University
- **Swope Munday**
  - Pager: 464-7462
  - Medical School: University of Kentucky
- **Danielle Patterson**
  - Pager: 478-0248
  - Medical School: University of Louisville
- **Benjamin Stahl**
  - Pager: 478-0114
  - Medical School: Medical College Georgia

*Administrative Chief Resident*

### Postgraduate Year IV:
- **Dylan Adamson**
  - Pager: 455-0945
  - Medical School: University of Toledo
- **Jordan Brown**
  - Pager: 478-0277
  - Medical School: Ohio State University
- **Charles Kimbrough**
  - Pager: 478-2847
  - Medical School: University of Texas-Galveston
- **Stephanie Mastrangelo**
  - Pager: 478-2574
  - Medical School: Medical College of Georgia
- **Garrett Mortensen**
  - Pager: 478-1385
  - Medical School: University of Wisconsin
- **Karen Parks**
  - Pager: 478-1522
  - Medical School: University of Alabama

### Postgraduate Year III:
- **David Albers**
  - Pager: 464-7018
  - Medical School: University of Texas-San Antonio
- **Samuel Carson**
  - Pager: 478-2945
  - Medical School: University of Texas-Houston
- **Shane Hiatt**
  - Pager: 478-0543
  - Medical School: Indiana University
- **Nathan Ludwig**
  - Pager: 478-2094
  - Medical School: University of Texas-San Antonio
- **Johongir Muradov**
  - Pager: 478-0003
  - Medical School: Second Tashkent State Medical Institute
- **Dustin Porter**
  - Pager: 478-0992
  - Medical School: Medical College of Wisconsin
- **Jo Muradov**
  - Pager: 478-0003
  - Medical School: Second Tashkent State Medical Institute
- **Andrea (Annie) Nagengast**
  - Pager: 478-1457
  - Medical School: University of Louisville
- **Jessica Raque**
  - Pager: 478-1000
  - Medical School: University of Louisville
- **Jonathan Rice**
  - Pager: 478-0482
  - Medical School: University of Texas-Galveston
### Postgraduate Year II:

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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Lindsay Arnold</td>
<td>478-2652</td>
<td>University of Tennessee</td>
</tr>
<tr>
<td>Jordan Bond</td>
<td>478-0373</td>
<td>University of Louisville</td>
</tr>
<tr>
<td>Ryan Chen</td>
<td>478-0032</td>
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<tr>
<td>Cameron Ghazi</td>
<td>478-2980</td>
<td>University of Louisville</td>
</tr>
<tr>
<td>Jeff Howard</td>
<td>478-1449</td>
<td>University of Louisville</td>
</tr>
<tr>
<td>Joanna Ohlendorf</td>
<td>478-1279</td>
<td>University of Louisville</td>
</tr>
<tr>
<td>Paul (Tripp) Palmer</td>
<td>478-0342</td>
<td>University of Texas-Houston</td>
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<tr>
<td>Lela Posey</td>
<td>478-0532</td>
<td>University of South Florida</td>
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<tr>
<td>Emily Rapstine</td>
<td>478-0217</td>
<td>University of Texas-SW</td>
</tr>
<tr>
<td>Micah Whited</td>
<td>478-1528</td>
<td>University of North Carolina</td>
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### Postgraduate Year I:

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<tr>
<td>Samantha Allen (ENT)</td>
<td>478-2521</td>
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<td>Eric Anderson</td>
<td>478-1523</td>
<td>Creighton University</td>
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<td>Beau Bush</td>
<td>478-1425</td>
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<tr>
<td>Mickey Ising</td>
<td>478-1558</td>
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<tr>
<td>Amanda Kistler</td>
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<tr>
<td>Christopher Murter</td>
<td>478-1476</td>
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<tr>
<td>Alexis Nickols</td>
<td>478-2205</td>
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<td>Mark Nicolas</td>
<td>478-0428</td>
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<tr>
<td>Ernesto Sepulveda</td>
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<td>Jonathan Vacek</td>
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<tr>
<td>Ashley Watson</td>
<td>478-2479</td>
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<tr>
<td>Thomas Fitzgibbon (GU)</td>
<td>478-0997</td>
<td>Rutgers University</td>
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<tr>
<td>Paul Knoll (GU)</td>
<td>478-0920</td>
<td>Meharry Medical College</td>
</tr>
</tbody>
</table>

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**Meghan Brakmeier**, Senior Residency Coordinator for Surgery  
Department of Surgery – Ambulatory Care Building, 2nd Floor  
Phone: 852-6191 ~ Email: meghan.brakmeier@louisville.edu

**Molly Burke-Poole**, Graduate Medical Education Administrator for Surgery  
Department of Surgery – Ambulatory Care Building, 2nd Floor  
Phone: 852-0325 ~ Email: mbpool01@louisville.edu
PLASTIC & RECONSTRUCTIVE SURGERY FELLOWS

Chief Year:
Joshua Choo
joshuachoomd@gmail.com
478-2838
Baylor College of Medicine
David Yonick
dyonick@yahoo.com
478-0494
University of Toledo

Second Year:
J. Stephen Gunn
sven182@aol.com
478-2838
University of South Alabama COM
Steven A. Schulz
sschulzdoc@yahoo.com
478-1379
Northeast Ohio University COM

First Year:
Jared Davis
Jmdavi20@louisville.edu
478-0661
Meharry Medical College
Thomas Lee
thomas.lee@louisville.edu
478-3385
University of Nevada

Sharlene Dillander, Plastic and Reconstructive Surgery Residency Coordinator
Department of Surgery – Ambulatory Care Building, 2nd Floor
Phone: 852-6880 ~ Email: srethe01@louisville.edu

COLON & RECTAL SURGERY FELLOW

Pager Medical School Fellowship Year(s)
Bogdan Protnyiak 478-1369 St. George University 2015-2016
protnyiak@gmail.com

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

Pager Medical School Fellowship Year(s)
Jorge Guzman 937-751-2365 Ohio State University 2015-2016
forskolin2002@gmail.com

Eric Stanelle 920-205-8743 University of Wisconsin 2015-2016
estanelle@gmail.com

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

<table>
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<tr>
<td>Tiffany N. Wright</td>
<td>421-4350 University of Kentucky</td>
<td>2015-2017</td>
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</table>

**Lindsey Gumer**, Pediatric Surgery Fellowship Coordinator  
Norton Healthcare Pavilion – 315 E. Broadway, Suite # 565  
Phone: 629-8630 ~ Email: lujone03@louisville.edu

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# Surgical Critical Care/Research Fellows

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<tbody>
<tr>
<td>Nicole Garcia</td>
<td>478-7231 Medical University of South Carolina</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Terry McKinney</td>
<td>478-0122 Univ of Tennessee HSC</td>
<td>2015-2016</td>
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</table>

**Machenize Sprenger**, Surgical Critical Care Fellowship Coordinator  
Department of Surgery – Ambulatory Care Building, 2nd Floor  
Phone: 852-1895 ~ Email: m.sprenger@louisville.edu

---

# Surgical Oncology Fellows

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<tr>
<td>Cathryn Anne Doughtie</td>
<td>485-5078 Texas Tech University</td>
<td>2014-2016</td>
</tr>
<tr>
<td>Jack W. Rostas, III</td>
<td>464-0300 University of South Alabama</td>
<td>2015-2017</td>
</tr>
</tbody>
</table>

**Cathy Buckley**, Surgical Oncology Fellow Coordinator  
Norton Healthcare Pavilion – 3rd Floor  
Phone: 629-3355 ~ Email: cathy.buckley@louisville.edu
“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
<table>
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<tr>
<th>University of Louisville Hospital</th>
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**Urology:**
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Knoll: Nov/Dec
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**Urology:**
FitzGibbon: Jan/Feb
Knoll: Nov/Dec
Master Schedule 2015-2016
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: Kosair Children’s Hospital, Norton & Jewish Hospitals, & University Hospital
### Division of Plastic Surgery ~ Rotation Schedule 2015-2016

<table>
<thead>
<tr>
<th></th>
<th>University</th>
<th>Hand/Univ</th>
<th>Reconstructive</th>
<th>VAMC</th>
<th>Head &amp; Neck</th>
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<td>Gunn</td>
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<td>Yonick (Elective)</td>
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**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.
- 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.
- Monday - covers the ACB for hand follow-ups.
- Tuesday - HCOC office.
- Wednesday and Thursday - OR
- Friday - covers hand cases with Dr. Sheker, Dr. Tien, or Dr. O'Daniel

**Reconstructive**
- Covers cases with Dr. McCurry or Dr. Tobin.
- Encouraged to attend office hours whenever possible.
- Thursday - allocated to pursue elective cases.

**VAMC**
- At VAMC every day.
- Wednesday - office hours all day.
- Friday - Dr. Kasdan may decide to have you break for some other unique cases.

**Head/Neck**
- Works with Dr. Little's private patients.
- Tuesday - works with Dr. Chariker.
- Friday - covers Dr. Little's office hours.

**Electives**
- Oculoplastic Surgery, Dermatology, Orthopedic Maxillofacial, Anesthesia and Elective
There are 5 major teaching hospitals through which our residents will rotate throughout their training period at the University of Louisville. These include ULH, VAMC, Norton, Kosair 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 trainee is 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 and the Program Director for the Surgical Critical Care Fellowship. Dr. Brian Harbrecht is Chief of Emergency Surgical Services. Private patients of other faculty are regularly hospitalized here. Three separate surgical services including 2 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. Earl Gaar is Chief of the Surgical Service and several attending surgeons are either part or full time there. Dr. William Cheadle is the Associate Chief of Staff for Research and Development at the VA Medical Center. The hospital has about 100 filled beds, and there are 2 resident surgical services, where a chief resident directs each service. The spectrum of disease seen is typical of any VA and includes vascular disease, cancer, hernias, complex intra-abdominal cases, and complicated wounds.
There is a busy endoscopy rotation centered at the VA where general surgery residents are staffed by surgeons with expertise in endoscopy. The surgery clinics are particularly efficient and include 2 general surgery clinics, 2 vascular clinics, and thoracic clinic. The electronic medical record is state of the art.

**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.

For description of these specialty services see below.

**Kosair Children’s Hospital**  
Ph: (502) 629-6000 / Operating Room: (502) 629-4800

The Kosair 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, together with a pediatric surgery fellow, as a chief resident on the service and is supported by 3 to 4 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 Kosair Children’s, the residents participate in a weekly scheduled residents’ 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. Mary Fallat is Surgeon-in-Chief and Director of Surgical Education at Kosair Children’s Hospital.

**Jewish 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 private general surgical service under the supervision of Dr. Michael Marvin, who is Director of the Surgical Education and Chief of Transplant at Jewish Hospital.

In addition, there will be a large experience with general thoracic and vascular surgical patients on Thoracic and Vascular Associates’ private service (directed by Drs. Bowling and Self), and one resident will be assigned to this service. Two surgical house officers also participate in the transplantation service. The hospital is home to all solid organ transplants.
Rural Surgical Experience

1) **Baptist Health Madisonville**  
   Ph: (270) 825-5100 / Operating Room: (270) 825-5115

Residents, midway through their residency training, will 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.

2) **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, cardiothoracic, 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, assistant 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, Kosair 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 by assigning the chief resident primarily to the VA and University Hospitals throughout the PGY-5 year, where he or she will be the team leader of the particular rotation. The chief residents will be responsible for supervising all in-hospital patient care and for supervising outpatient care in the clinics. The chief resident will be responsible for preparing the morbidity and mortality reports presented at the Quality Improvement Conference pertaining to their own patients, as well as determining the autopsy status on each death and the status of the transplanted organs from those patients; the latter will be done in conjunction with the transplant coordinator. The chief resident will become familiar with quality assurance issues by having a seat on the Quality Assurance Committee at University Hospital. The chief resident will develop clinical decision-making skills by interacting directly with the attending surgeon for critically ill patients and those undergoing operation. The chief resident will supervise and assist the junior residents in critical patient care, as well as in performing certain operations.
Rotation and PGY Level Specific Goals and Objectives for the Surgery Training Program

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

ELECTIVE GENERAL SURGERY SERVICE AT UL HOSPITAL

**GOALS:** To become competent in the management of surgical diseases in largely indigent patient population who are prone to obesity, malnutrition, diabetes, end stage renal disease, and late stage cancer. This will be accomplished in large part by an initial outpatient visit and formulation of a differential diagnosis, followed by appropriate laboratory and imagining workup, and finally by an elective operation and subsequent post-operative care. The general surgery residents will assume primary management of these patients.

**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 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-1 level

**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, breast, and gallbladder 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 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-2 level.
...become competent in the management of elective 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, breast, and gallbladder 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 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, 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

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.

**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, 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.
...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.

**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:** 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 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, 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

**GENERAL SURGERY AT NORTON HOSPITAL:** 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.

**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 (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

**PGY-5:** There are no PGY-5 residents on this rotation

**GENERAL SURGERY AT JEWISH HOSPITAL:** To become competent in the management of broad-based general surgery. The residents will also become competent in the management of vascular and general thoracic patients by working closely with faculty and their private patients.

**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

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 a PGY-4, PGY-3 and PGY-1 level resident. 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.

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

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-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 and laparoscopic colon 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, 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

**USA 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, and a PGY-2, and PGY-1, and attending vascular surgeons.

**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:**

**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 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-2 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, 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

**VASCULAR SURGERY AT JEWISH HOSPITAL:**

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. The PGY-2 or PGY-3 resident will gain understanding of the nature of a private vascular surgery practice. The residents will become familiar with the total management of the patient with vascular disease including catheter based and open surgical techniques. They will be responsible for all patients under the care of the vascular surgeons. This will include direct communication with the attending on a daily or more frequent basis as needed, and making daily rounds on all of these patients. The resident will serve as surgeon junior or first assistant to the attending depending on case complexity and resident experience. They will participate in the Jewish Hospital in-house call schedule.
OBJECTIVES: In the following competencies the resident should display...

**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 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-2 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 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
...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-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-3 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-3 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 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
...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

**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.

**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-3 or 4:
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 KOSAIR 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.

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-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 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-3 level.
...become competent in the management of both in-patient and outpatient pediatric 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 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 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 and more complex pediatric surgical diseases
...To become competent in the outpatient management, workup of routine elective pediatric 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

**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, 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

**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:**
**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 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-3 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

**ENDOSCOPY:**
Goals: On this rotation residents will become familiar with routine upper and lower endoscopy including esophagastroduodenoscopy (EGD), colonoscopy (including polypectomy), percutaneous endoscopic gastrostomy (PEG), and able to perform these procedures with minimal supervision independently. The residents must perform at least 50 colonoscopies and 35 upper endoscopies prior to application to the American Board of Surgery.

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

**PGY-3, 4, or 5:**
**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 management of patients requiring endoscopy for their care
...become competent in the management of both in-patient and outpatient endoscopic procedures
...To become competent in the performance of EGD, PEG, and colonoscopy

**Medical Knowledge**
...familiarity of the patho-physiologic basis of common diseases that require endoscopy for diagnosis or treatment by attending all relevant conferences, teaching, and daily bedside rounds, and completing SCORE models and ACS questions
...To become familiar with the diseases that are diagnosed and treated by endoscopic 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 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
Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Definition and Scope of the Specialty

The goal of a surgical residency program is to prepare the resident to function as a qualified practitioner of surgery at the advanced level of performance expected of a board-certified specialist. The education of surgeons in the practice of general surgery encompasses both didactic instruction in the basic and clinical sciences of surgical diseases and conditions, as well as education in procedural skills and operative techniques. The educational process must lead to the acquisition of an appropriate fund of knowledge and technical skills, the ability to integrate the acquired knowledge into the clinical situation, and the development of surgical judgment.

Int.C. Duration and Scope of Education

The length of a surgery residency program is five clinical years. (Core)*
I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.A.1. An accredited surgery program must be conducted in an institution that can document a sufficient breadth of patient care. At a minimum, the institution must routinely care for patients with a broad spectrum of surgical diseases and conditions, including all of the essential content areas in surgical education. In addition, these institutions must include facilities and staff for a variety of other services that provide a critical role in the care of patients with surgical conditions, including radiology and pathology. (Detail)

I.A.2. The program director must be provided with a minimum of 30% protected time, which may take the form of direct or indirect salary support, such as release from clinical activities provided by the institution. (Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Detail)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

I.B.3. Integrated and Non-Integrated Sites
An integrated or non-integrated site is defined as any site to which General Surgery residents rotate for an assigned experience. There are two types of institutional relationships: integrated and non-integrated.

I.B.3.a) An integrated site contributes substantially to the educational activities of the residency program.

I.B.3.a).(1) The program director must appoint the members of the teaching staff and the local program director at an integrated site. (Detail)

I.B.3.a).(2) The faculty at an integrated site must demonstrate a commitment to scholarly pursuits. (Detail)

I.B.3.a).(3) Clinical experiences in the essential content areas should be obtained in integrated sites. Exceptions will be considered on a case-by-case basis. (Detail)

I.B.3.a).(4) An integrated site should be in geographic proximity to allow all residents to attend core conferences. If the integrated site is geographically remote and joint conferences cannot be held, an equivalent educational program of lectures and conferences in the integrated site must occur and must be fully documented. Morbidity and mortality reviews must occur at each integrated site or at a combined central location. (Detail)

I.B.3.a).(5) Integration will not be approved between two sites if both have an accredited residency program in the same specialty. (Detail)

I.B.3.a).(6) Chief residents may be assigned only to participating integrated sites or to the primary clinical site/sponsoring institution. (Detail)

I.B.3.b) A participating non-integrated site should supplement resident education by providing focused clinical experience not available at the primary clinical site or at the integrated site. (Detail)

I.B.3.b).(1) Assignment to participating non-integrated sites must have a clear educational rationale. (Detail)

I.B.3.b).(2) Advance approval of the Review Committee is required for resident assignment of six months or more at a participating non-integrated site. (Detail)

I.B.3.b).(3) Advance approval of the Review Committee is not required for resident assignment of less than six months, but the educational rationale for such assignments will be evaluated at the time of each site-visit and accreditation review. (Detail)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. (Core)
II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.2.a) The program director's initial appointment should be for at least six years. (Core)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) current certification in the specialty by the American Board of Surgery, or specialty qualifications that are acceptable to the Review Committee; (Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment; (Core)

II.A.3.d) unrestricted credentials at the primary clinical site/sponsoring institution, and license to practice medicine in the state where the sponsoring institution is located; and, (Detail)

II.A.3.e) scholarly activity in at least one of the areas of scholarly activity delineated in Section II.B.5 of this document. (Detail)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. (Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for resident education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor resident supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. (Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program resident updates.
to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion; (Detail)

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, (Core) and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty; (Detail)

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; (Detail)

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

II.A.4.n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.4.n).(1) all applications for ACGME accreditation of new programs; (Detail)

II.A.4.n).(2) changes in resident complement; (Detail)

II.A.4.n).(3) major changes in program structure or length of training; (Detail)
II.A.4.n).(4) progress reports requested by the Review Committee; (Detail)

II.A.4.n).(5) responses to all proposed adverse actions; (Detail)

II.A.4.n).(6) requests for increases or any change to resident duty hours; (Detail)

II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs; (Detail)

II.A.4.n).(8) requests for appeal of an adverse action; (Detail)

II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and, (Detail)

II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches. (Detail)

II.A.4.o) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: (Detail)

II.A.4.o).(1) program citations, and/or, (Detail)

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)

II.A.4.p) devote his or her principal effort to the program. (Detail)

II.A.4.q) designate other well-qualified surgeons to assist in the supervision and education of the residents; (Detail)

II.A.4.r) be responsible for all clinical assignments and input into the teaching staff appointments at all sites; (Core)

II.A.4.s) along with the faculty, be responsible for the preparation and implementation of a comprehensive, effective, and well-organized educational curriculum; (Core)

II.A.4.t) ensure that conferences be scheduled to permit resident attendance on a regular basis, and resident time must be protected from interruption by routine clinical duties. Documentation of attendance by 75% of residents at the core conferences must be achieved; (Detail)

II.A.4.u) ensure that the following types of conferences exist within a program:

II.A.4.u).(1) a course or a structured series of lectures that ensures education in the basic and clinical sciences fundamental to surgery, including technological advances that relate to surgery and the care of patients with surgical diseases, as well as education in critical thinking, design of experiments and evaluation of data; (Detail)
II.A.4.u).(2) regular organized clinical teaching, such as grand rounds, ward rounds, and clinical conferences; (Detail)

II.A.4.u).(3) a weekly morbidity and mortality or quality improvement conference. (Core)

II.A.4.u).(3).(a) Sole reliance on textbook review is inadequate; (Core)

II.A.4.v) along with the physician faculty, assess the technical competence of each resident. (Core)

II.A.4.v).(1) The Review Committee requires that each resident perform a minimum number of certain cases for accreditation. Performance of this minimum number of cases by a resident must not be interpreted as an equivalent to competence achievement; (Detail)

II.A.4.w) ensure that each resident has at least 750 major cases across the five years of training. This must include a minimum of 150 major cases in the resident’s chief year; (Core)

II.A.4.x) ensure that residents have required experience with a variety of endoscopic procedures, including esophagastro-duodenoscopy, colonoscopy and bronchoscopy as well as experience in advanced laparoscopy; and, (Core)

II.A.4.y) ensure that residents have required experience with evolving diagnostic and therapeutic methods. (Core)

II.A.4.z) appoint an associate program director for programs with more than 20 categorical residents. (Detail)

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. (Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and, (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.1.c) for each approved chief resident position, consist of at least one full-time faculty member in addition to the program director (i.e., if there are three approved chief residents, there must be at least four fulltime faculty). The major function of these faculty is to support the program. These faculty must be appointed for a period sufficient to ensure continuity in the educational activities of the residency program; and, (Core)
II.B.2. The physician faculty must have current certification in the specialty by the American Board of Surgery, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)
II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)
II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)
II.B.5.b).(4) participation in national committees or educational organizations. (Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities. (Core)

II.B.5.d) The faculty must collectively document active involvement in scholarly activity. (Detail)

II.B.5.e) While not all members of the faculty can be investigators, clinical and/or basic science research must be:

II.B.5.e).(1) ongoing in the residency program; (Detail)
II.B.5.e).(2) based at the institution where residents spend the majority of their clinical time; and, (Detail)
II.B.5.e).(3) performed by faculty with frequent, direct resident involvement. (Detail)
II.B.5.f) Resident research is not a substitute for the involvement of the program director and faculty in research.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)
II.C.1. There must be a full-time surgery program coordinator designated specifically for surgical education. (Core)

II.C.1.a) Programs with more than 20 residents should be provided with additional administrative personnel. (Core)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core)

II.D.1. These resources must include:

II.D.1.a) a common office space for residents that includes a sufficient number of computers and adequate workspace at the primary clinical site; (Core)

II.D.1.b) internet access to appropriate full-text journals and electronic medical reference resources for education and patient care at all participating sites; (Core)

II.D.1.c) on-line radiographic and laboratory reporting systems at the primary clinical site and integrated sites; and, (Core)

II.D.1.d) software resources for production of presentations, manuscripts, and portfolios. (Core)

II.D.2. Resources must include simulation and skills laboratories. These facilities must address acquisition and maintenance of skills with a competency-based method of evaluation. (Core)

II.D.3. The institutional volume and variety of operative experience must be adequate to ensure a sufficient number and distribution of complex cases (as determined by the Review Committee) for each resident in the program. (Core)

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Programs must comply with the resident eligibility and admission prerequisites as outlined in the Institutional Requirements. (Core)

III.B. Number of Residents

The program’s educational resources must be adequate to support the number of residents appointed to the program. (Core)
III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

III.B.2. All resident positions must be approved in advance by the Review Committee. (Core)

III.B.3. Residency positions must be allocated to one of two groups: categorical or preliminary positions. (Detail)

III.B.3.a) Categorical (C) residents are accepted into the residency program with the expectation of completing the surgery program, assuming satisfactory performance. (Core)

III.B.3.a).(1) At the PG1, PG2, PG3, and PG4 levels, the number of categorical residents must not exceed the number of approved chief residency positions. (Detail)

III.B.3.b) Preliminary (P) residents are accepted into the program for one or two years before continuing their education. (Core)

III.B.3.b).(1) The number of preliminary positions in the PG1 and PG2 years combined must not exceed 300% of the number of approved categorical chief resident positions. (Detail)

III.B.3.b).(2) Documentation of continuation in graduate medical education for the preliminary residents must be provided at the time of each site visit. (Detail)

III.B.3.b).(3) It is the responsibility of the program director to counsel and assist preliminary residents in obtaining future positions. (Detail)

III.B.4. Increases in resident complement:

III.B.4.a) Both temporary and permanent increases in resident complement must be approved in advance by the Review Committee. (Core)

III.B.4.b) A sound educational rationale for an increase in complement must be submitted. Documentation of adequate clinical material and complex operative cases, as well as documentation of a quality didactic education, must also be submitted. A clearly outlined block diagram must accompany the request to illustrate the proposed clinical assignments. (Detail)

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident. (Detail)

III.C.1.a) The final two years of residency education (i.e., the PG 4 and PG 5 [chief] years) must be spent in the same program. (Core)

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion. (Detail)

III.D. Appointment of Fellows and Other Learners
The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents’ education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

III.D.2. All trainees in both ACGME-accredited and non-accredited programs in the sponsoring and integrated sites that may impact the educational experience of the surgery residents must be identified and their relationship to the surgery residents must be detailed. (Detail)

III.D.3. A chief resident and a fellow (whether the fellow is in an ACGME- accredited position or not) must not have primary responsibility for the same patient except that general surgeon and surgical critical care fellows may co-manage the non-operative care of the same patient. (Core)

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Outcome)

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)

IV.A.5.a).(2).(a) must demonstrate competence in manual dexterity appropriate for their level; and, (Outcome)
must develop competence in and execute patient care plans appropriate for the resident's level, including management of pain.  (Outcome)

**Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

(Outcome)

must demonstrate competence in the critical evaluation and demonstration of knowledge of pertinent scientific information;  
(Outcome)

must demonstrate knowledge of the fundamentals of basic science as applied to clinical surgery; and,  
(Outcome)

Residents must participate in an educational program that includes: applied surgical anatomy and surgical pathology; the elements of wound healing; homeostasis, shock and circulatory physiology; hematologic disorders; immunobiology and transplantation; oncology; surgical endocrinology; surgical nutrition, fluid and electrolyte balance; and the metabolic response to injury, including burns.  
(Core)

must demonstrate knowledge of the principles of immunology, immunosuppression, and the management of general surgical conditions arising in transplant patients.  
(Outcome)

**Practice-based Learning and Improvement**

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.  
(Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

identify strengths, deficiencies, and limits in one's knowledge and expertise;  
(Outcome)

set learning and improvement goals;  
(Outcome)

identify and perform appropriate learning activities;  
(Outcome)

systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;  
(Outcome)

incorporate formative evaluation feedback into daily practice;  
(Outcome)

locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;  
(Outcome)
IV.A.5.c).(7) use information technology to optimize learning; (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals; (Outcome)

IV.A.5.c).(9) participate in mortality and morbidity conferences that evaluate and analyze patient care outcomes; and, (Outcome)

IV.A.5.c).(10) utilize an evidence-based approach to patient care. (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable; (Outcome)

IV.A.5.d).(6) counsel and educate patients and families; and, (Outcome)

IV.A.5.d).(7) effectively document practice activities. (Outcome)

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; (Outcome)
sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; (Outcome)

high standards of ethical behavior; and, (Outcome)

a commitment to continuity of patient care. (Outcome)

**Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Residents are expected to:

1. work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)
2. coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)
3. incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)
4. advocate for quality patient care and optimal patient care systems; (Outcome)
5. work in interprofessional teams to enhance patient safety and improve patient care quality; (Outcome)
6. participate in identifying system errors and implementing potential systems solutions (Outcome)
7. practice high quality, cost effective patient care; (Outcome)
8. demonstrate knowledge of risk-benefit analysis; and, (Outcome)
9. demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management. (Outcome)

**Curriculum Organization and Resident Experiences**

Residents will participate in a program that must document a clinical curriculum that is sequential, comprehensive, and organized from basic to complex. (Core)

The clinical assignments should be carefully structured to ensure that graded levels of responsibility, continuity in patient care, a balance between education and service, and progressive clinical experiences are achieved for each resident. (Core)

The 60-month clinical program should be organized as follows: (Core)
At least 54 months of the 60-month program must be spent on clinical assignments in surgery, with documented experience in emergency care and surgical critical care in order to enable residents to manage patients with severe and complex illnesses and with major injuries. (Core)

42 months of these 54 months must be spent on clinical assignments in the essential content areas of surgery. (Core)

The essential content areas are: the abdomen and its contents; the alimentary tract; skin, soft tissues, and breast; endocrine surgery; head and neck surgery; pediatric surgery; surgical critical care; surgical oncology; trauma and non-operative trauma (burn experience that includes patient management may be counted toward non-operative trauma); and the vascular system; (Core)

A formal rotation in burn care, gynecology, neurological surgery, orthopaedic surgery, cardiac surgery, and urology is not required. Clearly documented goals and objectives must be presented if these components are included as rotations. (Detail)

Knowledge of burn physiology and initial burn management is required; (Core)

A formal transplant experience is required. It must include patient management. (Core)

Clearly documented goals and objectives must be presented for this experience; (Detail)

No more than six months total may be allocated to research or to non-surgical disciplines such as anesthesiology, internal medicine, pediatrics, or surgical pathology. (Core)

Gastroenterology is exempt from this limit if this rotation provides endoscopic experiences. (Detail)

No more than 12 months may be devoted to surgical discipline other than the principal components of surgery. (Core)

The Chief Year

Clinical assignments at the chief resident level should be scheduled in the final (5th) year of the program. (Core)

To take advantage of a unique educational opportunity in a program, up to 6 months of the chief year may be served in the next to the last year (4th). (Detail)
IV.A.6.a).(2).(f).(ii) This experience must not occur any earlier than the 4th clinical year. Any special Program of this type must be approved in advance by the Review Committee. Operative cases counted as the chief cases must be performed during the 12 months designated as the chief year. (Detail)

IV.A.6.a).(2).(f).(iii) The clinical assignments during the chief year must be scheduled at the primary clinical site or at participating integrated site(s). (Core)

IV.A.6.a).(2).(f).(iv) Clinical assignments during the chief year must be in the essential content areas of general surgery. No more than six months of the chief year may be devoted exclusively to only one essential content area. (Core)

IV.A.6.a).(2).(f).(v) Noncardiac thoracic surgery and transplantation rotations may be considered an acceptable chief resident assignment as long as the chief resident performs an appropriate number of complex cases with documented participation in pre and post-operative care (program director may use the flexibility outlined in Program Requirement IV.A.6.a).(2).(f).(i).(a)). (Detail)

IV.A.6.b) Operative Experience

IV.A.6.b).(1) The program must document that residents are performing a sufficient breadth of complex procedures to graduate qualified surgeons. (Core)

IV.A.6.b).(2) All residents (categorical and preliminary residents in ACGME-accredited positions) must enter their operative experience concurrently during each year of the residency in the ACGME case log system. (Core)

IV.A.6.b).(3) A resident may be considered the surgeon only when he or she can document a significant role in the following aspects of management: determination or confirmation of the diagnosis, provision of preoperative care, selection, and accomplishment of the appropriate operative procedure, and direction of the postoperative care. (Core)

IV.A.6.b).(4) When justified by experience, a PG 5 (chief) resident may act as a teaching assistant (TA) to a more junior resident with appropriate faculty supervision. Up to 50 cases listed by the chief resident as TA will be credited for the total requirement of 750 cases. TA cases may not count towards the 150 minimum cases needed to fulfill the operative requirements for the chief resident year. The junior resident performing the case will also be credited as surgeon for these cases. (Detail)
Each program is required to provide residents with an outpatient experience to evaluate patients both pre-operatively, including initial evaluation, and post-operatively. (Core)

At least 75% of the assignments in the essential content areas must include an outpatient experience of 1/2 day per week. (An outpatient experience is not required for assignments in the secondary components of surgery or surgical critical care). (Detail)

The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

Residents should participate in scholarly activity. (Core)

The participation of residents in clinical and/or laboratory research is encouraged. (Detail)

The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. (Detail)

The program director must appoint the Clinical Competency Committee. (Core)

At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)

There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

The Clinical Competency Committee should:

- review all resident evaluations semi-annually; (Core)
- prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)
- advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

Formative Evaluation
V.A.2.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (Detail)

V.A.2.b).(3) document progressive resident performance improvement appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each resident with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy. (Detail)

V.A.2.d) Semiannual assessment must include a review of case volume, breadth, and complexity, and must ensure that residents are entering cases concurrently. (Core)

V.A.2.e) Assessment should specifically monitor the resident's knowledge by use of a formal exam such as the American Board of Surgery In Training Examination (ABSITE) or other cognitive exams. Test results should not be the sole criterion of resident knowledge, and should not be used as the sole criterion for promotion to a subsequent PG level. (Core)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; and, (Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. (Detail)
V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. (Core)

V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). (Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.c).(1) The performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. At minimum, for the most recent five-year period, 65% of the graduates must pass each of the qualifying and certifying examinations on the first attempt. (Outcome)
V.C.2.d) program quality; and, (Core)
V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)
V.C.2.d).(2) The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program. (Detail)
V.C.2.e) progress on the previous year’s action plan(s). (Core)
V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)
V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

VI. Resident Duty Hours in the Learning and Working Environment
VI.A. Professionalism, Personal Responsibility, and Patient Safety
VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)
VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. (Core)
VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)
VI.A.4. The learning objectives of the program must:
VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, (Core)
VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations. (Core)
VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)
VI.A.6. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; (Outcome)
VI.A.6.b) provision of patient- and family-centered care; (Outcome)
VI.A.6.c) assurance of their fitness for duty; (Outcome)
VI.A.6.d) management of their time before, during, and after clinical assignments; (Outcome)

VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; (Outcome)

VI.A.6.f) attention to lifelong learning; (Outcome)

VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. (Outcome)

VI.A.7. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They 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. (Outcome)

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. (Core)

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care. (Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. (Detail)

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties. (Core)
VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care. (Core)

VI.D.1.a) This information should be available to residents, faculty members, and patients. (Detail)

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient’s care. (Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. (Core)

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care. (Detail)

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)
VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. (Core)

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. (Detail)

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. (Core)

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. (Outcome)

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. (Core)

VI.D.5.a).(1).(a) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program. (Detail)

VI.D.5.a).(1).(b) The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Detail)

VI.D.5.a).(1).(c) The program should use the template of definitions provided in the FAQ or a variation of the template to develop these definitions. (Detail)

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility. (Detail)

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. (Core)
VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)

VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. (Detail)

VI.E.3. The work of the caregiver team should be assigned to team members based on each resident’s level of education, experience, and competence. (Detail)

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. (Core)

VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)

VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)

VI.F.3. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Detail)

VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. (Core)

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

The Review Committee for General Surgery will not consider requests for exceptions to the 80-hour limit to the residents’ work week.
In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO. (Detail)

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. (Core)

Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

PGY-1 residents are not permitted to moonlight. (Core)

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

Duty periods of PGY-1 residents must not exceed 16 hours in duration. (Core)

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. (Detail)

Under those circumstances, the resident must:
appropriately hand over the care of all other patients to the team responsible for their continuing care; and, (Detail)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. (Detail)

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. (Detail)

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. (Core)

VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. (Core)

PGY-2 and PGY-3 residents are considered to be at the intermediate level.

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. (Outcome)

Residents at the PGY-4 level and beyond are considered to be in the final years of education.

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (Detail)

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float
Residents must not be scheduled for more than six consecutive nights of night float. (Core)

VI.G.6.a) Night float rotations must not exceed two months in duration, four months of night float per PGY level, and 15 months for the entire program. (Core)

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. (Detail)

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*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

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ACGME-approved: September 26, 2010 Effective: July 1, 2014
Special Requirements in Laparoscopy and Endoscopy

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

**Laparoscopy**

**Basic:**
- Cholecystectomy
- Appendectomy

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

**Endoscopy:**
- Upper endoscopy, including percutaneous endoscopic gastrostomy:
- Colonoscopy:

*60 total cases

*25 total cases

*85 total

*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 uncertainty 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
Policy for 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 also for the pursuit of higher degrees in areas such as science, public health, or business. All residents are required to submit at least two 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.
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 attendings 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 attendings 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.
Department of Surgery
University of Louisville School of Medicine

Surgical Resident Responsibilities

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

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

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

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

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

The resident will have x-rays displayed in the OR before starting his/her scrub. Surgical residents are responsible for filling out pathology sheets, writing post-op orders, and writing operative notes on the patient’s chart on each case on which they scrub. The pathology form is a request for consultation, and complete pertinent data should be provided.

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

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

IV. 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.

V. 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.
VI. 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.

VII. 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.

VIII. 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.

IX. 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.

X. 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.

XI. 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.

XII. 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.

XIII. 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.
XIV. 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.

XV. 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.

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

XVII. 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.

XVIII. 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.

XIX. 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.

XX. 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 web-site provided by the RRC for Surgery. 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 Commissions CPT code list) 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.
The Role of Surgical Residents in the Education of Medical Students

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

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

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

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

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

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

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

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

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

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

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

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

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

*Discrimination* is those behaviors, actions, interactions, and policies that have an adverse affect 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.
University of Louisville School of Medicine

Policy on 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.
University of Louisville School of Medicine

Policy Transfer of Patient Care

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 31, 2012
Department of Surgery  
University of Louisville School of Medicine

Promotion Policy

(1) Each resident will be evaluated and promoted 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.

Formal evaluations will occur at the end of each of the resident’s rotation in New Innovations. 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 shall review them on a regular basis.

(2) If at any time a resident’s performance is judged to be 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 25% 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 2 manuscripts. The form of such a project may be a review article, clinical or experimental paper, or book chapter. The manuscript must be considered suitable for submission for publication by the Department Chair or Program Director before it is submitted to a journal 6 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.
Faculty 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) bi-annually.

Numerous data points are collected (New Innovation 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 New Innovations. Residents are able to review their evaluations and their summary letter in New Innovations at their convenience.

New Innovations Residency Management Suite:

New Innovations Residency Management Suite 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, duty hours, and general personnel tracking.

The Department of Surgery requires that all surgery faculty use New Innovations to complete evaluations of surgical residents. Email evaluation notices are sent out at the end of each month (or rotation block), prompting faculty to log-in to the web-based database to complete their assigned evaluations.
Evaluations completed on New Innovations are secure as both residents and faculty must enter a unique username and password to access their evaluations.

**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 **25 percentile**. Performance below this standard will be considered **out of compliance** with department’s minimum standard.
Evaluations Completed by Residents

Each resident will be given the opportunity to complete a formal electronic evaluation (www.new-innov.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 semi-annual resident evaluation 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 New Innovations are automatically marked anonymous by the database.

**New Innovations Residency Management Suite:** New Innovations’ Residency Management Suite 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, duty hours, and general personnel tracking.

Please take time to learn how to access and electronically submit evaluation forms on the website available at www.new-innov.com.

Using New Innovations, the department requires that all residents complete:

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

The institution client login is “UL”(all caps). Permanent user-id and password may be obtained from your Residency Coordinator. Please contact your individual division coordinator for more detailed information on use.
Resident Duty Hour Policy

The policy set by the University of Louisville School of Medicine regarding duty 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 duty hours must not exceed 80 hours per week averaged over 4 weeks. Duty 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 night float responsibility.

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. Duty hours will be monitored by the resident and the program director, to ensure that duty hour limitations are not exceeded. The program has several processes to monitor resident duty hours specific to each rotation. Institutional mechanisms are in place for monitoring duty hours which include the internal review process, quarterly and monthly time studies completed by the residents on New Innovations.

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

13. PGY-1 residents should have 10 hours, and must have eight hours off for rest and personal activities between duty periods. Intermediate level residents should have 10 hours free of duty and must have eight hours between scheduled duty periods. Residents in their final years must have 8 hours free of duty between scheduled duty periods. All residents must have 14 hours off duty following a 24 hour call. Residents in the final years of education (as defined by the Review Committee) should have eight hours free of duty between scheduled duty periods, but there may be circumstances (as defined by the Review Committee) when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. This should be monitored by the Program Director.

14. Duty periods of PGY-1 residents must not exceed 16 hours duration. Resident assignments at the PGY 2 level and above 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. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. This should be justified by needed continuity of care in a critically ill patient, academic importance of an event or humanistic attention to the needs of a patient or family. The resident must hand over care of all other patients to the team responsible for continuity of care and then document the reasons for remaining. This documentation should be submitted 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 4.22.2011*
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 / Cheadle: 897-7289) for advice and counseling.

Cab Voucher Procedure

Additionally, the University of Louisville School of Medicine has instituted a “Cab Voucher System”, which is available to residents and on-call medical students, 24-hours a day. Residents who feel too fatigued to drive home can be issued a cab voucher, so they do not have to drive themselves home. A second voucher will be included for your return the next day. Policies and procedures relating to the Cab Voucher System are detailed below.

Contacts:

HSC Campus: 852-6111
Location: Abell Administration Building – 1st Fl.
Contact: Toshca Marshall (852-8939)

VA Campus: 287-6782
Location: Admissions & Evaluation Unit – Room B -165

OBTAINING A VOUCHER:
To obtain a cab voucher – residents and should call the U of L escort service (852-6111). A police officer will meet you at the security desk located in the first floor of the Abell Administration Building.

If you are at the VA, follow the same procedures, except pick the vouchers up in the Admissions & Evaluation Unit, Room B-165.

USING THE VOUCHER:
Once you have obtained the voucher, you may call yellow cab service (636-5511). Please hand them one of your vouchers. Retain the pink copy of the vouchers and place both voucher copies (pink) in the provided self-addressed/postage paid envelope and mail back to house staff council

*Please Note: Residents must have a form of ID for verification to receive a voucher! Instructions for vouchers will be included in the envelope you receive.
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 their mentor. Residents will be partnered with a faculty mentor with similar areas of interest to offer support and counseling to our residents. 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.
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 and laboratory rotations only with written consent of 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.

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
Department of Surgery
University of Louisville School of Medicine

Policy for Resident Time Off
(bereavement, maternity leave/ fraternity leave, job/fellowship interviewing, scientific meeting, etc.)

Time off in addition to regularly scheduled days off and approved vacation time may be granted at the
discretion of the Program Director or the Associate Program Director for a variety of reasons. These reasons
include bereavement, maternity leave/ fraternity leave, job/fellowship interviewing, attendance at a scientific
meeting, etc. In addition there may be other extenuating reasons that a resident would request additional time
off during the course of their training. The resident time off request form is mandatory to be filled out for this
time and leave to be approved. The form is available from the General Surgery Residency office or on New
Innovations. All important elements of this form must be completed in order for a time off request to be
approved.

It is the resident’s responsibility to arrange coverage for their duties during their absences as well as
notification of the attending physician responsible for the educational site at which they are rotating. Those
faculty include, Dr. Gaar (VA), Dr. Franklin (University), Drs. Scoggins and Martin (Oncology), Dr. Dwivedi
(Vascular), Dr. Galandiuk (Colorectal), Drs. Larson and Rodriguez (Endoscopy), Dr. Kehdy (Norton General
Surgery), Dr. Sutton (Jewish Hospital), Dr. Fallat (Kosair Children’s Hospital), and Dr. Marvin (Transplant).
Depending on the timing, the service, and the resident’s specific duties additional attendings may require
notification to ensure the smooth flow of patient care responsibilities. The resident time off request form must
be signed by the Program Director or Associate Program Director before the time off request is approved and
valid. These forms will be maintained in the Residency Coordinator’s office and the residents file as a
permanent record of time off during the residency training program.

Time off is readily granted when a resident is presenting a paper at a scientific meeting, but also needs to be
approved. Time off is typically granted for fellowship and job interviews, but this must be approved and will be
limited to 7-10 working days during the course of the year. Additional time off for interviewing may require the
use of the resident’s allotted vacation time. Extended periods of time off for medical leave and
maternity/paternity leave may also be necessary and require approval by the Program Director and
subsequent notification of the University’s GME office depending on the length of time and nature of the
request. Additional training time may be required by the American Board of Surgery. Please refer to the
Medical Leave and Maternity/Fraternity Policy for additional details.
Department of Surgery
University of Louisville School of Medicine

Leave of Absence Policy

Residents requesting a Leave of Absence must do so under the corresponding GME policy in place for that type of leave. These policies are available in the Resident Policies and Procedures Manual available online at http://louisville.edu/medschool/gme/current-residents.

Any leave of absence must be in compliance with the ACGME Program Requirements for Surgery concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program.

The leave of absence must also be in compliance with the eligibility requirements for certification by the American Board of Surgery (see below).

ABS 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. 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 problems or maternity 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.
- Unused vacation or leave time cannot be applied to reduce the amount of full-time experience required per year without prior written permission from the ABS. Such requests may only be made by the program director. Requests must be mailed on official letterhead to the ABS office (no e-mails or faxes).

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 on official letterhead to the ABS office (no e-mails or faxes).
- Use of the six-year option is solely at the program's discretion, and contingent on advance approval from the ABS. 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.

For questions regarding this policy, please contact the ABS coordinator.

Updated: March 2013

Approval Date: February 12, 2014
Residents are encouraged to submit research and manuscripts to National meetings for presentation. Residents with research accepted for presentation will be funded for travel. It is the expectation of the Department of Surgery that all travel will be approved IN ADVANCE by both the research mentor and the Office of Surgical Education (see form below). International travel MUST be applied for and approved at least 30 days in advance for reimbursement per University policy. On isolated occasions, travel may be approved for non-presentation participation in a meeting or training. Funds for reimbursement MUST be identified prior to travel for reimbursement to occur.

For information and assistance regarding travel arrangements and reimbursement, please contact the department’s accounting office:

Jacqueline Mason @ 852-1728       Lauren Bower @ 852-1511
Department of Surgery  
University of Louisville School of Medicine  

RESIDENT TIME-OFF TRAVEL REQUEST FORM  

Name: ___________________________  Date Submitted: ________________  

Dates / Times of Request: ____________________________________________  
____________________________________________________________________  
____________________________________________________________________  

Please Select the Type of Time-Off Requested:  
☐ Sick  ☐ Bereavement  ☐ Maternity/Paternity  ☐ Interviewing  ☐ Other  
☐ Meeting - please see questions below  

Name/Location of Meeting: ________________________________________________  

Are you presenting a paper?  ____ YES  ____ NO  
What is the title? ______________________________________________________  

Are you requesting reimbursement?  YES _____  NO ______  

From what source: Division ____  Department ____  Grant ____  
Private Practice Office _____  Other ____  Name of source ____________________________  

Emergency Contact Information: ____________________________  

Resident / Service Covering for You in Your Absence: ____________________________  

Resident Responsible for Covering My Duties: ____________________________  

I have discussed this with my service attending physician:  ____ YES  ____ NO  

SIGNATURE OF RESIDENT MAKING REQUEST  

Research Mentor (Research related travel only)  

APPROVED: ____________________________  
PROGRAM DIRECTOR / ASSOCIATE PROGRAM DIRECTOR  

APPROVED: ____________________________  
CHAIRMAN/VICE-CHAIRMAN FOR EDUCATION
Department of Surgery
University of Louisville School of Medicine

General Policies

I. Absences
When it is necessary for a house staff member to be absent from duty, he must inform his senior resident, his attending staff, hospital operators, and Molly Burke-Poole, Graduate Medical Education Coordinator at 852-0325.

II. Address and Phone Number Changes
It is important that Molly (852-0325) 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. Anyone experiencing sexual misconduct and/or sex discrimination has the right to obtain confidential support from the PEACC Program 852-2663, Counseling Center 852-6585 and Campus Health Services 852-6479.

Reporting your experience or incident to any other University employee (including, but not limited to, professors and instructors) is an official, non-confidential report to the University. To file an official report, please contact the Dean of Student’s Office 852-5787 and/or the University of Louisville Police Department 852-6111. For more information regarding your rights as a victim of sexual misconduct, see the Sexual Misconduct Resource Guide (http://louisville.edu/hr/employeerelations/sexual-misconduct-brochure).

**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 GroupWise email, to obtain important information about the Department and University.

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

**IX. Research Projects**
House staff members are required to engage in either clinical and 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 write at least 2 manuscripts. 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 or Program Director before it is submitted to a journal 6 months before graduation. A copy of the submitted manuscript must also be given to the Department Chair, Residency Coordinator, and Department Medical Editor. 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.

Policy for 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 also for the pursuit of higher degrees in areas such as science, public health, or business.

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 engage in 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. 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.

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 may 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.
### University of Louisville School of Medicine

**Resident Stipend Rates**

**2015-2016**

<table>
<thead>
<tr>
<th>PG Level</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>PG Level 1</td>
<td>$52,242</td>
</tr>
<tr>
<td>PG Level 2</td>
<td>$53,357</td>
</tr>
<tr>
<td>PG Level 3</td>
<td>$54,844</td>
</tr>
<tr>
<td>PG Level 4</td>
<td>$56,362</td>
</tr>
<tr>
<td>PG Level 5</td>
<td>$59,211</td>
</tr>
<tr>
<td>PG Level 6</td>
<td>$61,687</td>
</tr>
<tr>
<td>PG Level 7</td>
<td>$63,829</td>
</tr>
<tr>
<td>PG Level 8</td>
<td>$65,971</td>
</tr>
</tbody>
</table>
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 is 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

Dr. Roberta Schaffner  
Psychiatrist  
Office 852-7256

Dr. Quinn Chipley  
HSC Counselor  
Office: 852-0996

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 (Wright Natatorium: 852-0948 / Crawford Pool: 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 stickers for the Chief Residents all other PGY levels have a 1% stipend increase to cover the parking. (details at General Orientation).

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

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

6 - White coats provided for each resident by the Department of Surgery.

7 - Computers for residents are available for use at all times – located in the Resident Education Room, the Resident Conference Room, the Laparoscopic Skills Lab, the Trauma Call Room, and in all integrated hospitals.

8 - Laparoscopic Skill Trainers are available 24-hours a day for surgery residents to hone their laparoscopic techniques.

9 - The Hagan Memorial Library and the Polk Conference Room (ACB – 2nd Floor) house a collection of textbooks and journals in general surgery and its specialties. Residents are welcome to borrow these materials. The lending procedure is based on the honor system.

Travel
Any resident presenting a paper at an approved national or regional meeting may have his/her travel defrayed by the appropriate Division within the Department. The following rules and regulations regarding travel must be observed by all travelers.

1. A travel request form must be completed and submitted for approval to the Department Chairman and the Program Director. The source of funding also must be designated. This request must be submitted at least 1 month prior to date of travel (required even if reimbursement is not requested).

2. The appropriate Departmental Division will pay the following authorized travel expenses:

   a. Round trip tourist plane fare. Auto travel will be paid at 50 cents per mile not to exceed the cost of round trip tourist plane fare (mileage subject to change).

      If the traveler wishes to have the air fare paid in advance by U of L, please contact the accounting office. The University urges all travelers to be conscientious of travel costs when making their arrangements.

   b. The University requires all original receipts for travel. If a hotel room is shared with another person and the bill is in their name, the reimbursement will be made to the individual whose name is on the bill.
c. Hotel expense will be paid in full at the most economical single rate plus tax. The traveler may be required to document that the most economical single rate was secured. If sufficient documentation is not available, the traveler will be reimbursed at the most economical single room rate.

d. Meals not to exceed $30.00 per day for inside Kentucky, if it is an overnight stay, and $40.00 per day for outside Kentucky.

e. Registration fee.

f. Cab fare.

3. Reimbursement for the items listed above will be made upon submission of original receipts and/or canceled original checks which must be submitted within 30 days following completion of travel. Method of payment must be documented on receipts. If paid by check, copies of front and back of checks are required. If paid by credit card, the receipt should have at least 4 digits of credit card numbers documented. Balance of receipt should equal zero amount due.

Approximate processing time for reimbursement is 2 weeks.

** **

For information and assistance regarding travel arrangements and reimbursement, please contact the department’s accounting office:

Jacqueline Mason @ 852-1728  Lauren Bower @ 852-1511
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

PGY-1 residents who are planning to stay in the program the following year will be contacted concerning licensure by Kathy Sandman in the Graduate Medical Education office. Kathy will set up a time to meet with all PGY-1 residents to complete the licensure paperwork. Kathy can be reached at 852-3135. The licensure fee will be paid by U of L for all PGY 1’s remaining in the program. Renewal fees will be the responsibility of the resident. *When you receive your Kentucky license number, please report the number to Molly Burke-Poole at 852-0325 and/or Meghan Brakmeier at 852-6191.

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.
Mandatory conferences include Quality Improvement Conference, Grand Rounds, and Resident Teaching Conference on Fridays. Attendance at other conferences will be determined by individual rotations.

### MONDAYS

#### GENERAL SURGERY

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical ICU Rounds</td>
<td></td>
<td>7:00 am – 8:00 am</td>
</tr>
<tr>
<td>Burn Rounds</td>
<td></td>
<td>8:00 am – 8:30 am</td>
</tr>
</tbody>
</table>

#### MISCELLANEOUS

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interesting Case / M&amp;M Conference</td>
<td>Last Monday of the Month</td>
<td>4:00 pm – 5:00 pm</td>
</tr>
</tbody>
</table>

#### HAND SURGERY

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Conference</td>
<td>*First and Third Monday of the Month</td>
<td>3:00 pm – 4:00 pm</td>
</tr>
</tbody>
</table>

#### PLASTIC SURGERY

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indications Conference</td>
<td>ACB, 2nd Fl</td>
<td>1:30 pm – 2:30 pm</td>
</tr>
<tr>
<td>Anatomy Dissections</td>
<td>*First and Third Monday of the Month</td>
<td>Fresh Tissue Laboratory</td>
</tr>
<tr>
<td>Cosmetic Conference</td>
<td>*Second and Fourth Monday of the Month</td>
<td>ACB 2nd Fl</td>
</tr>
<tr>
<td>Plastic Surgery Research Conference</td>
<td>*First and Third Monday of the Month</td>
<td>ACB 2nd Fl</td>
</tr>
</tbody>
</table>

#### SURGICAL ONCOLOGY

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Multidisciplinary Conference</td>
<td>Brown Cancer Center ~ 4th Fl</td>
<td>Conference Room</td>
</tr>
<tr>
<td>Endocrine Tumor Board</td>
<td>*Second Monday of the Month</td>
<td>Norton Hospital ~ Dining Rooms A/B</td>
</tr>
</tbody>
</table>

#### COLON / RECTAL SURGERY

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon and Rectal Surgery Conference</td>
<td></td>
<td>6:30 am – 8:00 am</td>
</tr>
</tbody>
</table>

#### PEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Conference</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Surgery M&amp;M Conference</td>
<td></td>
<td>7:00 am</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Location</td>
</tr>
<tr>
<td>--------------</td>
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<tr>
<td>TUESDAY</td>
<td><strong>GENERAL SURGERY</strong></td>
<td></td>
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<tr>
<td>7:00 am – 8:00 am</td>
<td>Melanoma Conference</td>
<td>ACB ~ Glass Room (Basement)</td>
</tr>
<tr>
<td></td>
<td>General Surgery Teaching Rounds</td>
<td>VA Hospital, SICU ~ 4th Fl</td>
</tr>
<tr>
<td></td>
<td><strong>HAND SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hand Conference ~ Kleinert Kutz</td>
<td>Jewish Hospital Outpatient Care Bld. ~ 6th Fl</td>
</tr>
<tr>
<td></td>
<td>Kosair – Tumor Conference</td>
<td>Norton Hospital Auditorium</td>
</tr>
<tr>
<td></td>
<td>Kosair – Quality Improvement</td>
<td>Kosair Children’s Hospital K699</td>
</tr>
<tr>
<td></td>
<td>Pediatric Surgery Grand Rounds</td>
<td>Kosair Children’s Hospital K699</td>
</tr>
<tr>
<td></td>
<td><strong>PEDIATRIC SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td>12:00 pm – 1:00 pm</td>
<td>Radiology Conference</td>
<td>Kosair Children’s Hospital K699</td>
</tr>
<tr>
<td></td>
<td>Pediatric Surgery Tumor Conference</td>
<td>Norton Hospital ~ Dining Rooms A/B</td>
</tr>
<tr>
<td></td>
<td>Kosair – Tumor Conference</td>
<td>Norton Hospital Auditorium</td>
</tr>
<tr>
<td></td>
<td><strong>THORACIC &amp; CARDIOVASCULAR SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td>5:00 pm</td>
<td>Journal Club</td>
<td>TCVS Conference Room ~ 12th Fl</td>
</tr>
<tr>
<td></td>
<td>M &amp; M Conference</td>
<td>TCVS Conference Room ~ 12th Fl</td>
</tr>
<tr>
<td></td>
<td>MISCELLANEOUS</td>
<td></td>
</tr>
<tr>
<td>4:00 pm</td>
<td>Surgical Journal Club</td>
<td>Norton Hospital ~ Dining Rooms A/B</td>
</tr>
<tr>
<td></td>
<td><strong>SURGICAL ONCOLOGY</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgical Oncology Teaching Conference</td>
<td>Norton Hospital ~ Dining Rooms A/B</td>
</tr>
<tr>
<td></td>
<td><strong>COLON / RECTAL SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td>7:00 am – 8:00 am</td>
<td>Colon and Rectal Surgery Tumor Board Conference</td>
<td>ACB, Polk Conference Room ~ 2nd Fl</td>
</tr>
</tbody>
</table>

129
# WEDNESDAYS

## PLASTIC SURGERY

- **Aesthetic Conference**
  - *Third Wednesday of the Month*
  - Rudd Heart and Lung ~ 15th Fl, Conference Rm A
  - 7:00 am – 8:00 am

- **Reconstructive Conference**
  - *Second & Fourth Wednesday of the Month*
  - Rudd Heart and Lung ~ 15th Fl, Conference Rm A
  - 7:00 am – 8:00 am

## VASCULAR SURGERY

- **Vascular Case Conference**
  - Residents @ Jewish Hospital
  - Jewish Conference Room ~ 1st Fl
  - 7:00 am – 8:00 am

## PEDIATRIC SURGERY

- **Pediatric Surgery Student Presentations**
  - (Dr. Bond)
  - Kosair Hospital ~ Doctor’s Lounge 8th Fl
  - 8:15 am

## HAND SURGERY

- **Hand Conference ~ Kleinert Kutz**
  - Jewish Hospital Outpatient Care Building ~ 6th Fl
  - 6:30 am – 7:30 am

## SURGICAL ONCOLOGY

- **Hepatobiliary Multidisciplinary Conference**
  - *Second & Fourth Wednesday of the Month*
  - Norton Hospital ~ Dining Rooms A/B
  - 7:00 am

- **Melanoma/Sarcoma Conference**
  - *Quarterly*
  - ACB ~ Metro Conference Room
  - 7:00 am – 8:00 am

## MISCELLANEOUS

- **SSO National Videoconference**
  - *Quarterly*
  - Polk Conference Room
  - 6:00 pm – 7:00 pm

- **Tumor Board Conference**
  - (Dr. Gaar)
  - VA Hospital ~ Room D010 (Basement)
  - 4:00 pm

## TRAUMA/Critical Care

- **Trauma Multi-Disciplinary Conference**
  - *Third Wednesday of the Month*
  - ACB ~ Classroom (Basement)
  - 7:00 am – 8:00 am
### THURSDAYS

<table>
<thead>
<tr>
<th><strong>SURGICAL ONCOLOGY</strong></th>
<th><strong>HAND SURGERY</strong></th>
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<tbody>
<tr>
<td>Brown Cancer Center Multidisciplinary Breast Clinic</td>
<td>Hand Conference ~ Kleinert Kutz</td>
</tr>
<tr>
<td>Brown Cancer Center, Board Room ~ 4th Fl</td>
<td>Jewish Hospital Outpatient Care Building ~ 6th Fl</td>
</tr>
<tr>
<td>8:00 am – 9:00 am</td>
<td>KKA Conference Center</td>
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<td></td>
<td>6:30 am – 7:30 am</td>
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<table>
<thead>
<tr>
<th><strong>SURGICAL CRITICAL CARE</strong></th>
<th><strong>Trauma Quality Improvement Conference</strong></th>
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<tbody>
<tr>
<td>Critical Care &amp; Basic Science Surgical Conference</td>
<td>*First Thursday of the Month</td>
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<tr>
<td>*Second &amp; Fourth Thursday of the Month</td>
<td>ACB ~ Gymnasium (Basement)</td>
</tr>
<tr>
<td>ACB ~ Hagan Library</td>
<td>7:00 am – 8:00 am</td>
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### FRIDAYS

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<thead>
<tr>
<th><strong>GENERAL SURGERY</strong></th>
<th><strong>Hand Surgery</strong></th>
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<tr>
<td>Surgical Grand Rounds</td>
<td>Hand Conference ~ Kleinert Kutz</td>
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<tr>
<td>ACB ~ Auditorium (Basement)</td>
<td>Jewish Hospital Outpatient Care Building ~ 6th Fl</td>
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<tr>
<td>7:00 am – 8:00 am</td>
<td>KKA Conference Center</td>
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<tr>
<td>*Mandatory for General Surgery Residents</td>
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<tr>
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<th>Quality Improvement Conference</th>
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<td>Resident Teaching Conference</td>
<td>ACB ~ Room 1 (Basement)</td>
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<tr>
<td>ACB ~ Auditorium (Basement)</td>
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<tr>
<td>Jewish Hospital Outpatient Care Building ~ 6th Fl</td>
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<tr>
<td>KKA Conference Center</td>
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<td>6:30 am – 7:30 am</td>
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## Average of Cases
### 2011 to 2015

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<tr>
<td>Skin and Soft Tissue/Breast</td>
<td>67</td>
<td>105</td>
<td>121</td>
<td>114</td>
<td>98</td>
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<tr>
<td>Head and Neck</td>
<td>91</td>
<td>91</td>
<td>105</td>
<td>98</td>
<td>96</td>
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<tr>
<td>Alimentary Tract</td>
<td>266</td>
<td>275</td>
<td>314</td>
<td>320</td>
<td>285</td>
<td>72</td>
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<tr>
<td>Abdomen</td>
<td>294</td>
<td>325</td>
<td>349</td>
<td>312</td>
<td>323</td>
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<tr>
<td>Liver</td>
<td>29</td>
<td>21</td>
<td>27</td>
<td>26</td>
<td>26</td>
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<tr>
<td>Pancreas</td>
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<td>23</td>
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<td>27</td>
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<tr>
<td>Vascular</td>
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<td>173</td>
<td>197</td>
<td>106</td>
<td>183</td>
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<td>Endocrine</td>
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<td>30</td>
<td>39</td>
<td>40</td>
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<td>Trauma (Operative)</td>
<td>45</td>
<td>51</td>
<td>55</td>
<td>54</td>
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<td>Trauma (Non-Operative)</td>
<td>78</td>
<td>87</td>
<td>85</td>
<td>87</td>
<td>83</td>
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<td>Thoracic</td>
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<td>45</td>
<td>57</td>
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<td>Plastics</td>
<td>24</td>
<td>26</td>
<td>42</td>
<td>36</td>
<td>31</td>
<td>5</td>
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<tr>
<td>Laparoscopic Basic</td>
<td>132</td>
<td>150</td>
<td>168</td>
<td>164</td>
<td>150</td>
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<tr>
<td>Endoscopy</td>
<td>128</td>
<td>195</td>
<td>195</td>
<td>179</td>
<td>173</td>
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<tr>
<td>Laparoscopic Complex</td>
<td>123</td>
<td>127</td>
<td>130</td>
<td>116</td>
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<tr>
<th>CASE</th>
<th>2011-12 U of L Averages</th>
<th>2012-13 U of L Averages</th>
<th>2013-14 U of L Averages</th>
<th>2014-15 U of L Averages</th>
<th>Total Average</th>
<th>RRC Minimums</th>
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<tr>
<td>Surgeon Chief</td>
<td>203</td>
<td>184</td>
<td>223</td>
<td>222</td>
<td>202</td>
<td>150</td>
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<tr>
<td>Teaching Assistant</td>
<td>81</td>
<td>69</td>
<td>99</td>
<td>91</td>
<td>95</td>
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<tr>
<td>Total Major Cases</td>
<td>1,115</td>
<td>1,192</td>
<td>1,252</td>
<td>1,219</td>
<td>1,186</td>
<td>750</td>
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</table>
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 February of your chief year, the ABS will send instructions to your Residency Coordinator on how to submit your application and operative 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 May 1st, if they wish to be considered for the Part 1 examination (Qualifying Examination) to be given in August of that year. The qualifying exam will be given at several testing centers and are taken online at these centers. Application forms must be approved by the Program Director and Department Chair.

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 his professional maturity, surgical judgment, technical competence, and ethical standing. A candidate who has submitted an Application for Examination will be notified by the Board secretary as to his/her admissibility for examination.

***

Preparing Your Application for the American Board of Surgery Case Log & Operative Experience Requirements

The application for the American Board of Surgery (ABS) is available electronically. To begin the application process, go to [www.absurgery.org](http://www.absurgery.org).

Click the “My Records” tab, and log-in using the username and password provided to you. Next, click on “Online Applications” and “General Surgery Qualifying Examination.”

("Please make sure that you complete your on-line application in DRAFT form first for Dr. Cheadle’s review. DO NOT lock and/or make your form final until Dr. Cheadle approves it.

- **Step I**: Click “Edit Form” and complete all portions of this section which includes the Graduate Medical Education portion, i.e., your rotation experience. You will be provided with a copy of your rotations.

- **Step II**: The on-line operative experience form does not need to be completed. Do not enter anything in this section. We use the ACGME case log report instead.

- **Step III**: Print the on-line application in draft form, your ACGME defined category report, and your resident operative log for review.

- **Step IV**: Once Dr. Cheadle has approved your application and case log, you must access your on-line application and click “Make Final and Lock Form”. Then download the printer-friendly PDF file in Step I and print it for signatures. After you complete this, the box will become available for you to enter your credit card information for payment.

133
CASE LOG for ABS Application:

Defined Category Targets set by the Department of Surgery:

- SBBN +40
- HN +50
- ALTR 150
- AB 120
- Liver +10
- Pancreas +10
- Vascular 75
- Endo +25
- Trauma-Op 30-40
- Trauma-Non-Op 80-100
- Thoracic +25
- Pediatrics +75
- Plastics +10
- Lap-Basic 100
- Endoscopic +100
- Lap-Complex 70
- Total Major 1350
- Total Chief 220
- Total Teaching 100-120

*Remember that you must have the following included in your case log:
- Critical Care (managing 2 of 7 categories for each - see index below)
  - Plastic
  - Ortho
  - Hand
  - Neuro
  - OB/Gyn
  - Endovascular Diagnostic

Entering Critical Care Cases into the ACGME Case Log System:
Step I: Log into the ACGME Resident Case Log System
Step II: Click on case entry
Step III: Click on add from the procedure menu
Step IV: Next to the CPT code box, type in 99292 and then click search
Step VI: Click on area and select surgical critical care patient management
Step VII: Select one of the seven types of CC management for credit and then click on search
Step VIII: Click on select (in red on the right side of the screen)
Step X: Click the box – for credit and then save
Step XI: Be sure to enter 2 of the 7 categories available on each patient (below)

Critical Care Index:
1. Ventilatory Management
2. Bleeding (>3 units)
3. Hemodynamic Instability
4. Organ Dysfunction/Failure
5. Drhythms
6. Invasive Line Management
7. Nutrition
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. degree in Physiology over the last 2 decades under the tutelage of Drs. R. Neal Garrison and Hiram Polk, Jr. Such arrangements are best made 6 to 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.
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.
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**

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ben A. Reid, Sr. Professor and Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kelly M. McMasters, M.D., Ph.D.</td>
<td>852-5447</td>
<td>852-1704</td>
</tr>
<tr>
<td>Robert Wood Johnson Medical School</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:mcmasters@louisville.edu">mcmasters@louisville.edu</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Person: Pam Schmidt</strong></td>
<td>852-5447</td>
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**Professor and Vice-Chair-Education and Faculty Affairs**  
**Director of Emergency Surgical Services**

**Division Director of General Surgery**

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>J. David Richardson, M.D.</td>
<td>852-5452</td>
<td>852-8915</td>
</tr>
<tr>
<td>University of Kentucky</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:jdrich01@louisville.edu">jdrich01@louisville.edu</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Person: Vicky Chilton</strong></td>
<td>852-5452</td>
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**Colorectal Surgery**

**PROFESSORS:**

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<tr>
<th>Name</th>
<th>Office</th>
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<tbody>
<tr>
<td>Kelli Bullard Dunn, M.D.</td>
<td>681-1359</td>
<td>852-8915</td>
</tr>
<tr>
<td>Harvard University</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:kbdunn01@louisville.edu">kbdunn01@louisville.edu</a></td>
<td></td>
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</tr>
<tr>
<td><strong>Contact Person: Lynn Daugherty</strong></td>
<td>681-1359</td>
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**Director – Price Institute of Surgical Research**

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
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<tbody>
<tr>
<td>Susan Galandiuk, M.D.</td>
<td>852-4568</td>
<td>852-8915</td>
</tr>
<tr>
<td>Universitat Wurzburg, Germany</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:s0gala01@louisville.edu">s0gala01@louisville.edu</a></td>
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<td><strong>Contact Person: Julie Watkins</strong></td>
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<tr>
<td>Michael H. McCafferty, M.D.</td>
<td>852-1897</td>
<td>852-8915</td>
</tr>
<tr>
<td>University of Pittsburgh</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:m0mcca03@louisville.edu">m0mcca03@louisville.edu</a></td>
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<tr>
<td><strong>Contact Person: Kelly Curry</strong></td>
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**ASSISTANT PROFESSORS:**

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<tr>
<td>Peter Deveaux, M.D.</td>
<td>852-1897</td>
<td>852-8915</td>
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<tr>
<td>Rosalind Franklin University</td>
<td></td>
<td></td>
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<tr>
<td><a href="mailto:p0deve01@louisville.edu">p0deve01@louisville.edu</a></td>
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<tr>
<td>Russell Farmer, M.D.</td>
<td>852-1897</td>
<td>852-8915</td>
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<tr>
<td>University of Texas-Houston</td>
<td>583-8303</td>
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</tr>
<tr>
<td><a href="mailto:Russell.w.farmer@gmail.com">Russell.w.farmer@gmail.com</a></td>
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<tr>
<td><strong>Contact Person: Kelly Curry</strong></td>
<td>852-1897</td>
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### Communicative Disorders

#### PROFESSORS:

*Chief, Division of Communicative Disorders, Emeritus*

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
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<tbody>
<tr>
<td>David R. Cunningham, Ph.D.</td>
<td>852-5274</td>
<td>852-0865</td>
</tr>
<tr>
<td>University of Kansas</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:drcunn01@louisville.edu">drcunn01@louisville.edu</a></td>
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<tbody>
<tr>
<td>Jill E. Preminger, Ph.D.</td>
<td>852-5274</td>
<td>852-0865</td>
</tr>
<tr>
<td>University of Minnesota</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:jeprem01@louisville.edu">jeprem01@louisville.edu</a></td>
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#### ASSOCIATE PROFESSORS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Fax</th>
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<tbody>
<tr>
<td>George O. Purvis, Ph.D.</td>
<td>287-4000</td>
<td>852-0865</td>
</tr>
<tr>
<td>University of Cincinnati</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:george.purvis@med.va.gov">george.purvis@med.va.gov</a></td>
<td></td>
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#### ASSISTANT PROFESSORS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Fax</th>
</tr>
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<tbody>
<tr>
<td>Lynzee Cornell, Ph.D.</td>
<td>852-5274</td>
<td>852-0865</td>
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<tr>
<td>University of Tennessee</td>
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<tr>
<td><a href="mailto:lnalwo01@louisville.edu">lnalwo01@louisville.edu</a></td>
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<th>Name</th>
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<tr>
<td>M. Gay Masters, Ph.D.</td>
<td>852-5274</td>
<td>852-0865</td>
</tr>
<tr>
<td>State University of New York – Buffalo</td>
<td>583-8303</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:mgmast01@louisville.edu">mgmast01@louisville.edu</a></td>
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<td>Rhonda Mattingly, Ed.D.</td>
<td>852-5274</td>
<td>852-0865</td>
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<tr>
<td>University of Louisville</td>
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<tr>
<td><a href="mailto:rrmatt02@louisville.edu">rrmatt02@louisville.edu</a></td>
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<tr>
<td>Jeffrey Weihing, Ph.D.</td>
<td>852-5274</td>
<td>852-0865</td>
</tr>
<tr>
<td>University of Connecticut</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:jaweih02@louisville.edu">jaweih02@louisville.edu</a></td>
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#### LECTURER:

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<thead>
<tr>
<th>Name</th>
<th>Office</th>
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<tr>
<td>Alan Smith, Ph.D.</td>
<td>852-3970</td>
<td>852-0865</td>
</tr>
<tr>
<td>Clayton College</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:afsmith01@louisville.edu">afsmith01@louisville.edu</a></td>
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<th>Name</th>
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<tr>
<td>Barbara Eisenmenger, Au.D.</td>
<td>852-5274</td>
<td>852-0865</td>
</tr>
<tr>
<td>University of Louisville</td>
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</tr>
<tr>
<td><a href="mailto:baeise01@louisville.edu">baeise01@louisville.edu</a></td>
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<td></td>
</tr>
</tbody>
</table>
**General Surgery**  
**PROFESSORS:**
Associate Chief of Staff for Research and Development – VAMC
Program Director – General Surgery Residency
William G. Cheadle, M.D.  
University of California – Irvine  
wgcchea01@louisville.edu  
*Contact Person: Tracy Kern*  
852-5675  
852-8915  

Chief of Surgical Services – VAMC
Edwin Earl Gaar, M.D.  
University of Louisville  
earl.gaar@med.va.gov  
*Contact Person: Kelli Peters*  
287-6247  
287-6825  

R. Neal Garrison, M.D.  
Emory University  
rngarr01@louisville.edu  
*Contact Person: Brenda Dawson*  
852-5676  

Gerald M. Larson, M.D.  
University of Minnesota  
gmlars01@louisville.edu  
*Contact Person: Tracy Kern*  
852-5675  

Gary C. Vitale, M.D.  
Yale University  
garyvitale@gmail.com  
*Contact Person: Judy Slaughter*  
629-2278  
629-7421  

**ASSOCIATE PROFESSOR:**
Baochun Zhang, Ph.D.  
Beijing Medical School  
b0zhan03@louisville.edu  

**ASSISTANT PROFESSOR:**
Michael Bahr, M.D.  
University of Tennessee College of Medicine  
Mhbahr02@louisville.edu  
*Contact Person: Judy Slaughter*  
629-2278  
629-7421  

**Institute for Cellular Therapeutics**  
Jewish Hospital Distinguished Chair in Transplantation Research  
Professor and Director
Suzanne T. Ildstad, M.D.  
Mayo Medical School  
suzanne.ildstad@louisville.edu  
*Contact Person: Carolyn DeLautre*  
852-2080  
852-2079  

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
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<td>William G. Cheadle, M.D.</td>
<td>852-5675</td>
<td>852-8915</td>
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<tr>
<td>Edwin Earl Gaar, M.D.</td>
<td>287-6247</td>
<td>287-6825</td>
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<tr>
<td>R. Neal Garrison, M.D.</td>
<td>852-5676</td>
<td>852-8915</td>
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<tr>
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<td>Gary C. Vitale, M.D.</td>
<td>629-2278</td>
<td>629-7421</td>
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<tr>
<td>Michael Bahr, M.D.</td>
<td>629-2278</td>
<td>629-7421</td>
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<tr>
<td>Suzanne T. Ildstad, M.D.</td>
<td>852-2080</td>
<td>852-2079</td>
</tr>
<tr>
<td>Minimally Invasive Surgery</td>
<td>Office</td>
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<td><strong>ASSOCIATE PROFESSORS:</strong></td>
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<tr>
<td>Farid Kehdy, M.D.</td>
<td>852-5676</td>
<td>852-8915</td>
</tr>
<tr>
<td>American University of Beirut</td>
<td></td>
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</tr>
<tr>
<td><a href="mailto:fjkehdy01@louisville.edu">fjkehdy01@louisville.edu</a></td>
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<tr>
<td><em>Contact Person: Judy Slaughter</em></td>
<td>629-2278</td>
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<tr>
<td><strong>ASSISTANT PROFESSORS:</strong></td>
<td></td>
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<tr>
<td>Erica Sutton, M.D.</td>
<td>852-5676</td>
<td>852-8915</td>
</tr>
<tr>
<td>Johns Hopkins University School of Medicine</td>
<td></td>
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</tr>
<tr>
<td><a href="mailto:erica.sutton@gmail.com">erica.sutton@gmail.com</a></td>
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<tr>
<td><em>Contact Person: Brenda Dawson</em></td>
<td>852-5676</td>
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<td><strong>Pediatric Surgery</strong></td>
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<td><strong>PROFESSORS:</strong></td>
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<tr>
<td>Sheldon Bond, M.D.</td>
<td>629-8630</td>
<td>583-9735</td>
</tr>
<tr>
<td>Medical College of Wisconsin</td>
<td>583-7337</td>
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</tr>
<tr>
<td><a href="mailto:sjbond01@louisville.edu">sjbond01@louisville.edu</a></td>
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<tr>
<td><em>Contact Person: Lindsey Gumer</em></td>
<td>629-8630</td>
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<tr>
<td><strong>Director of Pediatric Surgery</strong></td>
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<tr>
<td>Mary E. Fallat, M.D.</td>
<td>629-8638</td>
<td>583-9735</td>
</tr>
<tr>
<td>Health Science Center – Syracuse</td>
<td>583-7337</td>
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<tr>
<td><a href="mailto:mefall01@louisville.edu">mefall01@louisville.edu</a></td>
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<tr>
<td><em>Contact Person: Becky Parr</em></td>
<td>629-8638</td>
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<tr>
<td><strong>Professor Emeritus</strong></td>
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<tr>
<td>Diller B. Groff, M.D.</td>
<td>629-8630</td>
<td>583-9735</td>
</tr>
<tr>
<td>Duke University</td>
<td>583-7337</td>
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<tr>
<td><a href="mailto:dbgrof01@louisville.edu">dbgrof01@louisville.edu</a></td>
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<tr>
<td><em>Contact Person: Becky Parr</em></td>
<td>629-8638</td>
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<td><strong>ASSOCIATE PROFESSORS:</strong></td>
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<tr>
<td>Cynthia Downard, M.D.</td>
<td>629-8630</td>
<td>583-9735</td>
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<tr>
<td>Vanderbilt University</td>
<td>583-7337</td>
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<tr>
<td><a href="mailto:c0down01@louisville.edu">c0down01@louisville.edu</a></td>
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<tr>
<td><em>Contact Person: Lindsey Gumer</em></td>
<td>629-8630</td>
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<td><strong>ASSISTANT PROFESSORS:</strong></td>
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<tr>
<td>Paul Matheson, Ph.D.</td>
<td>287-5247</td>
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<tr>
<td>University of Louisville</td>
<td>583-7337</td>
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<tr>
<td><a href="mailto:pjmath01@louisville.edu">pjmath01@louisville.edu</a></td>
<td></td>
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<tr>
<td>Chad Wiesenauer, M.D.</td>
<td>629-8630</td>
<td>583-9735</td>
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<tr>
<td>Indiana University</td>
<td>583-7337</td>
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<tr>
<td><a href="mailto:cawies01@louisville.edu">cawies01@louisville.edu</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Contact Person: Lauren Wiley</em></td>
<td>629-8632</td>
<td></td>
</tr>
</tbody>
</table>
Zaria Murrell, M.D.
University of Maryland
zaria.murrell@louisville.edu
  Contact Person: Lindsey Gumer
Office  Fax
629-8630  583-9735

Plastic and Reconstructive Surgery

PROFESSORS:
Gordon R. Tobin, M.D.
University of California – San Francisco
gordon.tobin@louisville.edu
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  852-8915

Professor Emeritus
Robert D. Acland, M.D.
London Hospital Medical College
rdacla01@louisville.edu
  Contact Person: Sharlene Dillander
Office  Fax
852-1244  852-6880

Clinical Professor
Morton L. Kasdan, M.D.
University of Louisville
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  852-8915

Professor Emeritus
Leonard J. Weiner, M.D.
Albert Einstein College of Medicine
drpanache@aol.com
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  852-6880

Leonard J. Weiner Professor and Chair of Plastic Surgery, Program Director
Bradon J. Wilhelmi, M.D.
Rush Medical College
bjwilh01@louisville.edu
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  852-8915

ASSISTANT PROFESSORS:
Larry D. Florman, M.D.
Catholic University of Louvain (Belgium)
ldflor02@louisville.edu
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  852-8915

Jarrod A. Little, M.D.
University of Texas-Houston
Jalitt02@louisville.edu
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  853-8915

Terry M. McCurry, M.D.
University of Louisville
tmmccu01@louisville.edu
  Contact Person: Sharlene Dillander
Office  Fax
852-6880  852-8915
<table>
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<tr>
<th>PROFESSORS:</th>
<th>Office</th>
<th>Fax</th>
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<tr>
<td>Michael B. Flynn, M.D.</td>
<td>629-3355</td>
<td>629-3030</td>
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<td>University of Dublin</td>
<td>583-8303</td>
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<td>Trinity College</td>
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<tr>
<td><a href="mailto:mbflyn01@louisville.edu">mbflyn01@louisville.edu</a></td>
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<tr>
<td><strong>Contact Person:</strong> JoAnn Lindeman</td>
<td></td>
<td>629-3355</td>
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<tr>
<td>Sam and Lolita Weakley Professor, Director of Surgical Oncology</td>
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<tr>
<td><strong>Robert C.G. Martin, II, M.D., Ph.D.</strong></td>
<td>629-3355</td>
<td>629-3030</td>
</tr>
<tr>
<td>University of Louisville</td>
<td>583-8303</td>
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<tr>
<td><a href="mailto:robert.martin@louisville.edu">robert.martin@louisville.edu</a></td>
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<tr>
<td><strong>Contact Person:</strong> Joanne Lindeman</td>
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<td>629-3355</td>
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<tr>
<td>Ben A. Reid, Sr. Professor and Chair</td>
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<tr>
<td><strong>Kelly M. McMasters, M.D., Ph.D.</strong></td>
<td>582-5447</td>
<td>852-1704</td>
</tr>
<tr>
<td>Robert Wood Johnson Medical School</td>
<td>583-8303</td>
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<tr>
<td><a href="mailto:mcmasters@louisville.edu">mcmasters@louisville.edu</a></td>
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<tr>
<td><strong>Contact Person:</strong> Pam Schmidt</td>
<td></td>
<td>852-5447</td>
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<tr>
<td>Ben A. Reid, Sr. Professor, Emeritus</td>
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<tr>
<td><strong>Hiram C. Polk, Jr., M.D.</strong></td>
<td>852-1897</td>
<td>852-8915</td>
</tr>
<tr>
<td>Harvard Medical School</td>
<td>583-8303</td>
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<tr>
<td><a href="mailto:hcpolk01@louisville.edu">hcpolk01@louisville.edu</a></td>
<td></td>
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</tr>
<tr>
<td><strong>Contact Person:</strong> Kelly Curry</td>
<td></td>
<td>852-1897</td>
</tr>
<tr>
<td>Vice Chair, Surgery for Operations and Finance</td>
<td></td>
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<tr>
<td><strong>Charles R. Scoggin, M.D., M.B.A.</strong></td>
<td>629-6950</td>
<td>629-3183</td>
</tr>
<tr>
<td>University of Texas</td>
<td></td>
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<tr>
<td><a href="mailto:crscog01@louisville.edu">crscog01@louisville.edu</a></td>
<td></td>
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<tr>
<td><strong>Contact Person:</strong> Cathy Buckley</td>
<td></td>
<td>629-6950</td>
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<tr>
<td>ASSOCIATE PROFESSORS:</td>
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<tr>
<td><strong>Yan Li, Ph.D.</strong></td>
<td>629-3355</td>
<td>629-3030</td>
</tr>
<tr>
<td>Chengdu University of China Medicine</td>
<td></td>
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</tr>
<tr>
<td><a href="mailto:y0li0004@louisville.edu">y0li0004@louisville.edu</a></td>
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<tr>
<td>ASSISTANT PROFESSORS:</td>
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<tr>
<td><strong>Nicholas Ajkay, M.D.</strong></td>
<td>629-3355</td>
<td>629-3030</td>
</tr>
<tr>
<td>Rosario University</td>
<td></td>
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<tr>
<td><a href="mailto:nicholas.ajkay@louisville.edu">nicholas.ajkay@louisville.edu</a></td>
<td></td>
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<tr>
<td><strong>Contact Person:</strong> JoAnn Lindeman</td>
<td></td>
<td>629-3355</td>
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<tr>
<td><strong>Hongying Hao, M.D.</strong></td>
<td>629-3355</td>
<td>629-3030</td>
</tr>
<tr>
<td>Institution of Hematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:hohao001@louisville.edu">hohao001@louisville.edu</a></td>
<td></td>
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<tr>
<td><strong>Prejesh Philips, M.D.</strong></td>
<td>629-6950</td>
<td>629-3183</td>
</tr>
<tr>
<td>Maulana Azad Medical College</td>
<td></td>
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</tr>
<tr>
<td><a href="mailto:p0phil02@louisville.edu">p0phil02@louisville.edu</a></td>
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<tr>
<td><strong>Contact Person:</strong> Cathy Buckley</td>
<td></td>
<td>629-6950</td>
</tr>
</tbody>
</table>
Amy Quillo, M.D.  
University of Louisville  
alridd01@louisville.edu  
Contact Person: Cathy Buckley  
Office 629-6950  
Fax 629-3183

Transplant Surgery

ASSOCIATE PROFESSORS:
Surgical Director of Kidney Transplantation for the Division of Transplantation
Mary Eng, M.D.  
Rush Medical College  
mary.eng@louisville.edu  
Contact Person: Lois Inlow  
Office 587-4607  
Fax 852-8915

Michael R. Marvin, M.D.  
Columbia University  
mrmarv01@louisville.edu  
Contact Person: Lois Inlow  
Office 587-4607

ASSISTANT PROFESSORS:
Eric Davis, M.D.  
University of Louisville  
egdavi01@louisville.edu  
Contact Person: Lois Inlow  
Office 587-4607

Michael Hughes, M.D.  
Indiana University  
mghugh02@louisville.edu  
Contact Person: Lois Inlow  
Office 587-4607

Associate Director of Live Transplantation for the Division of Transplantation
Chief of Transplantation
Christopher Jones, M.D.  
Georgetown University  
Christopher.jones@kentuckyonehealth.com  
Contact Person: Lois Inlow  
Office 587-4607

Trauma and Critical Care Surgery

PROFESSORS:
Glen A. Franklin, M.D.  
University of Louisville  
glen.franklin@louisville.edu  
Contact Person: Machenize Sprenger  
Office 852-1895  
Fax 852-8915

Chief of Trauma
Brian G. Harbrecht, M.D.  
University of Louisville  
brian.harbrecht@louisville.edu  
Contact Person: Tracy Kern  
Office 852-5675  
Fax 852-8915
### Emeritus

**Frank B. Miller, M.D.**  
Indiana University  
fbmill01@louisville.edu  
*Contact Person: Brenda Dawson*  
852-5676  
852-8915

**Jorge L. Rodríguez, M.D.**  
University of Virginia  
jlordr02@louisville.edu  
*Contact Person: Brenda Dawson*  
852-5676

### ASSOCIATE PROFESSOR:

**Hiram C. Polk, Jr./Lily Banerjee Professor in Surgery**  
**Chief of the Division of General Surgery**

**Jason Smith, M.D.**  
The Ohio State University  
j0smit19@louisville.edu  
*Contact Person: Machenize Sprenger*  
852-1895  
852-8915

### ASSISTANT PROFESSORS:

**Matthew Benns, M.D.**  
Indiana University  
m0benn02@louisville.edu  
*Contact Person: Machenize Sprenger*  
852-1895  
852-8915

**Matthew Bozeman, M.D.**  
Texas Tech University  
Mcboze01@louisville.edu  
*Contact Person: Machenize Sprenger*  
852-1895  
852-8915

**Keith Miller, M.D.**  
Indiana University  
krmill01@louisville.edu  
*Contact Person: Machenize Sprenger*  
852-1895  
852-8915

**Nick Nash, M.D.**  
University of Louisville  
Nanash01@louisville.edu  
*Contact Person: Machenize Sprenger*  
852-1895

---

### Vascular Surgery

**ASSISTANT PROFESSORS:**  
**Chief of Vascular Surgery and Endovascular Therapeutics**

**Amit Dwivedi, M.D.**  
Mumbai University  
amit.dwivedi@louisville.edu  
*Contact Person: Tracy Kern*  
852-5675  
852-8915
<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Abindra Sigdel, M.D.</td>
<td>852-5675</td>
<td>852-8915</td>
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<td>Contact Person: Tracy Kern</td>
<td>852-5675</td>
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<tr>
<td>B.P. Koirala Institute of Health Science</td>
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<tr>
<td><a href="mailto:amsidg01@louisville.edu">amsidg01@louisville.edu</a></td>
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<th>Name</th>
<th>Office</th>
<th>Fax</th>
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<tr>
<td>Eric Wayne, M.D.</td>
<td>852-5675</td>
<td>852-8915</td>
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<td>Contact Person: Tracy Kern</td>
<td>852-5675</td>
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<tr>
<td>University of Iowa</td>
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<td><a href="mailto:eric.wayne@louisville.edu">eric.wayne@louisville.edu</a></td>
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<td>Ahmad, Waheed, M.D.</td>
<td>(502) 896-4585</td>
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<td>Alankar, Suresh, M.D.</td>
<td>(502) 589-3173</td>
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<td>Atasoy, Erdogan, M.D.</td>
<td>(502) 561-4263</td>
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<td>Banis, Joseph C. Jr., M.D.</td>
<td>(502) 589-8000</td>
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<td>Bergamini, Thomas M., M.D.</td>
<td>(502) 897-5139</td>
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<td>Blandford, Joseph Jr., M.D.</td>
<td>(502) 366-1090</td>
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<td>Brose, Brittany A., AuD</td>
<td>(614) 266-6440</td>
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<td>Brown, Donald E., M.D.</td>
<td>(606) 679-5161</td>
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<td>Browning William, M.D.</td>
<td>(502) 338-6151</td>
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<td>Brunson, Bernie, M.D.</td>
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<td>Calobrace, M. Bradley, M.D.</td>
<td>(502) 899-9979</td>
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<td>Campbell, Robert A. II, M.D.</td>
<td>(502) 589-3173</td>
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<td>Campbell, Michael, M.D.</td>
<td>(270) 842-1660</td>
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<td>Chapar, Anees, M.D.</td>
<td>(203) 200-1518</td>
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<td>Chariker, Mark, M.D.</td>
<td>(502) 584-2201</td>
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<td>Citak, Michael S., M.D.</td>
<td>(606) 679-4847</td>
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<td>Cooper, Courtney L., AuD</td>
<td>(816) 679-6165</td>
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<td>Crase, Phillip W., M.D.</td>
<td>(606) 886-8240</td>
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<td>Cronen, Paul Jr., M.D.</td>
<td>(812) 273-1591</td>
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<td>Cross, Tracy G., M.D.</td>
<td>(606) 387-3000</td>
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<td>Derr, John W. Jr., M.D.</td>
<td>(502) 589-6000</td>
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<td>DeSimone, Kenneth J., M.D.</td>
<td>(502) 932-4203</td>
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<td>Dever, Shantel J., AuD</td>
<td>(502) 744-2377</td>
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<td>DeWeese, R. Craig, M.D.</td>
<td>(502) 629-5440</td>
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<td>Digenis, Alexander G., M.D.</td>
<td>(502) 589-5544</td>
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<td>Dowdy, James, M.D.</td>
<td>(270) 753-2444</td>
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<td>Faber, David, M.D.</td>
<td>(502) 348-5885</td>
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<td>Fox, Martin S., M.D.</td>
<td>(502) 895-5850</td>
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<td>Galvis, Leon Elkin Jair, M.D.</td>
<td>(502) 562-0362</td>
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<td>Gardner, F. Todd, M.D.</td>
<td>(502) 366-1090</td>
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<td>George, Salem M. Jr., M.D.</td>
<td>(502) 897-0635</td>
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<td>Glaser, Christopher C., M.D.</td>
<td>(270) 683-3720</td>
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<td>Gossman, M. Douglas, M.D.</td>
<td>(502) 495-2122</td>
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<tr>
<td>Hamman, Jack L., M.D.</td>
<td>(270) 825-7325</td>
<td></td>
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<tr>
<td>Hicks, Adam, DPM</td>
<td>(502) 533-2615</td>
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</table>
Jones, W. Scott, M.D. (General Surgery) (502) 897-5139
Juhl, Gregory, M.D. (General Surgery) (502) 587-7737

Kasdan, Morton, M.D. (Plastic & Reconstructive) (502) 897-1601
Katz, Lowell D., M.D. (Colon & Rectal Surgery) (502) 564-6666
Kaufman, Christina, Ph.D. (Hand Surgery) (502) 562-0326
Kelty, Stephen J., M.D. (General Surgery) (502) 637-3311
Klammer, Thomas, M.D. (General Surgery) (502) 897-0635
Klapheke, Patrick, M.D. (General Surgery) (270) 651-8328
Kutz, Joseph E., M.D. (Hand Surgery) (502) 561-4263

Lacy, John H., M.D. (General Surgery) (859) 236-2222
Lakshmanan, Jaganathan, PhD (General Surgery) (270) 326-3800
Luftman, Martin, M.D. (Plastic & Reconstructive) (859) 278-8504
Lusco, Vincent C. III, M.D. (General Surgery) (502) 366-1090

Manche, Julie, AuD (Comm Disorders) (502) 583-3277
Manon-Matos, Yorell, M.D. (Hand Surgery) (502) 562-0362
McCabe, Megan, AuD (Comm Disorders) (859) 281-4972
McMillin, Rodney D., M.D. (General Surgery) (502) 366-1090
Miller, Frank B., M.D. (General Surgery) (502) 896-9652
Moats, Shelley, AuD (Comm Disorders) (502) 409-4327
Moreno, Rodrigo, M.D. (Hand Surgery) (502) 561-4263

Nagy, Ferenc P., M.D. (General Surgery) (502) 589-3173
Napolitano, Margaret, M.D. (Hand Surgery) (502) 561-4263
Noel, R. Thomas, M.D. (General Surgery) (502) 895-5466

Ozyurekoglu, Tuna, M.D. (Hand Surgery) (502) 561-4623

Palazzo, Michelle, M.D. (Hand Surgery) (502) 561-4263
Peterson, Gilman P., Jr., M.D. (General Surgery) (270) 651-8328
Polk, Jr., Hiram C., M.D. (General Surgery)

Rao, Mohan, M.D. (General Surgery) (270) 825-7324
Reid, Benjamin, M.D. (General Surgery)
Romines, Robert B., M.D. (General Surgery) (502) 465-2821
Rosenbloom, Philip, Ph.D. (General Surgery) (502) 636-0574
Rutledge, Caset, Au.D. (Comm Disorders)

Salzman, Marc J., M.D. (Plastic & Reconstructive) (502) 894-9900
Scheker, Luis R., M.D. (Hand Surgery & Plast Reconst) (502) 561-4263
Schell, Robert, M.D. (General Surgery) (270) 683-3720
Self, Stephen B., M.D. (General Surgery) (502) 589-3173
Shina, Mark A., M.D. (General Surgery) (502) 899-7620
Shively, Eugene H., M.D. (General Surgery) (270) 465-2821
Siow, Yong, Ph.D. (General Surgery) (502) 852-0722
Stephens, Natalie C., M.D. (General Surgery) (502) 583-5948
Stephens, Natalie G., M.D. (General Surgery) (502) 899-6150
Stevens, Gregory, M.D. (General Surgery) (502) 895-1995

T
Thirklannad, Sunil, M.D. (Hand Surgery) (502) 561-4233
Tien, Huey-Yuan, M.D. (Hand Surgery) (502) 561-4263
Tsai, Tsu-Min, M.D. (Hand Surgery) (502) 561-4263
Tyrell, Dana, M.D. (General Surgery) (270) 441-4303

UV
Vallance, Steve, M.D. (General Surgery) (502) 223-7629

W
Watkins, James M., M.D. (General Surgery) (502) 465-2821
Whitt, John J., M.D. (Plastic & Reconstructive) (502) 895-5466
Williams, Russell A., M.D. (General Surgery) (502) 583-5948
Wolf, Bruce, M.D. (General Surgery) (270) 737-0256
Wolff, Bruce A., M.D. (General Surgery) (502) 412-3929

XYZ
Yancey, Andrea E., M.D. (General Surgery) (502) 457-0712
Yang, Cuibo, M.D. (General Surgery) (502) 412-3929
Endowed Professorships & 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 Jason W. Smith, M.D., Ph.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.

Heuser Hearing Institute Professor of Otology
~ The professorship is held by Arun Gadre, M.D.

Kenneth F. Von Roenn, M.D. Family Chair in Surgical Endocrinology
~ The chair is held by Amy Quillo, 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.
Departmental Awards & Recipients

JOHN W. PRICE 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:
2005 Bradley Thomas, M.D., Aaron Brown, M.D. & Swapna Kartha, M.D.
2006 Tedros Andom, M.D., Jarrod Little, M.D., Juan Quintero, M.D. & Gerame Wells, M.D.
2007 Gerame Wells, M.D.
2008 Quincy Greene, M.D.
2009 Quincy Greene, M.D.
2010 Russell W. Farmer, M.D.
2011 Keith R. Miller, M.D. & Nicholas Nash, M.D.
2012 Russell W. Farmer, M.D.
2013 Russell W. Farmer, M.D.
2014 Paul Linsky, M.D.

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:
2005 Steven Casós, M.D. & Bryce Schuster, M.D.
2006 A. Britton Christmas, M.D.
2007 Eric Davis, M.D.
2008 John M. Draus, Jr., M.D.
2009 Quincy Greene, M.D.
2010 Matthew V. Benns, M.D.
2011 Michael P. Mays, M.D.
2012 Suzanne C. Schiffman, M.D.
2013 Matthew P. Fox, M.D. & Russell W. Farmer, M.D.
2014 Matthew Bozeman, 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:
2005 Sebastian Eid, M.D.
2006 Michael Mays, M.D.
2007 Matthew P. Fox, M.D.
2008 Joshua Judge, M.D.
2009 Eric Davis, M.D.
2010 Heather Calvert, M.D.
2011 Kristen M. Blaker, M.D.
2012 Charles Scoggins, M.D.
2013 Alison Burton, M.D.
2014 Farid Kehdy, 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:
2005 Eric G. Davis, M.D.
2006 Christine Landry, M.D.
2007 Graham Englund, M.D.
2008 Matthew Benns, M.D.
2009 Michael Mays, M.D.
2010 Nicholas Nash, M.D.
2011 Michael Egger, M.D.
2012 Brady T. Harris, M.D.
2013 Charles Kimbrough, M.D.
2014 John Majiub, 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:
2005 A. Britton Christmas, M.D.
2006 Bruce Hermann, M.D.
2007 John Draus, M.D.
2008 Christine Landry, M.D.
2009 W. Patrick Klapheke, M.D.
2010 Vedra Augenstein, M.D., Jerome A. Byam, M.D, Michael P. Mays, M.D.
2011 Suzanne Schiffman, M.D.
2012 Robert M. Cannon, M.D.
2013 Robert Cannon, M.D. & Michael Egger, M.D.
2014 Michael Egger, M.D. & Sarah Walker, 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:
2005 Robert Kanard, M.D.
2006 Stephen M. Glatz, M.D.
2007 John Draus, M.D.
2008 Amy Quillo, M.D.
2009 Ariel Santos, M.D.
2010 John Trombald, M.D.
2011 Keith Miller, M.D.
2012 Dustin R. Neel, M.D.
2013 Alexandra Maki, M.D. and Matthew Golden, M.D.
2014 Sarah Walker, 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:
2005    Jeff Jorden, M.D.
2006    John M. Draus, M.D.
2007    (No award)
2008    (No award)
2010    Vedra Augenstein, M.D. & Matthew Benns, M.D.
2011    Robert Cannon, M.D., Michael Egger, M.D., Thomas Lee, M.D., & Alexandra Maki, M.D.
2012    Michael Egger, M.D., Paul Linsky, M.D., John Majub, M.D., & Sarah Walker, M.D.
2013    Heather Calvert, M.D., Jonathan Rice, M.D., Erin Schumer, M.D., Charles Kimbrough, M.D. & Michael Mackowski, M.D.
2014    Charles Kimbrough, M.D., Jessica Raque, M.D., Jonathan Rice, M.D., Erin Schumer, M.D. & Jessica Weaver, 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:
2005    Michael Mays
2006    Matthew Fox
2007    Joshua Judge
2008    Eileen Duggan
2009    Gregory C. Wilson
2010    Taylor C. Brown
2011    Natalia Paez Arango
2012    Katherine M. Huber
2013    Joanna Ohlendorf
2014    Daniel Hall

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

Recipients:
2005    Christine Landry, M.D.
2006    Gerame Wells, M.D.
2007    Adrianne Bowen, M.D. & Keith Miller, M.D.
2008    Adrianne Bowen, M.D. & Nicholas Nash, M.D.
2009    Vedra Augenstein, M.D. & Michael Egger, M.D.
2010    Michael Mays, M.D. & Matthew Golden, M.D.
2011    Anne Doughtie, M.D. & John Trombold, M.D.
2012    Keith R. Miller, M.D. & Paul L. Linsky, M.D.
2013    Matthew Bozeman, M.D. & Jessica Raque, M.D.
2014    Sarah Walker, M.D. & Alison Burton, M.D.

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

Recipients:
2012    Omar Hamdallah, M.D., Abindra Sigdel, M.D., & Noah Scherrer, M.D.,
2013    Erik Wayne, M.D., Noah Scherrer, M.D. & Karen Parks, M.D.
2014    Matthew Bozeman, M.D. & Karen Parks, M.D.
2014 Publications
Faculty names are **bolded** and residents/fellows are **underlined**.

A


B


QR


UVW


XYZ


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.

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.
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:
Drs. Cheadle and Garrison maintain extensive research laboratories at the Louisville VAMC. There are full-time investigators, fellows, and students who assist with various surgical research projects.

Drs. Cheadle and Garrison both have had continuous VA Merit Review funding for over 20 years and have participated in the training of fellows and residents. In addition, Dr. Garrison is the Principal Investigator of an NIH R01 research award for his work on direct peritoneal resuscitation from hypovolemic shock.

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

University of Louisville: www.louisville.edu

Department of Surgery: www.louisvillesurgery.com
Website contains links to:
Colon & Rectal Surgery, Communicative Disorders, Pediatric Surgery, Plastic & Reconstructive Surgery, Surgical Critical Care & Price Institute of Surgical Research.

UofL, Department of Surgery Alumni: www.facebook.com
ACGME: www.acgme.org

New Innovations: www.new-innov.com

Clinical Trials Information:
www.AboutMelanoma.com
www.AboutBreastHealth.com
www.AboutLiverTumors.com

University of Louisville & Affiliated Hospitals

University of Louisville Hospital: 562-3000
OR: 562-3504 Fax: 562-4237

VA Medical Center: 287-4000
OR: 287-6808 Fax: 287-4203

Norton Hospital: 629-8000
OR: 629-7100 Fax: 629-3089

Kosair Children’s Hospital: 629-6000
OR: 629-4800 Fax: 629-4913

Jewish Hospital: 587-4011
OR: 587-4234 Fax: 587-4234