Chief Resident Interview Project
Dr. Brian Gulack, 27 June 2018 at Duke Hospital

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Barr: Good afternoon. This is an interview of Dr. Brian Gulack on Wednesday, 27th June 2018 in Duke Hospital by Justin Barr as part of the Chief resident interview project. Thanks for joining us, Brian. Could you start off just by talking a little bit about your background, where you grew up, where you went to undergrad, and your college experience.

Dr. Gulack: I was born on a cold October day in 1985. I grew up in Rochester, New York. My father and mother had a daughter, my sister, Sarah, a year and a half after I was born. My mother actually died from a cerebral aneurysm about four months after my sister was born. I was obviously under two. My father raised the two of us, with the help of my aunts from my mother's side and my father's side, on his own for quite some time. Which is something that, as a child, I always had a father and I was the same difficult kid that every kid is. Recently, it really occurred to me about how much of a struggle it must have been for him to raise two small children as a single father at that time, or anytime, really. It's only recently that this has really touched me.

I stayed in a Rochester, New York. I met my best friend in second grade named Jacob. Unfortunately, his parents were divorced and he had a sister named Meriam who's best friends with my sister, Sarah. Obviously, our parents ended up meeting and they got married in the summer of '97. There was four kids, four children in about two years of each other in one house, which is probably a bit crazy.

I often joked that I peeked in high school. I was the smartest and the most social I'll ever be when I was in high school. I developed a very strong interest in biology. I always kind of knew I was getting into medicine. Probably some of the best years of my life in Brighton High School in Rochester New York.

Barr: What did your dad do for a living?

Dr. Gulack: My father was a volunteer firefighter but his full-time job was in emergency managements of the county. I was the cool kid -- when I was younger, my dad had the light up the roof and we'd race the firefighters and it was awesome. When you're in high school, it was embarrassing as heck. He put this big reflector stripe around my car - [laughs]- for safety's sake. It was a difficult transition for me. So I graduated from Brighton in 2003 and then I matriculated to Union College in Schenectady, New York, which I only found out about through a friend. I actually only applied there because the application was free if you did online. Back then that was a big deal.

I didn't get into my top choices, very luckily, because Union College ended up being an amazing experience for me. It's a small school, 2,000 kids. A lot of kids that don't

seem to really want to take advantage of the resources, they just kind of want to party and hang out. That made it a great time for me to really take in everything the college had to offer. I got very involved in the student government. I was student class president in my sophomore year then student body president for two years.

I served on a lot of committees. The classroom structure there is roughly 12 kids to one professor. It's a really great kind of learning environment. Really, college to me was kind of learning to learn. You really get a chance to figure out how to do , coursework and do all that kind of stuff at the same time as you're multi-tasking and balancing everything else you do in your life. I got involved in fraternity and everything else. I pretty much just did everything I could, realizing college is once in a lifetime opportunity, and it's really what you make of it.

As I say I was very lucky that I ended up in Union because I saw a lot of friends ended up at bigger schools – Ivy League schools where they are kind of a small fish in a big pond and it's a lot harder for you to get involved in these things because you have a lot of competition. In Union, it's just kind of like, "Do you want to do this? Go for it." A lot of volunteer opportunities, adopted a highway, all that fun stuff, worked with kids in a little community.

I was actually between medicine and dentistry for a little bit in college. By the time this is ever heard, no one's going to remember what AOL was, but I put on my info on AOL, I said, "Should I be a doctor or a dentist? You vote." The vote came back 18 to 16 in favor of doctor. Next day, I signed up on MCATs and decided to go to medical school, which was definitely the right choice for me.

Barr: What was your major at Union?

Dr. Gulack: I was a biochemistry major and an economics minor. It would have been nice to take a year off before medical school, just do more exploring of myself in the world, but finances were always very tight for us growing up. It was not going to be easy. I also realized that my application for medical school probably was never going to get stronger than it was. It was really difficult to get into medical school, at least you think it is. I applied to medical school straight from college and ended up--

I was between the University of Pittsburgh in Mt. Sinai, and one of my good friends at the time was going to Pitt for dental. She just told me, Brian you're going to Pitt for medical school. I said, "Okay." [laughs] Then I went to Pittsburgh. Pittsburgh is an amazing place and amazing city. It was another place that really kind of let me grow and thrive and become who I am today. Again, a lot of very down to earth teaching styles.

The classroom was not mandatory. Everything was videotaped. You got to just learn at your own pace. I enjoyed a lot of my studies in undergrad, but a lot of them were "you just need to memorize this." But medicine is so interesting. It was the first time that I really start to enjoy a lot of my studies, especially anatomy. I knew pretty early on I wanted to be a surgeon because I like hands on. I like being in the blood and

guts. I spent a lot of my early time in medical school shadowing just to rule out pretty much everything that wasn't general surgery.

I spent some time in neurosurgery. I spent some time doing some cardiac surgery, not really plastics or anything else, ENT. I did a bunch of that my first year in medical school while I was in between studies and pretty quickly ruled out that I didn't want to do any of those sub-specialties. I knew that I should just go for general surgery. It will give me a lot of exposure and give me some time to help me get a better decision.

I applied and obviously I ended up matching at Duke University.

Barr: When you were at Pittsburgh, what was your surgery clerkship like? Did you have any mentors in that department that helped push you forward?

Dr. Gulack:. I didn't have any great connections with any specific mentors. Clark Gamblin, who's a hepatobiliary surgeon now in Wisconsin, was probably my first real mentor. It wasn't "I want to be just like him" thing, as much as he was a nice guy who showed me the ropes. I had a good time on his rotation. The best connection in mentorship is really from my other medical student friends. There was a group of us all going into surgery together. We all kind of pushed each other along and did the MIS practice things in the Sim lab, got involved in surgery group together and stuff like that.

Dr. Gulack: Well, I was going to say, Dr. Ferson, a thoracic surgeon. He was also very good. He mentored all of us in Pittsburgh at the time. I am not sure if he's still alive. He, unfortunately, had a really bad pulmonary disease that came from-- Rumor had it that he had a hepatitis exposure when he was a resident. Actually, the prophylaxis that they gave him led to this pulmonary disease. By the time I left, he was on oxygen a lot. Unfortunately, I don't know how he's doing. Those are probably my two mentors.

I'll be honest with you, Duke was not my first choice for residency program. I was 25, I was looking to explore some more. I wanted to go out west or go south. And so some of the California programs and Emory were higher on the list for me. Again, as seems to be the recurring theme of my life, everything happens for a reason. I do not think that I would have gotten matched into pediatric surgery if it was not from me ending up at Duke.

I remember interviews very vividly, Dr. Smith, Dr. Onaitis, and Dr. Jacobs. My personal statement indicated an interest in cardiac surgery. I remember one, whose name I shall not say, made fun of my clinical research that I had done at Pittsburgh, which irked me a little bit. That kind of made me want to prove him wrong. I was very happy when I opened the envelope. I matched here with an amazing group of residents.

Barr: Who was in your intern class?

Dr. Gulack: Yes. It was Christopher Cam McCoy, Jeff Keenan, Danny Nusbaum, me, and Jeff Yang. Then Hang Hang Wang, who ended up taking off a couple of years to

do a Ph.D, so she did not finish with us. Then a medical student from Duke named Emma Neff who unfortunately dropped out in month four. She had a MD/JD and so she went up going to Chicago to be a lawyer. Hear she is doing really well now. We got here, we were very close to the start. I think everyone says it's harder when we were an intern than when you were an intern, but I truly believe the program now is in such a better place than where it used to be.

The rumors on the trails was this was a very malignant program. I don't think it was malignant from an attending perspective as Duke once was. The "Decade with Dave" et cetera, but there was a lot of malignancy from the senior residents. I remember getting bit, just left and right for things that now looking back made no sense and don't matter at all, even by the SAR-1s, who, now as I look back, they were barely even residents, yet they took the time to just try to tear me apart.

It was very tough and I think that my co-residents being there for me was really important. I do think, especially my second year, I was probably a little clinically depressed just working so hard and always feeling like I had done something wrong and waiting until the next time I get yelled at. I even had thoughts about leaving surgery and going into anesthesia. I talked to some of the anesthesia residents and attendings at Duke about that experience. Fortunately, I lasted through that and I made it to the lab. The lab is a time I really re-energized and really refocused on what I want to do in my life.

Barr: Any fun stories from your intern year?

Dr. Gulack: Not too many. There was a time that Danny Nussbaum got some sort of GI bug. Never have the chicken salad in the cafeteria by the way; I don't even think they serve it anymore. But he got bad food poisoning. Back then, even if you got sick, you didn't leave. He stayed and was vomiting while rounding on 2300. He got really dehydrated, and we brought him into the old bunker, threw some IV's in him. There's a great picture of him sitting in a wheelchair with some IV's in him.

Barr: Aside from the hyper-criticism, how do you think intern year has changed from when you were an intern to seven years later as you're graduating?

Dr. Gulack: The biggest change is the hiring of all the APPs, the middle-level providers that we have now. When I was an intern there was one APP on vascular who came and left. They went through like three of them in a year. Then there were none on transplant, none on trauma. I'm trying to remember if we had one gold yet. I think we did, I think Jackie Sullivan was already here when I got to gold. I think she came half way through the year.

So we really didn't have APPs, and so our job was to take care of the patients on the floor and then if we had time, we'd go sneak into the OR. Brian Clary was our program director when I got here. He was famous whenever he was doing a whipple or a hepatectomy, and was taking out the gallbladder, he would always call on the intern to do the open gallbladder. We spent probably a lot less time in the OR than you guys

get now and a lot more time on the floor. And we viewed the floor as our source of pride.

It was our service. Having all labs ordered every day and all the notes done right, everything set so that when your resident or attending came to round, everything was ready for them -- that was a great source of pride. It actually stopped us from wanting to leave the floor even to go to the OR. I had a lot of stress when I was in the operating room about what was happening on the floor.

I remember actually doing a vascular case with Dr. Shortell and Vanessa Schroder when she was a resident. It was like a quick stab phlebotomy. But my pager started going off because one of the nurses was upset about some of my opioid orders. Vanessa was like, "Calm down, don't worry about it. It's not a big deal." The nurse threatened to write me up via page if I didn't hurry up and get there. Finally, just said "I need to go" and left the OR to deal with the floor issue.

Later when Vanessa sent me down and told me "We're actually very disappointed that you left the OR. You should not leave the OR for these things." Everything else was above and beyond, but taking care of the floor, of my patients was the primary possibility.

Then second year changed a lot too now again because of the APPs. The second year was the year you learn how to take care of patients in ICU. The way I have always thought of general surgery is: first year, you learn how to be an intern and take care of patients on the floor. Second year is about intensive care and the beginning of becoming an operator.

When we were in the ICU, if you were in the surgical ICU, you were the only resident there often. You would be alone in there, and it was the old 16-bed unit on 2200. It's not the same we have now, with 24 beds. It was a little bit slower. But it was you and the attending. There was no fellowship either, there's no fellows around. There were a lot of nights when the attending would go to bed and you'd be the only person in the SICU. Overall care of patients is probably a little bit better when you have a lot of providers around who have experience, but at the same time, being there and being on your own forces you to learn a lot more.

I think that we learned better how to be interns and then intensive care doctors based on the time we spent alone. You always had somebody to call. They were always happy to come help. I don't think it was dangerous.

My worry, a little bit, is that people, as we've taken away some of the education, that residents are coming through that don't have the same training. That being said, when you don't do it again for five years, you probably forget a lot of it. Is it going to actually make a difference 20 years from now that surgeons don't know how to take care of critical care patients? I don't think that's going to end up being the case, but it was definitely a different experience.

Like I said, there was this very big animosity between the senior residents and the junior residents. We did not hang out with them outside the program, there was not a family feel. I think that- I don't want give ourselves the credit- I think getting rid of certain people and just having our classes move up through the ranks, the atmosphere has just changed a lot. There are still little individual issues between certain people. You're never going to escape when you have 40+ people in a program there's definitely much more of a community feeling. The chiefs love to hang out with the interns and everyone else in middle as well. It's definitely changed.

Barr: When do you think that family-feel started to become obvious? You said that the first two years you were here it was absolutely not the case.

Dr. Gulack: Yes, I think it was when I was in the lab was when the changes started to occur. The senior residents who moved up the couple of years above us were very open to that. I can't name anyone specifically. Obviously, Drew Barbas I would classically say, "the best resident to ever complete Duke surgery residency and also the nicest person ever to complete duke surgery residency" was probably a big pull in that. Georgia Beasley was a very go-to person. There was a lot more than them and I feel badly leaving people out by saying some names, but those years just changed things.

There was also change in the program at the time. Every day, as an intern, you would have to have every lab on every patient every day. You'd had to have certain things set up. It became a bit more relaxed in the way that we treat our patients. I think it was much for the better. I think that overtesting and keeping nasogastric tubes in until bowel function and everything else that goes with it, prolongs the patients' stay and created more cost to the hospital would absolutely have no benefit.

There was the realization that just because things were done the way they were done before it doesn't mean that it's the right way and should continue. I think that opened people to thinking more for themselves of how to treat these patients, how do I want to treat these patients and not just doing it because that's the way we've always done it. This also lead to relaxation in the program.

The senior didn't always bite the intern because there weren't labs. Usually it was, "oh you didn't get labs today; is there anything I should be concerned about?" We would teach the intern, "if we were worried about this and we should still check a CBC" et cetera. It became a bit more of a relaxed program. I remember being an intern it was like the temperature broke 38.3, that was a fever and that needs a workup. If it wasn't 38.3, if it was 38.2, that's not a fever and they don't need a workup. If they are a transplant patient, then it is 38.0. These dogmas don't make sense. If the nurse gave the Tylenol fast enough that broke the fever early enough, then it's not an infection?? This more academic way of thinking of things I think also translated into a program of being thinkers and realizing that everyone has a different way of doing things, made it a bit more relaxed.

You always have something to learn, even from the people below you. I always remember John Yerxa had taught me -- and I've never given him credit for this, so

please don't play this for him – but John Yerxa, my intern when I was a SAR-1 taught me that you get hypertensive sometimes after strokes. This is commonly known, but sometimes in med school you have so much to study you just miss things

We had a patient who was hypertensive and he said "I am worried about a stroke." We got a CT of the brain and sure enough, the patient had had a stroke. There's always something to learn from everyone, and everyone deserves to be treated with respect. I think the program grew on those principles.

I went into the lab, and I was interested at the time in cardiac, but I had also become interested in pediatric surgery. I set up my lab experience trying to do both. I was very interested in going clinical research, and I was interested in getting a master's in health sciences when I was here. Fortunately, Peter Smith in the division of cardiac surgery took me under his wing. He had a grant that paid for the master's. Then, the department, as it has been and will hopefully continue to be, was willing to fund our two years in the lab. I applied for grants but did not get them. I ended up setting myself up at the DCRI, the Duke Clinical Research Institute, with two mentors, one was Matt Brenan, who was a cardiologist, and the other one was Brian Smith, who's a pediatrician.

Unfortunately, we did not and do not have very good surgical people over there. It's very difficult. 1) It's not in this building and 2) surgeons just do not seem to be interested. So you have to get set up with the cardiac people. The cardiology department at Duke has really figured out clinical research.

The DCRI, for some time, I'm sure it still is, was the largest academic clinical research organization in the country, if not the world. There were so many international randomized controlled trials running through there...They housed the Society of Thoracic Surgeons data and their data center, at that time at least. They've outsourced some of it since. The opportunities were just endless and the mentorship was exceptional. These are people who've been awarded tons and tons of grants, and just real success stories.

Between getting some actual education from the master's, as well as pretty much hopping on any projects anyone would let me hop on, in both Peds and cardiac surgery, I had a phenomenal research experience. I put out a large number of publications. Really, the best experience came from things that you never got published on, but you just get to be involved in. We helped with some of the big RCTs. We were involved in conference calls with statisticians and outside investigators, especially for the Society of Thoracic Surgeons.

Part of me wishes I had gone into cardiac surgery because I would have had a phenomenal outreach already from people I've worked. When I would have gone on interviews, I could have been like, "We are on this paper together."

I went to Guatemala. I went for two years in a row, I think both years when I was in the lab, with Henry Rice, who's the chief of pediatric surgery. He was doing mission trips down there for a week. We would go down on a Saturday. Sunday was our clinic

day where we saw the kids that the center had set up who might need pediatric surgery.

It was us and a urology team, an attending and a resident. Then we brought all the nurses and anesthesiologists and CRNAs that we needed and a lot of equipment too. Then Monday through Friday, we'd operate. We do our big cases Monday so you'd actually be there for a few days in case something happened, and then just operate and operate, operate. Then Friday, you'd be done half a day early, the kids and their parents will throw a little party. We'd spend Saturday and Sunday just relaxing in the country and then flew back.

That experience started pushing me back towards pediatric surgery. It was really a discussion with Kevin Shah while we're in between cases as my SAR one year out at Duke Raleigh. I think it was a Saturday, too. We went to the cafeteria to get a cup of coffee and he sits there and says, "What you do want to do?" And I'm like, "You know, I'm not sure."

At the time, I was between three options, it was cardio-thoracic, Peds and I was thinking about trauma/ACS a little bit. He gave me the thing that I didn't want to hear, which was, "You got to make a decision." I was like, "I know." We went through, I don't know if he was planning on doing this…I've since, probably much to his chagrin, sent multiple residents to him saying, "If you can't decide, sit down with Kevin Shah. He's the guy."

We went through the pros and cons of everything. Cardiac surgery is always just like this intense, the best of the best type of feeling to it. The drive that's pushed us all into surgery, that is the drive that continues pushing you into cardiac. It took me a while to say, "Where am I happy? What do I want to do?" The variability, I realized I don't really want to do CABGS and valves my whole life and I don't want to do heart failure. Although I love the physiology of the heart, I didn't really want to operate on it that much.

Then we talked about thoracic. I don't just love lung resections and so I realized pretty quickly that what I really want to do was not cardiac or thoracic surgery. I realized I love to operate, which eliminated trauma/ACS/ critical care.

Peds has great variability. You have the ability to have things set up where you're just doing hernias and G tubes things at the same time as you have a couple of days that you're going to end up doing big cases. You are the last bastion of general surgery.

I've always loved the Peds teams here. I worked with pediatricians, the Peds cardiac guys, the Peds ICU people. You really have to have a team approach to things, which I've always liked. Then, obviously, the idea of getting out of bed in 50 years or however long, I'm lucky enough to continue to operate for a child versus an adult who kind of brought on some of their own risk factors…. It was the realization that pediatric surgery would probably be a career that was most fulfilling for me. I spent a little extra time with the pediatric surgery service and loved every moment of it.

I had some great mentorship from Henry Rice. He said the most touching thing to me. The last operation we're doing when I was on Peds surgery I think two months ago, he's like, "Brian, this connection is going to last forever. You're going to be calling me for years and years for advice on things, so this is not goodbye." It was very, very touching.

I applied and interviewed. Really, the interview trail for fellowship is one of the most invigorating and inspiring things you could do. You meet all these heads of pediatric surgery around the country and then at the same time, you also meet all these future pediatric surgeons. It was odd to me because I feel like I met everybody who's going to pediatric surgery. I met one year of people who were going to pediatric surgery. There are years above and years below that I'm never going to meet...

I interviewed at 29 places. You really get to know your co-applicants. We're still in very close touch and hope we will be for life as we continue to move forward as pediatric surgeons. It was a real adventure. I was fortunate enough, as you're well aware, to match at the Hospital for Sick Children, also known as SickKids in Toronto, where I'll be heading in a few days to start my fellowship.

Barr: That, certainly, is a remarkable trajectory here at Duke and in Durham. When you came out of the lab, Duke kids since instituted Epic, which did not exist when you were...

Dr. Gulack: Actually it did. It came out, I was really excited about this, it came out two weeks before we went into the lab. I was like, "Why can't they hold so I don't have to learn this new system two weeks before I go into the lab?" Yes, it had come out two weeks before and we moonlight throughout the lab, so you got used to it.

Barr: What was that transition like from predominantly paper charts and electronic ordering system to an entire electronic medical records system?

Dr. Gulack: When we were here, PowerChart was the option. PowerChart was an electronic medical record. The only difference was our daily notes were still handwritten. Our history and physicals, our discharge summaries, all that stuff was on there, all the labs, micro, and orders were all in there. I actually liked PowerChart. It was a lot simpler of a program, so it was really easy to find stuff. You could comb through a patient's whole history very quickly, versus Epic which has so much in there that it can actually take a while and be very confusing.

Also, writing paper notes-- When we think about documentation, there are three things: You document to bill, you document for communication with other people, and you document history so you can go back and look at things later and figure out what happened if you need to.

For pretty much all of those things, paper charts were horrible, but they were amazing for efficiency and rounding. We would write up our notes as we rounded in the morning, and the attending would come by later and sign them all. They were not legible. The physical exam usually say something like, "AO x3, CTAB RRR," it was

just a bunch of initials. Then the plan was always like, "Continued advancing diet." If you ever went back, they would photocopy all these into the electronic system so you can always go back and see it later but combing through those notes, which I had to do a few times to try to figure out what happened to a patient, was just horrible. It wasn't that big a jump really from where we were to Epic.

I think one of the biggest changes has been that the role of a medical student on the surgical team has dropped incredibly since I was a medical student. When I was a medical student in Pittsburgh, we had paper charts. All our notes were paper. As a medical student, I would, especially during my sub-I, I wrote every note and then handed it to the resident who read through and made sure it was okay, if he could read it, and then sign it.

I would collect all the labs and all the ins and outs and everything else and put that in that note as well. I was an integral part of the team. When we got out of the OR, I wrote the quick op note and then hand it off to them. You could just do more, at the same time you could also be more involved in patient care. I was pulling chest tubes, pulling lines. I remember pulling pace wires one time and I understood that if you pull too hard you could really do some damage in there. I remember the attending coming to the doorway and watching me over the shoulder-- I didn't realize it. And I slowly pulled these out and I finish and I look up and I was like, "Did I do something wrong?" He said "No I was just watching. You did it just right". And then he walked away.

I was taught how to pull chest tubes by an ED Resident. The ED Residents at Pittsburgh are phenomenal and they actually rotate on trauma surgery and they're actually part of the team. Here, they don't get the same experience, so we treat them more as an intern or helper but he taught me that when you pull out the chest tube properly, there's always a splatter pour of pleural fluid on the wall behind you.

[laughter]

You could do so much more as a medical student. It makes me very nervous…now with Epic they can't write notes, and the APPs and just the crack down on what we're letting medical students do. They really just observers. They really can't get involved. Part of being a medical student is observing, but you are so much more inspired to try harder when you feel like you are being of use to someone.

I remember saying that when I got home from my surgical clerkship one day: the days that I feel like I was actually useful member of the team were my happiest and best days. Some days they pretended like, "Hey, we got to get moving to the next case. You mind closing the skin?" They were in the corner probably half writing notes and half checking their phone for text messages. It's important to make them feel needed and we've lost that ability. I think we're still searching for a way to try to include them in the team and, unfortunately, it just hasn't clicked yet.

I know we're started talking about the change for paper to charts at EMR, but that one of the biggest mortalities of EMRs: the medical students and their ability to get involved.

Barr: What are the other big changes that happened as you can into the lab as the new Chairman, Dr. Kirk? What do you think he brought to the department?

Dr. Gulack: Yes. When I was on my interview day, we interviewed with Danny Jacobs who was the Chair and Brian Clary, who was the program director. You get a couple of couple of questions with both of them, and my question was "Are you planning on going anywhere? You going to be here for a little while?" I didn't want a lot of turbulence in the program while I was there. And the both of them said "We have no plans to leave".

It was one year and both of them had left, moving onto other jobs. When you are in a 7 year program, the average lifespan of a Chairman and program director is probably around ten years, and so the odds are someone is going to change while you're there. You know I was talking to the new interns sometime this year and I said that to them "there's a decent chance. Dr. Kirk might move on to another position by the time you finish. Here may not be your Chairman when you finish," which is hard to imagine when you're a new resident. This is the Kirk Program.

There was definitely a lot of change. My understanding is that a lot is over your head. You just don't realize it. The program grew. I think the faculty doubled in size under Jacobs. He really grew the program. Unfortunately, a lot of that was built up kind of on an administrative and business side. There was a big loss in the academic mission and the research mission.

When I was a medical student, the first time I heard about Duke is if you looked at surgical departments and how much money they brought in for research, Duke was number one, and not just by a couple of hundred dollars. Duke was number one by millions of dollars. That number slowly dropped over the last five or seven years before I got here. Part of that was a little bit of a bookkeeping game where a lot of divisions that were not under the department of surgery and other places were in the department here, and so that inflated the numbers a little bit. But definitely, the numbers are going down. The number of grants available for surgical residents dropped to one and by the time I got here, T32s.

I think that even that lost funding. It was for bad reasons -- people just didn't re-apply for them. There was a little bit of a drop. So Jacobs left and we had Dr. Ted Pappas as interim chair for two years, which was a fun two years. There is nothing like you know-- Dr. Kirk's Chairman rounds are amazingly in their own way but we loved Pappas rounds. We looked forward to Fridays at 4:30. We didn't have Chairman rounds with Jacobs. It's somebody he got rid of. But Pappas brought it back.

He would always come in-- Friday was his operative day. Pappas used to have two ORs running every Friday when he was really busy. He'd have his main OR where the Chief was operating and there were some big pancreas case and he always had his hernias in the other room. When you were an intern, you were really lucky when you got a Pappas hernia day. I remember him-- he always has very interesting ways of expressing disappointment when I think he's not really that disappointed as much as he's trying to make himself laugh. But I remember as an intern doing a hernia with

him, and one time in the middle of the operation, he walked over and started banging his head against the wall-

So, his Chairman rounds, he would come in with his scrubs and cap still on. There's two Pappas'. There the Pappas outside the OR, when he is well dressed and very cordial and nice. And then there's…I don't know what he does. He puts on his thick black OR shoes that he has and his glasses he has, and he changes. His persona changes. He's phenomenal. Both sides of Pappas. He would come in still in his scrubs and he would just pull up two patient cases and he would go through them with you.

He would just present to you the history and physical and some sort of imaging and he would say, "What do you want to do?". You would just go through it with him and he'd mock your answers. We all really looked forward to his Fridays. He did what you're supposed to do when a new chairman comes and stepped back and lets him take over, do things his way. I do really miss those Fridays.

Dr. Kirk showed up while I was at the lab. Everyone doesn't really like change right away and so we were all a little nervous about the changes. He made some very quick changes early on and a couple of us were thrown back by but in hindsight they were the right decisions, obviously. There was a very sudden and quick change towards the research and academic mission of the program.

You could see it. You could see fear in some of the eyes of the attendings who were not necessarily very academically-oriented. They've realized like, "Wow. Things are changing. I need to get involved in more stuff." Since I was a resident, it was great because there was now a lot more focus on it and for us getting involved in research. A lot of my research was done was kind of me searching it out. We had times when we would have a project idea and plan. We almost went shopping for attendings. So we'd go find an attending whom we thought was a good person to be involved with it and asked them if they wanted to be a part of it, and if they were interested in it then then we'd do the projects and they might give us some mentorship usually about the manuscript as it was coming out, but not much. But then it switches very quickly to being more of a driven top down. It started remarkable things. You guys that are going into the lab I think have much better set ups and much more interesting set ups than we did. And so there was a change in that way. There was more professionalism when he came. There was a bit more of a reintroduction to that. We were much more worried that we'd be seen without our shirts and ties, outside the OR with Kirk.

He's been a phenomenal chairman and mentor to us.
When you are Chief, you get your admin chief time. Your admin chief time is nothing like it used to be where you just published the case assignments for the day and then had a whole bunch of attendings email you back and tell you that they didn't want to work with this or that resident.

Barr: Does that still happen?

Dr. Gulack: No. Something happened in the middle of my residency. I just know that this happened because you hear the stories. There was some sort of final push and then Dr. Migaly, and I don't know if Dr. Kirk was involved in this or if was before he got here, but something happened where they finally said, "The schedule's final. The residents do it and you get whom you get," and since then the pushback stopped. I can only remember once getting an email from an attending and it was for a clinic. It wasn't that they didn't like the residents, it was that they didn't have a resident and thought that they deserved a resident for clinic and so we gave him one. But none of that happens anymore. But now when you're the admin Chief, every day you meet for half an hour with Dr. Kirk.

I remember the chiefs who were leading last year that gave us-- we always have a little chief-to-chief signout, and one of the things that I remember Paul Speicher saying was, "I think we all realize now what an experience that is to be able to have one-on-one time with a leader in surgery and how little we made of it because we were so busy, and it's right before you run to the OR."

I was the admin chief for the last six weeks of my residency, and I made a list before I did about different things I want to be sure to get through and ask Dr. Kirk about before I left. It was an amazing mentorship opportunity and sometimes he has something on his mind, he starts talking about it, other times, you have something you want to talk about, and you have 20 minutes just to dish back and forth on "how do you think that this change is going to affect surgery" and a lot about looking for jobs and how we go about things, et cetera.

Then every Friday, all the chiefs meet with him as well. He's chairman of the entire Department of Surgery, Surgeon Chief of the hospital, he has a lot of residency programs under him, but I think because he came through our program, he has an interest in it. So we get an exposure that the Urology residents and no one else seem to gets and phenomenal mentoring. It's been great. I was probably near the end, he came up to me at chief's dinner and he goes "Hey, great job. We're really excited for you, if you ever need anything at all, you come back to us and ask us."

You feel as though he was very sincere that if anything ever happens or you ever have questions, you are welcome to call. He always told us, when you guys get your first contracts, First off, if you're arguing over your salary that means there's something else going on that's wrong. It's never going to be a couple however many dollars this way or that way that's really going to make you happy or not happy. If there are other things you're worried about the contract, send it to me, I'll be happy to look over it. You get that feeling is once a Duke surgeon, always a Duke surgeon.

As he says at the chief dinner, it's really touching, "Please help me welcome Dr. so and so as a Duke surgeon." We were earlier talking about family. The family of residents is now going to be the family of Duke Surgeons that I have now been a part of.

Barr: It's a pretty awesome accomplishment.

Dr. Gulack: Yes, I get chills just thinking about it. People ask me, my non-medical friends who still can't figure out how it is that I'm still on training and that I'm still not done, and they see all these pictures on Facebook of another graduation. They stopped saying congratulations a long time ago. When they ask what I am now, I say I am a board eligible general surgeon, which of course means nothing to them. It is kind of amazing to think how these seven years have gone by. 2011 when I got in, how much different things were then.

Barr: Any other major differences that we haven't talked about.

Dr. Gulack: Within Duke, not really. There's been a growth obviously. Duke Raleigh wasn't around. There have been increasing volumes in some of these places. One of the changes that unfortunately we've seen, and the question is how do we make up for it, is there's been a loss of independence in the OR. Before I got here, at the VA, the attendings were across the street at Duke while you're operating at the VA alone. Is that right? No. If you get into trouble, there's no one there to bail you out.

But there is a happy medium where you get some time alone in the OR with attending either unscrubbed doing some work on their laptop on the side or in the second OR but always available if you need them. And always just coming back every like half-hour, looking over your shoulder making sure things are going right. I remember my first alone hernia at the VA. When an attending is with you, you don't realize how much they're setting you up.

You get this feeling like, "I can do this operation, easy" and then they're not there and you have an intern or a junior resident that you're taking to the operation and you're just like, "This looks different, why is the view not as good as when Pappas setup my hernia." You get a chance to struggle a little bit and then figure it out. That was the day I learned how to do hernia was the day I did alone. I knew the steps, but that was the day I figured out okay, so I had to retract here, retract here and see this, et cetera.

There's some attendings that get it and who are remarkable and let you have some autonomy. Dr. Blazer, Dr. Pappas, Dr. Barbas, will say, "Hey, you want to start this? You get this started and I'll be right here but won't say anything or will be in the other OR," and you call in and really still give you that chance, but there are a lot of attendings who don't get that. I don't blame them. I think it's a changing culture partly related to outcomes. With NSQUIP and all the other outcomes that we're following, everyone has gotten a lot more concerned about their outcomes.

The sad part of that is that there are data that show that if a resident is involved in your case, now this isn't showing resident alone v. resident with an attending, but Residents being involved in your case does nothing different for the patient. There's no change in outcomes except it increases the operating time and it increases your SSI rate. Not because residents are dirty but operative time increases your SSI rate so most likely, the longer your OR time, the more likely you'll have an SSI.

I don't think what we were doing was dangerous. I think that maybe it increased the operative time, but because of this everyone is being very concerned about that and

everyone wants to do it their way. So we have had this loss of independence. For all of us, we're going to finishing school in fellowship. It doesn't really matter for us, I don't need to be independent year. But for general surgeons, if you actually were to be program where you're sending off general students to the world, you almost need another year now where you're a junior faculty type position but where you still call people in to help when you need them while you're still having that independence growth.

That's been one of the changes. When I got here, my chiefs would still be doing cases alone and now I can count on two hands the number of cases that have really gotten not even the whole case alone but just a good hour and a half to get the Whipple started before the attending comes in to help out. How to change that, I don't know. That's a question you guys. It's nationwide. It's something that we talked about a lot on the interview with my fellow Pediatric surgery applicants. Hopefully one of us will figure it out.

Barr: Is there anything else that I haven't asked you that you want to talk about regarding your time here at Duke.

Dr. Gulack: No. I think we've covered it all, the story of Brian Gulack. If I had thought about it ahead of time, I could have written down some stories that I wanted to make sure you got on tape, some embarrassing stories about my co-residents or something.

Barr: Surely you have one about Danny, everyone seems to.

Dr. Gulack: My favorite Danny Nussbaum story is always going to be--- As you work your way through residency, you try to avoid it, you're eventually going to have a procedure named after you or a technique or something like that. The Brian Gulack, unfortunately, there's three Brian Gulack's now. One of the Gulack's, I think "Gulack 1" is using the LigaSure and forgetting to press the burn button before cutting. This happened three times.

One time I did it on purpose because I didn't think it was a little vein. I thought it was just a piece of adhesive tissue. It turned out to be a vein. One time, they didn't plug the LigaSure in. So I actually pushed the button but then it didn't fire, there's a loud OR I didn't hear the absence of the beep, and I still cut it. Unfortunately, both of those were the same attending and she will never let me have that down because that was, unfortunately, our pediatric surgeon, Dr. Tracy. Now, it'll forever be something ingrained into me.

Then the third time Danny Nussbaum was in the room talking to us. This is a classic case of when your attention is off. I was talking to Danny as I was coming across the mesentery of the small bowel and forgot to hit burn, and so bleeding starts for a second until we quickly grab it. Dr. Shah thought that there was something wrong with the device at first like, "Oh, throw that device off, it's bad." I was like, "No, I forgot which button you push first, sir."

I'm trying to remember the Gulack 2.. I think they were trying to make the Gulack 2 getting into the bladder. I got into the bladder twice while doing a sigmoid, a colovesicular fistula. Taking the sigmoid off the bladder, that happened sometimes. That wasn't as embarrassing as the other one. I can't remember what the third one is.

The Danny Nussbaum 1 is stabbing yourself in the operating room, in the belly. Nussbaum was unfortunately handed a scalpel. It was a miscommunication between him and the scrub tech. He asked for some instrument and he accidentally got a scalpel instead. Not only did he get a scalpel, somehow got the scalpel handed to him in his hand backwards. He is looking over into the patient and puts his hand out and he goes to readjust the instrument on his belly to re-adjust it up his hand and stabs himself. Luckily it was just a little skin nick by the time it got through the gown and srubs, but still. He goes, "Ow," and then "I think I needed to scrub out." That is the Danny Nussbaum 1, It's stabbing yourself with a scalpel somewhere besides your hands.

Then, the Danny Nussbaum 2, is the operation he did with Cox where he was opening up the arm to do it. According to Dr. Cox, the technical definition is when you have to change the operation based on the mistake you made during skin incision. While they are opening up their arms to do a BC fistula, he somehow went straight into the brachial artery with his knife, so changed the operation.

Danny Nussbaum, Jeff Keenan, and I were very close for the last seven years and I'm trying to remember if there's Keenan story. The kid is so damn meticulous. It's unfortunate. Keenan will always go down as one of the best residents that I've had the pleasure of working with. Cam McCoy and Jeff Yang, who were the five of us who made it from start to finish together. Everyone else has been phenomenal as well but those guys all have their own thing.

Cam McCoy is always just cool and calm and collected. I remember being asked once, I'm the loud guy, I remember being asked by the chief who said, "Why can't you be more like Cam McCoy?" Which is something I am repeating a lot now that I am finishing chief year. I go up to Cam and say, "Cam, the most touching words ever said to me during residency were, 'why can't I be more like Cam McCoy?' and everyday I've waken up since and asked myself that.

Jeff Yang -- A lot of people are saying recently, they're saying, "I'm going to be nice to Jeff Yang now because when I work for him in the future, I want him to like me." He's going to become a chair. He gave one of the best chief talks I've ever seen. Just going from the inspiration very quickly into, this is thoracic surgery, these are some things we're working on and here are all the studies that I've done that that have plugged up these holes.

Not only that but then did shoutouts to other residents who've done great work and who have had plenary presentations in Thoracic surgery that he had the pleasure of working with. I don't think he meant to do this, but it showed the amount of things he had his hand in and wouldn't have gotten done if he wasn't around. For a lot of those

plenaries, he was the one who instigated the project in the first place. It was just a phenomenal talk. He's going to make such a great researcher.

It makes me a little sad. He went into the lab to do basic science. He had a basic science grant. His most successful material was in clinical research and he will be an amazing clinical researcher. I feel bad that he kind of lost the taste for the basic science. But he will make some amazing changes in thoracic surgery.

One of the saddest things about general surgery is that we all go off into our different fields, and so it's not like, "Oh, I'll see him at thoracic conferences from now on," because he is not going to be there. Every once in a while we might be at ACS together, but you are not going to see these guys at your specialty conferences or be able to shoot questions off them and say, "Hey I was doing this and it didn't work and things like that." But a remarkable group of guys.

There's one time when I was a junior resident. Cam McCoy had just come off 222, our consult resident service. He decided to play a prank on me. Everyone always hates the peri-rectal abscesses. He sent me a page with a patient's room number and a fake name and he said "sorry but I just got this and can you take care of this pararectal abscess?" so I said sure. So I go up and talk to the patient and did not look in the chart ahead of time to get the information. Sometimes I like to talk the patient ahead of time to get first person perspective. I talked to the patient and he was like "I've been having all these peri-rectal issues," not realizing that this was not a real patient. I did the ano-rectal exam, the digital exam and everything. I said "I don't feel one there, but you have been having pain when you defecate." And he said, "yea, a lot of pain when I defecate." Then I come down and talk to John Scarborough, who was one. I start telling him the story. And he goes, "how do you know this guy has a pararectal abscess? There's no imaging, the story is not great." I said, "Well, I got this page..." and then I read the page and realized the names did not match. So I called Cam and asked him what was going on, and he confessed to the prank. Scarborough, being the gentleman that he is, said "don't tell anyone about this and I won't tell anyone about this. It's fine." Unfortunately, he's married to Kyla Bennet. He told Kyla probably within half an hour, and Kyla told the rest of the residency. That one was a hard one to live down for a little while.

I became a better surgeon as I became more meticulous. It's funny to think about the things that you learn through residency. Day 3 I was on trauma. We had a level 3 come in, a kid, I think he was 17, high speed MVC. Primary and secondary survey were pretty clean. Got a chest Xray to rule out a pneumothorax. My chief at the time, Dawn, goes, "Brian just look at the CXR and if it looks good, you can send him out of here." I pulled up the CXr, it looked clean, and I was getting ready to discharge him. She calls me about 45 minutes later and say, "Brian, you are sending this patient home? Take a look at the CXR with me." I pulled up the x-ray and it turns out that he has a pneumothorax. She goes, "Do you think this is a clean x-ray?" I realized that it had been from actually two years before and I pull up the wrong film. Now I always remember to check the name and date every time I look at a film. Everyone's going to make mistakes, and you're going to get worked up over it. Everybody makes

mistakes. The important thing is `that you learn from that mistake. It all makes sense, it was long ago.

Barr: Thanks for joining us we really appreciate it.

Dr. Gulack: My pleasure.

Barr: Pleasure to have you, good luck.

[00:57:30] [END OF AUDIO]