Supplementary Online Content

Healy JM, Davis KA, Pei KY. Comparison of internal medicine and general surgery residents' assessments of risk of postsurgical complications in surgically complex patients. JAMA Surg. Published online October 11, 2017. doi:10.1001/jamasurg.2017.3936

eFigure 1. Scenario 1 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

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eFigure 10. Subgroup Analysis: Internal Medicine and Surgery Senior Residents Have Similar Estimates of Surgical Risk

This supplementary material has been provided by the authors to give readers additional information about their work.
eFigure 1. Scenario 1 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

A 74 year old woman with history of hypertension and rheumatoid arthritis on chronic steroids presents with fulminant *C. difficile* colitis. She is in MICU on norepinephrine and vasopressin, anuric with creatinine of 3.5. Her BMI is 39.9. Required operation is a total abdominal colectomy with ileostomy.
eFigure 2. Scenario 2 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

78 year old man with insulin dependent diabetes and hypertension presents with perforated duodenal ulcer. He lived in an assisted living facility and is currently oliguric on norepinephrine. He sustained MI 6 years ago but has had no further cardiac events since. His BMI is 24.4. Required procedure is omental patch for the perforation.
eFigure 3. Scenario 3 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

49 year old man with cirrhosis MELD 15, ascites, dyspnea at rest, and smoker presents with painful, incarcerated inguinal hernia. Required surgery will be emergent repair of inguinal hernia. His BMI is 24.4
52 year old man with failing liver transplant on chronic steroids, baseline hypertensive, active smoker, dyspnea on exertion presents with intra-abdominal free air. He has marginal urine output and waxing and waning mental status, although he is not currently on pressors. Required operation is exploratory laparotomy.
eFigure 5. Scenario 5 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

A 48 year old mentally retarded man who lives in a chronic nursing facility, who has a history of dialysis dependent ESRD presents with perforated viscous most likely small bowel in origin which will require enterectomy with enterostomy. His BMI is 19.9
**eFigure 6.** Scenario 6 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

87 year old man in MICU with history of CHF, dyspnea on exertion, current smoker, and ascites from his CHF develops emphysematous cholecystitis with severe sepsis. Required surgery is laparoscopic cholecystectomy with intraoperative cholangiogram. His BMI is 23.1. He lived in a assisted living facility.
eFigure 7. Scenario 7 Representative of a Diverse Emergency General Surgery Practice in Complex Patients Likely to Be Comanaged by Medical and Surgical Services

66 year old, diabetic, hypertensive woman with diagnosis of inflammatory breast cancer underwent chemoradiation therapy. She was on steroids for Lupus. Her BMI is 38. The proposed operation is total mastectomy.
eFigure 8. Subgroup Analysis: Internal Medicine Senior Residents Significantly Overestimate Risk Compared to Internal Medicine Interns
**eFigure 9.** Subgroup Analysis: Surgery Senior and Junior Residents Have Similar Estimates of Surgical Risk

![Subgroup Analysis Chart](chart.png)

- Junior Resident
- Senior Resident
- *p-value < 0.05

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eFigure 10. Subgroup Analysis: Internal Medicine and Surgery Senior Residents Have Similar Estimates of Surgical Risk